PATIENT INFORMATION (CONFIDENTIAL)

Name_____ Date_____
(First) (Middle Initial) (Last)

Address_____ City_____ State_____ Zip_____

E-Mail_____

Wk # _____ Hm # _____ Cell # _____ Birthdate _____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Spouse/Guardian Name _____

If College Student, FT / PT, Name of School _____

Whom may we thank for referring you? _____

Person to contact in case of an emergency _____ phone _____

RESPONSIBLE PARTY – (Responsible for paying account)

Name_____ Relationship to Patient_____

Address_____

Driver's License_____ Birthdate_____

Is this person currently a patient in our office? ☐ Yes ☐ No

DENTAL INSURANCE INFORMATION

Name_____ Relationship to Patient_____

Birthdate_____ SS# / ID# _____

Employer _____ wk # _____

Insurance Carrier _____ Phone _____ Grp # _____

Ins Address _____ City_____ State _____ Zip_____

DO YOU HAVE ADDITIONAL DENTAL INSURANCE? ☐ YES ☐ NO IF YES, COMPLETE THE FOLLOWING:

Name_____ Relationship to Patient_____

Birthdate_____ SS# / ID# _____

Employer _____ wk # _____

Insurance Carrier _____ Phone _____ Grp # _____

Ins Address _____ City_____ State _____ Zip_____

Patient/Guardian Signature_____ **Date** _____

REGISTRATION

PATIENT NAME_____ **Date of Birth**_____

ALTHOUGH DENTAL PERSONNEL PRIMARILY TREAT THE AREA IN AND AROUND YOUR MOUTH, YOUR MOUTH IS A PART OF YOUR ENTIRE BODY. HEALTH PROBLEMS THAT YOU MAY HAVE, OR MEDICATION THAT YOU MAY BE TAKING, COULD HAVE AN IMPORTANT INTERRELATIONSHIP WITH THE DENTISTRY THAT YOU WILL BE RECEIVING. THANK YOU FOR ANSWERING THE FOLLOWING QUESTIONS.

	YES	NO
1. Are you in good health	☐	☐
2. Have there been any changes in your general health within the past year . . .	☐	☐
3. Date of your last physical exam:_____		
4. MD's Name _____ Phone #_____		
5. Are you now under the care of a physician	☐	☐
6. Have you been hospitalized – explain: _____ _____		
7. Please list medications (including non prescriptions) _____		
8. Have you had abnormal bleeding	☐	☐
9. Do you bruise easily	☐	☐
10. Have you ever had a blood transfusion	☐	☐
11. Have you had a recent weight loss	☐	☐
12. Have you ever taken Fen-Phen/Redux	☐	☐
13. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing Bisphosphonates	☐	☐
14. Have you taken Viagra, Revatio, Cialis or Lavitra in the last 24 hours	☐	☐
15. Do you use tobacco	☐	☐
16. Do you or have you used controlled substances	☐	☐
17. Do you wear contact lenses	☐	☐
18. Do you have a persistent cough	☐	☐
19. Do you have any disease, condition or problem not listed above I should know about	☐	☐
Women Only:		
Are you pregnant or think you may be pregnant	☐	☐
Are you nursing	☐	☐

	YES	NO
ARE YOU ALLERGIC TO OR HAVE YOU HAD REACTIONS TO:		
Local Anesthetics Like Novocaine	☐	☐
Penicillin or other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates, Sedatives or Sleeping Pills	☐	☐
Aspirin	☐	☐
Iodine	☐	☐
Any Metals (Nickel, Mercury, Etc.)	☐	☐
Latex / Rubber	☐	☐
Anything not listed _____		
DO YOU HAVE OR HAVE YOU EVER HAD THE FOLLOWING:		
Rheumatic Heart Disease/ Rheumatic Fever	☐	☐
Scarlet Fever	☐	☐
Heart Defect or Heart Murmur	☐	☐
Heart Trouble, Heart Attack or Angina	☐	☐
Chest Pains	☐	☐
Shortness of Breath	☐	☐
Pacemaker	☐	☐
Heart Surgery	☐	☐
High/Low Blood Pressure	☐	☐
Congenital Heart Problem	☐	☐
Swelling of Feet, Ankles, Hands	☐	☐
Hepatitis, Jaundice or Liver Disease	☐	☐
Stroke	☐	☐
Sinus Trouble	☐	☐
Lung or Breathing Problems	☐	☐
Asthma or Hay Fever	☐	☐
Eating Disorders	☐	☐
Hypoglycemia	☐	☐
Cold Sores/Fever Blisters	☐	☐
Hives or Skin Rash	☐	☐
Fainting or Dizzy Spells	☐	☐
Diabetes	☐	☐
Aids or HIV Infections	☐	☐
Thyroid Problems	☐	☐
Allergies	☐	☐
Arthritis or Rheumatism	☐	☐
Joint Replacement or Implant	☐	☐
Stomach Ulcer	☐	☐
Kidney Trouble	☐	☐
Tuberculosis	☐	☐
Persistent Cough	☐	☐
Cough that Produces Blood	☐	☐
Chemotherapy (Cancer, Leukemia)	☐	☐
Sexually Transmitted Disease	☐	☐
Epilepsy or Seizures	☐	☐
Anemia	☐	☐
Glaucoma	☐	☐
Nervousness	☐	☐
Tonsillitis	☐	☐
Tumors	☐	☐
Mental Health Care	☐	☐
Back Problems	☐	☐
Chemical Dependency	☐	☐
Mitral Valve Prolapse	☐	☐
Cortisone Treatment	☐	☐

