Date___/____/_____

Welcome to our practice! We are glad you are here. Please take a few minutes to give us the following information. Th more detailed you are with these questions the better we can serve you.
Our goal is to provide for you in all of your dental needs.

Patient information

Name_____preferred name_____

Male Female Date of birth ___/_____/_____Age_____ S.S.#_____

Address_____ Home #(_____)_____
City:_____Zip Code:_____ Cell #(_____)_____
Work #(_____)_____

E-mail_____Best way to reach you_____
Marital status_____ Employer_____

Whom may we thank for referring you?_____

Last dentist_____Last visit_____

Emergency contact

Name_____ Home number (___)_____
Cell number (____)_____ Work number (___)_____

Insurance information

Primary

Insurance Co. Name_____

Insurance Co. Phone #_____group#_____

Policy Holder's Name_____relation_____

Policy Holder's DOB____/_____/_____Policy Holder's S.S. or I.D#_____

Secondary

Insurance Co. Name_____

Insurance Co. Phone #_____group#_____

Policy Holder's Name_____relation_____

Policy Holder's DOB____/_____/_____Policy Holder's S.S. or I.D#_____

Read the following general health questions and answer by circling Y for yes or N for no

Are you allergic to, or have had a poor reaction to any of the following?

Y/N Dental anesthetics

Y/N Aspirin/ibuprofen

Y/N Latex

Y/N Sulfites

Y/N Penicillin or other anti-biotics

Y/N Any metals

Y/N Others

Y/N Codeine

Y/N Are you under the active care of a physician, or have any present medical issues?
Please explain_____

_____

Y/N Do you need to premedicate with antibiotics for any conditions prior to a dental visit? Please explain_____

_____

_____

Are you taking any of the following medications?

Y/N Antacids
Y/N St john's wart or kava-kava
Y/N Bisphosphonates- fosamax, zometa, actonel
Y/N Dilantin or tegretol
Y/N Coumadin or other blood thinners
Y/N Do you use tobacco? How much per week?_____
Y/N Do you drink alcohol? how much per week?_____
Y/N Do you drink sugary beverages? How many per week?_____
Y/N Do you have any history of substance abuse?
Y/N Do you have high or low blood pressure?

For women:

Y/N are you pregnant?
Y/N are you currently nursing?
Y/N are you taking birth control?

List all current medications you are taking, including over the counter and supplements

_____

_____

_____

Carefully read these conditions and circle those that apply to you:

1. Mital valve prolapse
2. Heart disease/problems
3. Rheumatic or scarlet fever
4. Diabetes
5. Heart murmur
6. Stroke
7. Epilepsy
8. Arthritis
9. Sinus problems
10. Cancer or tumor
11. Venereal disease
12. Radiation therapy
15. Kidney disease
16. Hepatitis
17. HIV+/AIDS
18. Asthma/emphysema
19. Tuberculosis
20. Seizures
21. Alzheimer's disease
22. Anemia
23. Blood transfusion
24. Colitis
25. Difficulty breathing
26. Frequent headaches
28. Herpes/fever blisters
29. Nervous/anxious
30. Thyroid problems
31. Ulcers
32. Abnormal bleeding

13. Hip/joint replacement
14. Liver disease
27. Hemophilia

Read the following dental health questions and answer by circling Y for yes or N for no

Y/N Are your teeth darkened, or stained?

Y/N Are there spaces between any of your teeth?

Y/N Are your gums red, puffy, or do they bleed?

Y/N Do you have any old crowns that have dark edges?

Y/N Have you ever had orthodontic treatment? **Y/N** If yes, do you still wear your retainer?

Y/N Do you have any gray or silver (mercury) dental fillings in your teeth that you want to replace?

Y/N Do you grind your teeth or are any of the biting edges of your teeth chipped or worn?

Y/N Have you ever experienced pain or discomfort in your jaw joint? (TMJ/TMD)

Y/N Do you experience general sensitivity to cold things on your teeth?

Y/N Would you be concerned if you lost your teeth and had to wear false teeth?

Y/N Have you ever had trouble getting numb and/or had reactions to local anesthetic?

Y/N Do you snore frequently or heavily?

Y/N Do you experience severe daytime drowsiness?

Y/N Have you ever been told you "stop breathing" while sleeping?

How you do you feel about the appearance of you teeth?_____

Have you ever considered changing your smile?_____

How often do you brush?_____Floss?_____

Do you use an electric or manual toothbrush?_____Soft medium hard (circle one)

Do you drink mostly bottled, tap or filtered water?_____

Have you ever had problems associated with previous dental treatment?_____

_____

Do you have any treatment diagnosed by a previous dentist that still needs to be done?_____

_____

Are you fearful of dental treatment? Please explain_____

_____

I have carefully read the questions on these forms and answered to the best of my ability. I understand that the above information is necessary to provide the best, safest and most efficient dental care. I will inform the dentist of any changes to this information and understand it will be held in the strictest of confidence.

Patient (print)_____Patient Signature_____

Dr.'s notes :

Aaron C. Verbarg, D.D.S., P.C.

Financial Policy

We are pleased you selected us for your dental needs. Our aim is to provide you with the highest quality dental care. In order to keep our standard of care to the level that best serves your needs, we ask that you please observe the following requests.

Financial policy: Payment for services is required at the time of your visit unless you make payment arrangements.

Payment arrangements: Cash or check – We offer a 5% discount when paying in full at time of service with cash or check. There is a $25 charge for all returned checks.
Care Credit – Pays for treatment over 6 or 12 months with no interest. Interest will be charged to your account from the purchase date if the promotional purchase is not paid in full within the promotional period or if you make a late payment.

Insurance: If you do have dental insurance we are happy to file the forms necessary to see that you receive the full benefits of your coverage; however we can make no guarantee of any estimated coverage. Because the insurance policy is a contract between you and the insurance company, we ask that all patients be directly responsible for all charges. Please know that we will do everything possible to see that you receive the full benefits of your policy. If for some reason your insurance company has not paid their portion within in 60 days from the date of treatment you are responsible for payment at that time.

Our goal with each of our patients is to help them enjoy the benefits of good oral health. With proper care, they may be able to have strong teeth and gums, a healthy and attractive smile, and keep their own natural teeth for life!

If you have any questions regarding our financial policy, please ask. We are committed to providing you with the most positive experience in dental care.

Patient's Name: _____ Date:_____

Parent/Legal Guardian/Responsible Party Signature:_____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can an will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organizatio has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name _____

Relationship to Patient: _____

Signature: _____

Date _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practice Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:

NOTICE OF PRIVACY PRACTICES

(DENTAL)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include teeth cleaning services.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

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- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of _____, 20___ and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775