Altoona Family Dentistry LLC

NOTICE OF PRIVACY PRACTICE SUMMARY

This summary discloses how Healthcare information about you may be used by Dr. Katherine Dangler. A full notice of your privacy rights has been provided to you.

Treatment, Payment, Operations. We may use health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive.

Uses and Disclosures for Appointment Reminders. We may use and disclose your Healthcare information to contact you as a reminder that you have an appointment at the office. If you request that such communications be made confidentially, please contact our office in writing. We will accommodate all reasonable requests.

Authorization for Use and Disclosure. We will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so.

Public health, research, health and safety, government, works compensation. We may disclose your information for public health activities, research, health and safety, governmental function, and in order to comply with workers compensation laws and regulations.

Rights. You have a right to inspect and copy information used to make decisions about your care, to request an amendment of the information, to an accounting of disclosures, to request communication with you by alternate means, to request restrictions on the information we use, and to revoke your authorization for release of information.

Complaints. You may complain to the Privacy Information Director at (814) 944-8055 or to the Department of Health and Human resources if you believe your privacy rights have been violated. You will not be retaliated against for filing a complaint.

Organization duties. We must maintain the privacy of protected health information, provide you with notice of our legal duties and privacy practice with respect to your health information, abide by the terms of the notice, notify you if we are unable to agree to the requested restriction on how your information is used or disclosed, accommodate reasonable requests you may make to communicate with health information by alternative means or by alternative locations, and obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted under law.

"I acknowledge that I have received the full Privacy Notice."

______________________	______________________	__________
Name (print)	Signature	Date
______________________	______________________	__________
Witness	Signature	Date

DENTAL HISTORY

Name______________________________ Nickname_____________________________ Age_________
Referred by__________________________How would you rate the condition of your mouth? Excellent Good Fair Poor
Previous Dentist ______________________________How long have you been a patient?___________Months/Years
Date of most recent dental exam ______/______/______ Date of most recent x-rays ______/______/______
Date of most recent treatment (other than a cleaning) ______/______/______
I routinely see my dentist every: 3 mo. 4 mo. 6 mo. 12 mo. Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? ____

PLEASE ANSWER YES OR NO TO THE FOLLOWING: **YES NO**

PERSONAL HISTORY

1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [___] ______________________
2. Have you had an unfavorable dental experience? ______________________
3. Have you ever had complications from past dental treatment? ______________________
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? ______________________
5. Did you ever have braces, orthodontic treatment or had your bite adjusted? ______________________
6. Have you had any teeth removed? ______________________

GUM AND BONE

7. Do your gums bleed or are they painful when brushing or flossing? ______________________
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth? ______________________
9. Have you ever noticed an unpleasant taste or odor in your mouth? ______________________
10. Is there anyone with a history of periodontal disease in your family? ______________________
11. Have you ever experienced gum recession? ______________________
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? ____________
13. Have you experienced a burning sensation in your mouth? ______________________

TOOTH STRUCTURE

14. Have you had any cavities within the past 3 years? ______________________
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? ______________________
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? ______________________
17. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? ______________________
18. Do you have grooves or notches on your teeth near the gum line? ______________________
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? ______________________
20. Do you frequently get food caught between any teeth? ______________________

BITE AND JAW JOINT

21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) ______________________
22. Do you feel like your lower jaw is being pushed back when you bite your teeth together? ______________________
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? ____________
24. Have your teeth changed in the last 5 years, become shorter, thinner or worn? ______________________
25. Are your teeth becoming more crooked, crowded, or overlapped? ______________________
26. Are your teeth developing spaces or becoming more loose? ______________________
27. Do you have more than one bite, squeeze, or shift your jaw to make your teeth fit together? ______________________
28. Do you place your tongue between your teeth or rest your teeth against your tongue? ______________________
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? ______________________
30. Do you clench your teeth in the daytime or make them sore? ______________________
31. Do you have any problems with sleep (i.e. restlessness), wake up with a headache or an awareness of your teeth? ______________
32. Do you wear or have you ever worn a bite appliance? ______________________

