

PATIENT INFORMATION AND HEALTH HISTORY

Welcome! So that we may provide you with the best possible care, please complete both sides of this medical/dental history form. All information is completely confidential.

DATE _____

DR., MR., MRS., MISS _____ PATIENT NAME _____ DATE OF BIRTH _____

ADDRESS _____ SS# _____

CITY _____ STATE _____ ZIP _____ HOME PHONE _____

E-MAIL _____ CELL PHONE _____

PREFERRED METHOD OF CONTACT (Circle all that apply)

EMAIL

CELL

TEXT

HOME

WORK

YOUR EMPLOYER _____

DENTAL INSURANCE (IF ANY) _____

EMERGENCY CONTACT _____ PHONE _____

NEAREST RELATIVE NOT LIVING WITH YOU _____ PHONE _____

HOW DID YOU HEAR OF OUR PRACTICE: _____

MEDICAL HISTORY

PHYSICIAN'S NAME _____ DATE OF LAST PHYSICAL EXAM _____ PHONE _____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING - PLEASE CHECK

(You can provide additional information on the lines at the bottom of this page.)

Heart (Surgery, Disease, Attack)	<input type="checkbox"/>	Artificial Joints (hip, knee, etc.)	<input type="checkbox"/>	Hepatitis A (infectious) B (serum)	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	Kidney Trouble	<input type="checkbox"/>	Hepatitis C	<input type="checkbox"/>
Congenital Heart Disease	<input type="checkbox"/>	Excessive Bleeding from Cuts/Extractions	<input type="checkbox"/>	Venereal Disease	<input type="checkbox"/>
Heart Murmur - Functional	<input type="checkbox"/>	Coumadin/Blood Thinners	<input type="checkbox"/>	A.I.D.S.	<input type="checkbox"/>
Heart Murmur - Nonfunctional	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	H.I.V. Positive	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Blood Transfusion	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>
Mitral Valve Prolapse	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	Bisphosphonates	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	Chronic Cough	<input type="checkbox"/>	Liver Disease or Jaundice	<input type="checkbox"/>
Artificial Heart Valve	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	Neurological Disorders	<input type="checkbox"/>
Cardiac Stents	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Epilepsy or Seizures	<input type="checkbox"/>
Heart Pacemaker	<input type="checkbox"/>	Hay Fever/Allergies	<input type="checkbox"/>	Fainting/Dizzy Spells	<input type="checkbox"/>
Atrial Fibrillation	<input type="checkbox"/>	Sinus Trouble	<input type="checkbox"/>	Nervous/Anxious	<input type="checkbox"/>
Arthritis/Rheumatism	<input type="checkbox"/>	Tumors/Malignancies	<input type="checkbox"/>	Psychiatric/Psychological Care	<input type="checkbox"/>
Cortisone Medicine	<input type="checkbox"/>	Radiation Therapy ..	<input type="checkbox"/>	Parkinson's Disease	<input type="checkbox"/>
Swollen Ankles	<input type="checkbox"/>	Chemo-Therapy ..	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	Previous History of Cancer	<input type="checkbox"/>	Sleep Apnea/Snoring	<input type="checkbox"/>

Women. Are you pregnant? Yes No Nursing? Yes No Taking birth control pills? Yes No

Have you ever had a reaction to dental anesthesia? Yes No Are you allergic to latex or examination glove powder? Yes No

Have you ever had an allergy or reaction to any medication or drugs? Yes No What? _____

Additional Information: _____

DENTAL HISTORY

WHAT IS THE REASON FOR YOUR VISIT TODAY? _____

DATE OF LAST DENTAL VISIT _____ LAST DENTAL CLEANING _____

LAST FULL MOUTH X-RAYS: _____ PREVIOUS DENTIST NAME: _____

DO YOU HAVE OR DO YOU USE ANY OF THE FOLLOWING - INDICATE WITH A (✓)