MEDICAL HEALTH HISTORY

PATIENT NAME_____ **Date of Birth**_____

Reason for this visit_____

When was your last dental visit_____What was done then_____

How often did you visit the dentist before then_____

General Dentist _____ Prior (if less than 2 yrs)_____

Have you had a complete series of x-rays taken (when/where)_____

How often do you brush your teeth_____ How often do you floss_____

Type of toothbrush used_____

Is your drinking water fluoridated_____

	YES	NO		YES	NO
Do your gums bleed while brushing/flossing	☐	☐	Do you bite your lips or cheeks frequently	☐	☐
Are your teeth sensitive to hot or cold	☐	☐	Have you noticed any loosening of your teeth	☐	☐
Are your teeth sensitive to sweet or sour foods	☐	☐	Does food get caught between your teeth	☐	☐
Do you feel pain to any of your teeth	☐	☐	Have you ever had periodontal treatment	☐	☐
Do you have any sores or lumps in or near			Ever worn a bite plate or other appliance	☐	☐
Your mouth	☐	☐	Have you ever had any difficulty with extractions	☐	☐
Have you had any head, neck or jaw injuries	☐	☐	Have you had prolonged bleeding after extractions	☐	☐
Have you ever experienced any of the following problems in your jaw?					
Clicking	☐	☐			
Pain (joint, ear, side of face)	☐	☐	Do you wear Dentures or Partials	☐	☐
Difficulty in opening or closing	☐	☐	If yes, date of placement_____		
Difficulty in Chewing	☐	☐			
Do you have frequent headaches	☐	☐	Have you ever received oral hygiene instruction		
Do you clench or grind your teeth	☐	☐	regarding the care of your teeth and gums	☐	☐

If you could change anything about your smile, what would you change?_____
_____

AUTHORIZATION AND RELEASE

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION TO THE BEST OF MY KNOWLEDGE. THE ABOVE QUSTIONS HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I AUTHORIZE THE DENTIST TO RELEASE ANY INFORMATION INCLUDING THE DIAGNOSIS AND THE RECORDS OF ANY TREATMENT OR EXAMINATION RENDERED TO ME OR MY CHILD DURING THE PERIOD OF SUCH DENTAL CARE TO THIRD PARTY PAYORS AND/OR HEALTH PRACTITIONERS.

I AUTHORIZE AND REQUEST MY INSURANCE COMPANY TO PAY DIRECTLY TO THE DENTIST INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I UNDERSTAND THAT MY DENTAL INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL BILL FOR SERVICES. I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON MY BEHALF OR MY DEPENDENTS.

PATIENT/GUARDIAN SIGNATURE _____ **DATE** _____

DOCTOR'S COMMENTS _____

_____

Doctor Signature _____ Date _____

DENTAL HEALTH HISTORY

HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information
(Required by Health Insurance Portability and Accountability Act – 45 CFR Parts 160 and 164)

1. I hereby authorize **DR. CHRIS CARNEY AND STAFF** to use and/or disclose the protected health information described below to the follow people:

   a) My referring dentist: DR. _____

   b) My physician: DR. _____ Phone: _____

   c) Family Member(s): _____

2. Authorization for Release of Information. (check one)
   - ☐ Covering the period of health care from past, present and future periods
   - ☐ Covering the period of health care from _____ to _____

   Check one

3.
   - ☐ I hereby authorized release of my complete health record (including records relating to mental health care, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).
   - ☐ I hereby authorized release of my complete health record with the exception of the follow information. (circle which applies)
     - Mental health records
     - Communicable diseases (including HIV and AIDS)
     - Alcohol/drug abuse treatment
     - Other (please specify) _____

   Check one

4. This medical information may be used by the person(s) I authorize to receive this information medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization shall be in force and effect until I choose to revoke the authorization, at which time the authorization will be considered expired.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Printed Name Relationship to Patient

ProSoft
Implantology & Periodontics, PLLC
by Christopher M. Carney, D.D.S., M.S.

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY
We are required by applicable federal and state law to maintain the privacy of your health information. We are also required by law to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in the Notice while it is in effect. This Notice takes effect April 14, 2003 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make changes in our privacy practices effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make a new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION
We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your healthcare information to obtain payment for services we provided to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations, including quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing, or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or health operations, you may give us written authorization to use your health authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it is in effect. Unless you give us written authorization, we cannot use or disclose your health information for any reason except those described in the Notice.

To Your Family and Friends: We must disclose your health information to you as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, or your location your general condition or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communication without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Christopher M. Carney, DDS, MS
www.ProSoftPerio.com
1759 Broad Park Circle South, Ste. 109, Mansfield, TX 76063 Ph: 817-225-6600 Fax: 817-225-6601

Abuse or Neglect: We may disclose or your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence and other national activities. We may disclose to correctional institutions or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get or get copies of your health with limited exceptions. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for the expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you per page. If you prefer we will prepare a summary or an explanation of your health information for a fee.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative mean or to alternative location. (You must make your request in writing). Your requests must specify the alternative means and location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing and it must explain why the information should be amended). We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our website or by electronic mail (email), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at an alternative location, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Human Services. You will find the address listed below.

We support your right to the privacy of your health information. We will not retaliate in any way if you chose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer:

Dr. Christopher M. Carney
1759 Broad Park Circle S, #109
Mansfield, TX 76063
817-225-6600

For more information about HIPPA or to file a complaint:
U. S. Department of Health & Human Services
200 Independence Ave. SW
Washington, DC 20201
877-696-6775

_____

Signature