SMILE CHARACTERISTICS

33. Is there anything about the appearance of your teeth that you would like to change? ______________________
34. Have you ever whitened (bleached) your teeth? ______________________
35. Have you felt uncomfortable or self conscious about the appearance of your teeth? ______________________
36. Have you been disappointed with the appearance of previous dental work? ______________________

Patient's Signature ____ Date______________________
Doctor's Signature ____ Date ______________________

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MEDICAL HISTORY

Patient Name ______________________ Nickname ______________ Age ________

Name of Physician/and their specialty ______________________________

Most recent physical examination ______________________ Purpose ______________________

What is your estimate of your general health? Excellent Good Fair Poor

DO YOU HAVE or HAVE YOU EVER HAD: YES NO

1. hospitalization for illness or injury ______
2. an allergic reaction to
   - aspirin, ibuprofen, acetaminophen, codeine
   - penicillin
   - erythromycin
   - tetracycline
   - sulfa
   - local anesthetic
   - fluoride
   - metals (nickel, gold, silver, ____________)
   - latex
   - other ______
3. heart problems, or cardiac stent within the last six months __
4. history of infective endocarditis ______
5. artificial heart valve, repaired heart defect (PFO) ______
6. pacemaker or implantable defibrillator ______
7. orthopedic implant (joint replacement) ______
8. rheumatic or scarlet fever ______
9. high or low blood pressure ______
10. a stroke (taking blood thinners) ______
11. anemia or other blood disorder ______
12. prolonged bleeding due to a slight cut (INR > 3.5) ______
13. emphysema, shortness of breath, sarcoidosis ______
14. tuberculosis, measles, chicken pox ______
15. asthma ______
16. breathing or sleep problems (i.e. sleep apnea, snoring, sinus)
17. kidney disease ______
18. liver disease ______
19. jaundice ______
20. thyroid, parathyroid disease, or calcium deficiency ______
21. hormone deficiency ______
22. high cholesterol or taking statin drugs ______
23. diabetes (HbA1c =_______) ______
24. stomach or duodenal ulcer ______
25. digestive disorders (i.e. celiac disease, gastric reflux) ______
26. osteoporosis/osteopenia (i.e. taking bisphosphonates) __

YES NO

27. arthritis ______
28. autoimmune disease ______ (i.e. rheumatoid arthritis, lupus, scleroderma)
29. glaucoma ______
30. contact lenses ______
31. head or neck injuries ______
32. epilepsy, convulsions (seizures) ______
33. neurologic disorders (ADD/ADHD, prion disease) ______
34. viral infections and cold sores ______
35. any lumps or swelling in the mouth ______
36. hives, skin rash, hay fever ______
37. STI / STD / HPV ______
38. hepatitis (type ___) ______
39. HIV / AIDS ______
40. tumor, abnormal growth ______
41. radiation therapy ______
42. chemotherapy, immunosuppressive medication ______
43. emotional difficulties ______
44. psychiatric treatment ______
45. antidepressant medication ______
46. alcohol / recreational drug use ______

ARE YOU:

47. presently being treated for any other illness ______
48. aware of a change in your health in the last 24 hours (i.e. fever, chills, new cough, or diarrhea) ______
49. taking medication for weight management ______
50. taking dietary supplements ______
51. often exhausted or fatigued ______
52. experiencing frequent headaches ______
53. a smoker, smoked previously or use smokeless tobacco _
54. considered a touchy / sensitive person ______
55. often unhappy or depressed ______
56. FEMALE - taking birth control pills ______
57. FEMALE - pregnant ______
58. MALE - prostate disorders ______

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections)

____

List all medications, supplements, and or vitamins taken within the last two years.