<input type="checkbox"/> Teeth sensitive to cold, heat, sweets or pressure?	<input type="checkbox"/> Clenching or grinding	<input type="checkbox"/> Serious injury of mouth or head
<input type="checkbox"/> Bleeding gums. How long_____	<input type="checkbox"/> A biteguard	<input type="checkbox"/> Cigarettes, pipe, cigar smoking, chewing tobacco
<input type="checkbox"/> Food impaction. Where_____	<input type="checkbox"/> Have tired jaws, especially in the morning	<input type="checkbox"/> Texture of toothbrush_____
<input type="checkbox"/> Loose teeth	<input type="checkbox"/> Bad breath, unpleasant taste	<input type="checkbox"/> Frequency of brushing_____
<input type="checkbox"/> Burning of tongue	<input type="checkbox"/> Complications from extractions	<input type="checkbox"/> Dental Floss
<input type="checkbox"/> Swelling or lumps in mouth	<input type="checkbox"/> Periodontal treatment	<input type="checkbox"/> Inter dental stimulators
<input type="checkbox"/> Frequent blisters on lips/mouth (cold sores, fever blisters)	<input type="checkbox"/> Orthodontic treatment	<input type="checkbox"/> Water jet device
<input type="checkbox"/> Pain around ear	<input type="checkbox"/> Mouth breathing	<input type="checkbox"/> Disclosing tablets or solutions
<input type="checkbox"/> Unusual sounds in ear while eating	<input type="checkbox"/> Oral habits, i.e. fingernail biting, cheek biting, etc.	<input type="checkbox"/> Fluoride supplements

Are you satisfied with your teeth's appearance? Yes No

Do you expect to keep all of your teeth the rest of your life? Yes No

Do you feel nervous about dental treatment? Yes No

Have you ever had an upsetting dental experience? Yes No

If so, what is your biggest concern_____

If yes, please describe_____

Is there anything else about dental treatment you would like us to know? Yes No

If yes, please describe_____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all the questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

I agree to be responsible for payments of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made.

Patient _____ Date _____

HISTORY REVIEW

DOCTOR'S SIGNATURE: _____ DATE: _____

Medical History Medication List

Patient: _____

Date: _____

Please write down the names and doses of any medications you are currently taking:

1) _____

2) _____

3) _____

4) _____

5) _____

6) _____

7) _____

8) _____

9) _____

10) _____

11) _____

12) _____

Please write down the name, address and phone number of your current physician:

Name: _____

Address: _____

Phone: _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, HOW YOU CAN GET ACCESS TO THIS INFORMATION, YOUR RIGHTS CONCERNING YOUR HEALTH INFORMATION AND OUR RESPONSIBILITIES TO PROTECT YOUR HEALTH INFORMATION.
PLEASE REVIEW IT CAREFULLY.

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We are required to abide by the terms of this Notice of Privacy Practices. This Notice will take effect on 5-14-13 and will remain in effect until it is amended or replaced by us.

We reserve the right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer, Beverly Peter. Information on contacting us can be found at the end of this Notice.

We will keep your health information confidential, using it only for the following purposes:

Treatment: While we are providing you with health care services, we may share your protected health information (PHI) including electronic protected health information (ePHI) with other health care providers, business associates and their subcontractors or individuals who are involved in your treatment, billing, administrative support or data analysis. These business associates and subcontractors through signed contracts are required by Federal law to protect your health information. We have established "minimum necessary" or "need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations, collections or other third parties that may be responsible for such costs, such as family members.

Disclosure: We may disclose and/or share protected health information (PHI) including electronic disclosure with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so. As of March 26, 2013 immunization records for students may be released without an authorization (as long as the PHI disclosed is limited to proof of immunization). If an individual is deceased you may disclose PHI to a family member or individual involved in care or payment prior to death. Psychotherapy notes will not be used or disclosed without your written authorization. Genetic Information Nondiscrimination Act (GINA) prohibits health plans from using or disclosing genetic information for underwriting purposes. Uses and disclosures not described in this notice will be made only with your signed authorization.

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures" of your protected information if the disclosure was made for purposes other than providing services, payment, and or business operations. In light of the increasing use of Electronic Medical Record technology (EMR), the HITECH Act allows you the right to request a copy of your health information in electronic form if we store your information electronically. Disclosures can be made available for a period of 6 years prior to your request and for electronic health information 3 years prior to the date on which the accounting is requested. If for some reason we aren't capable of an electronic format, a readable hardcopy will be provided. To request this list or accounting of disclosures, you must submit your request in writing to our Privacy Officer. Lists, if requested, will be \$____ for each page and the staff time charged will be \$____ per hour including the time required to locate and copy your health information. Please contact our Privacy Officer for an explanation of our fee structure.

Right to Request Restriction of PHI: If you pay in full out of pocket for your treatment, you can instruct us not to share information about your treatment with your health plan; if the request is not required by law. Effective March 26, 2013, The Omnibus Rule restricts provider's refusal of an individual's request not to disclose PHI.

Non-routine Disclosures: You have the right to receive a list of non-routine disclosures we have made of your health care information. You can request non-routine disclosures going back 6 years starting on April 14, 2003.

Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, insurance operations, health care clearinghouses and individuals performing similar activities.

Required by Law: We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.)
We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

Abuse or Neglect: We may disclose 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. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so. Effective March 26, 2013, we are required to obtain an authorization for marketing purposes if communication about a product or service is provided and we receive financial remuneration (getting paid in exchange for making the communication). No authorization is required if communication is made face-to-face or for promotional gifts.

Fundraising: We may use certain information (name, address, telephone number or e-mail information, age, date of birth, gender, health insurance status, dates of service, department of service information, treating physician information or outcome information) to contact you for the purpose of raising money and you will have the right to opt out of receiving such communications with each solicitation. Effective March 26, 2013, PHI that requires a written patient authorization prior to fundraising communication include: diagnosis, nature of services and treatment. If you have elected to opt out we are prohibited from making fundraising communication under the HIPAA Privacy Rule.

Sale of PHI: We are prohibited to disclose PHI without an authorization if it constitutes remuneration (getting paid in exchange for the PHI). "Sale of PHI" does not include disclosures for public health, certain research purposes, treatment and payment, and for any other purpose permitted by the Privacy Rule, where the only remuneration received is "a reasonable cost-based fee" to cover the cost to prepare and transmit the PHI for such purpose or a fee otherwise expressly permitted by law. Corporate transactions (i.e., sale, transfer, merger, consolidation) are also excluded from the definition of "sale."

Appointment Reminders: We may use your health records to remind you of recommended services, treatment or scheduled appointments.

Access: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian.) We will provide access to health information in a form / format requested by you. There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the request form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. Copies, if requested, will be \$____ for each page and the staff time charged will be \$____ per hour including the time required to copy your health information. If you want the copies mailed to you, postage will also be charged. Access to your health information in electronic form if (readily producible) may be obtained with your request. If for some reason we aren't capable of an electronic format, a readable hardcopy will be provided. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our Privacy Officer for an explanation of our fee structure.

Amendment: You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Breach Notification Requirements: It is presumed that any acquisition, access, use or disclosure of PHI not permitted under HIPAA regulations is a breach. We are required to complete a risk assessment, and if necessary, inform HHS and take any other steps required by law. You will be notified of the situation and any steps you should take to protect yourself against harm due to the breach.

QUESTIONS AND COMPLAINTS

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us in writing. Request a Complaint Form from our Privacy Officer. We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services. **HOW TO CONTACT US:**

Practice Name: Charles A. Peter, DMD, PL Privacy Officer: Beverly Peter

Telephone: 727-785-7202 Fax: 727-785-6985

Email: drpeter@drcharlespeter.com

Address: 29605 US Hwy 19 North, Suite 310, Clearwater, FL 33761

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES / USE AND DISCLOSURE FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. We provide this form to comply with the Health Insurance Portability and Accountability Act (HIPAA). Please review the Notice of Privacy Practices thoroughly before signing this acknowledgement form. If terms of our Notice change, a revised copy will be made available to you.

By signing this form, you acknowledge that our practice may use and disclose PHI about you for treatment, payment and healthcare operations. You have the right to request that we restrict how PHI about you is used or disclosed for treatment, payment or healthcare operations.

Signature of Patient or Legal Representative

Date

Printed Name of Patient

Legal Relationship to the Patient
(If required)

We cannot discuss your health information with anyone other than yourself unless you authorize us to do so. Please list below names of the individuals you authorize our office to discuss care with.

I give you permission to share my health information with:

1. Name _____ Relationship _____ Phone _____
2. Name _____ Relationship _____ Phone _____

Consent to email or text for appointment reminders and other healthcare communication.

If you approve, we may contact you via email and/or text messaging to remind you of an appointment or provide general health reminders or information. I understand that once I have consented to receive communications via text or email, I still have the right to revoke the consent at any time.

The cell phone number I authorize to receive text messages for appointment reminders and general health information is _____. Please initial _____.
Or

_____ I decline to receive communications via text.

_____ I decline to receive communications via email.

Revocation – Use this area to document revocation of a previous form of communication.

_____ I hereby revoke my request to receive future appointment reminders or healthcare updates via text.
_____ I hereby revoke my request to receive future appointment reminders or healthcare updates via email.

Patient signature _____ Date requested: _____

Reminder - Keep information to the minimum necessary and encrypt emails and texts whenever possible

HIPAA Acknowledgement of Receipt of the Notice of Privacy Practices 2018

This form does not constitute legal advice and covers only federal, not state, law.