Drug	Purpose	Drug	Purpose

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature ______________________ Date ______________

Doctor's Signature ______________________ Date ______________

ASA ______ (1-6)

PLEASE PRINT

CONFIDENTIAL INFORMATION QUESTIONNAIRE

PATIENT'S LEGAL NAME LAST, FIRST MI	DATE OF BIRTH	SEX	SSN(US) / SIN(CAN)

PREFER TO BE CALLED	HOME PHONE #	CELL PHONE #

PATIENT'S ADDRESS STREET APT# CITY STATE ZIP/POSTAL CODE	E-MAIL

MARITAL STATUS S M W D UNDER AGE 18	PATIENT'S / GUARDIAN'S EMPLOYER	OCCUPATION

WORK ADDRESS STREET APT# CITY STATE ZIP/POSTAL CODE	WORK PHONE #

SPOUSE'S NAME LAST, FIRST MI	SPOUSE'S EMPLOYER	OCCUPATION

SPOUSE'S WORK ADDRESS STREET APT# CITY STATE ZIP/POSTAL CODE	WORK PHONE #

OTHER FAMILY MEMBERS THAT ARE PATIENTS HERE	WHO CAN WE THANK FOR REFERRING YOU TO OUR OFFICE?

EMERGENCY CONTACT INFORMATION

PERSON WE MAY CONTACT IN CASE OF AN EMERGENCY (OTHER THAN YOUR FAMILY HOME)

NAME	RELATIONSHIP

HOME PHONE #	WORK PHONE #	CELL PHONE #

REQUEST FOR CONFIDENTIAL COMMUNICATION

AS MY DENTAL CARE PROVIDER, YOU MAY DO THE FOLLOWING WITH MY PERMISSION:

	YES	NO
Contact me at home		
Contact me via cell phone		
Contact me at work		
Contact me via e-mail		
Leave messages on my home voicemail / answering machine		
Leave messages on my cell phone voicemail		
Leave messages on my work voicemail / answering machine		

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INSURANCE AND FINANCIAL INFORMATION

INSURANCE COVERAGE (YES / NO)	INSURANCE COMPANY NAME	INSURANCE ADDRESS	INSURANCE PHONE

SUBSCRIBER'S NAME	PATIENT'S RELATIONSHIP TO SUBSCRIBER (SELF / SPOUSE / DEPENDENT)	SUBSCRIBER'S BIRTHDAY	SSN(US) / SIN(CAN)

GROUP / PROGRAM NUMBER	EMPLOYER (IF DIFFERENT FROM ABOVE)	EMPLOYER'S ADDRESS

SECONDARY COVERAGE (YES / NO)	INSURANCE COMPANY NAME	INSURANCE ADDRESS	INSURANCE PHONE

SUBSCRIBER'S NAME	PATIENT'S RELATIONSHIP TO SUBSCRIBER (SELF / SPOUSE / DEPENDENT)	SUBSCRIBER'S BIRTHDAY	SSN(US) / SIN(CA)

GROUP / PROGRAM NUMBER	EMPLOYER (IF DIFFERENT FROM ABOVE)	EMPLOYER'S ADDRESS

RELEASE INFORMATION

YOU MAY DISCUSS MY HEALTHCARE WITH

	YES	NO
Health Care Providers		
Insurance Companies		

OTHERS (PLEASE PRINT)

1.

2.

CONFIRMATIONS

DO YOU PREFER A CONFIRMATION CALL

No, it is unnecessary

Yes, it is a helpful reminder

ASSIGNMENT & RELEASE

I hereby authorize (1) any available insurance benefits to be paid directly to my dentist, (2) the release of my dental health care information in connection with any insurance claim for such care, (3) my dentist to use my dental records in any professional manner that he/she so determines, (4) the making of videotapes, photographs, and x-rays of the dental treatment that I receive before, during and after such treatment (collectively "My Images"), and (5) my dentist to use My Images in scientific papers, demonstrations and/or presentations without compensation to me. If I am signing this form as the guardian of a patient then the above authorization is on behalf of such patient.

I acknowledge and agree that if certain costs of my dental care is not covered by insurance, I am financially responsible and obligated to pay my dentist such uninsured cost in accordance with the payment terms and policies of my dentist. If I am signing this form as the guardian of the dentist's patient, the dentist agrees that my signature does not make me personally liable for the payment of any uninsured costs.

Finally, I by signing below I acknowledge my understanding of the risks and limitations involved with the dental treatment that I am to receive or that the patient is to receive if I am signing as such patient's guardian.

SIGNATURE - PATIENT / GUARDIAN	DATE
WITNESS SIGNATURE	DATE

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