Thomas E. Wright III, D.D.S., Inc.
Practice Limited to Periodontics and Dental Implants

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ABOUT YOU

Today's Date:_____ E-mail address: _____

Name:_____ I prefer to be called: _____
Last First Middle

D.O.B: __/__/___ Age:____ Social Security #:_____ Male or Female Status: ___S ___M___D ___W

Home Address:_____
Number Street City State Zip

Home #:_____ Work #: _____ Mobile #: _____

Best phone number to confirm appointments:_____

Have you ever been a patient of our practice? Yes or No When?_____ Whom may we thank for referring you?_____

Spouse Name: _____ D. O. B:___/___/____ Social Security #: _____

Employer: _____ Occupation: _____

Employer's address: _____

If minor, Father's name: _____ Phone #: _____ Address: _____

If minor. Mother's name: _____ Phone #: _____ Address: _____

Emergency Contact Information

His/Her name: _____ Relationship:_____

Contact #: _____ Alternate contact #:_____

Insurance Information

ALL INSURANCE INFORMATION MUST BE COMPLETE IN ORDER FOR OUR OFFICE TO FILE.

Primary Insurance Dental coverage? ___Yes ___No Medical coverage? ___Yes ___No

Insurance Company Name:_____ Group # (Plan, Local, or Policy #): _____

Insurance company address:_____ Insurance phone #:_____

Insured's name:_____ Insured's Date of Birth:___/___/_____ Insured's S.S.N:_____

Patient's relationship to insured:_____

Insured's Empolyer:_____ Employer's address:_____

Secondary Insurance Dental coverage? ___Yes ___No Medical coverage? ___Yes ___No

Insurance Company Name:_____ Group # (Plan, Local, or Policy #): _____

Insurance company address:_____ Insurance phone #:_____

Insured's name:_____ Insured's Date of Birth:___/___/_____ Insured's S.S.N.: _____

Patient's relationship to insured: _____

Insured's Empolyer: _____ Employer's address: _____

For all first time appointments, payment is due in full. Today I will be paying today with __Cash ___Check ___Credit Card

DENTAL HISTORY

What is your chief complaint about your mouth? _____
Are you currently in pain? Yes or No if YES, please explain _____
Is your current dental health ____Good ____Fair ____Poor
Do you floss daily? __YES __NO Do you brush daily? __YES __NO
Do your gums ever bleed? __YES __NO Do your gums itch? __YES __NO
Do your jaws click/pop? __YES __NO
Do you grind your teeth? __YES __NO
Do you have red/swollen gums? __YES __NO
Do you get fever blisters? __YES __NO

Are your teeth sensitive to cold, hot, or anything else? _____
Are any of your teeth loose? ___ Yes ___ No
Do you still have your wisdom teeth? ____ Yes ___ No
Previous dentist _____Present dentist _____
When did you have your teeth cleaned last? _____
Have you ever had periodontal treatment? ___Yes ___No
If so, when _____ Doctor's name _____
Are you currently taking any antibiotics? ___ Yes ___ No
What are you taking? _____

MEDICAL HISTORY

Primary Care Physician's Name: _____ Telephone: _____
In addition to my PCP, I am currently under the care of the following specialist(s):
Name: _____ Specialty: _____ Telephone: _____
Name: _____ Specialty: _____ Telephone: _____
Have you had any major illness, operation, or hospitalization in the past five years? ____ Yes ____ No
If so, what and when? _____
Do you smoke or use any form of tobacco? ____ Yes ____ No What type? _____ How often? _____
Have you ever taken Phen-Fen, Redux, or Pondimin? ____ Yes ____ No
Female Patients: Pregnant or Possibly? _____ Expected due date: _____ Currently nursing? _____
Taking birth control pills? _____

Do you have or experienced any of the following? Check all that apply

___ Abnormal Bleeding
___Artificial Bones/Joints
___Cancer type_____
___Congenital Heart Defect
___Emphysema
___Glaucoma
___Heart Surgery
___ Herpes
___ Liver Disease
___ Pacemaker
___ Radiation Treatment
___ Shingles
___Steroid Therapy
___ Tonsillitis
___ Alcohol Abuse
___ Artificial Valves
___ Chemotherapy
___ Diabetes type _____
___ Epilepsy
___ Hay Fever
___ Hemophilia
___ High Blood Pressure
___ Low Blood Pressure
___ Persistent Cough
___ Rheumatic Fever
___ Sickle Cell Disease
___ Stroke
___ Tuberculosis (TB)
___Anemia
___ Asthma
___ Chicken Pox
___Difficulty Breathing
___ Fainting Spells
___ Headaches
___Hepatits __A __B __ C
___ HIV/AIDS
___ Lupus
___ Psychiatric Treatment
___ Scarlet Fever
___ Sinus Problems
___ Thyroid Problems
___ Ulcers
___ Arthritis
___ Blood Transfusion
___ Colitis
___Drug Abuse
___ Gall Bladder stones
___ Heart Attack
___ Kidney Problems
___ Mitral Valve Prolapse
___ Seizures
___ Venereal Disease

Have you ever been told to take antibiotics **prior** to your **dental appointment** or **surgery**? ___ Yes ___ No
If so, what: _____
Please list ALL medications, OTC drugs, and herbal/natural or homeopathic you are presently taking:

Are you allergic to any of the following? Check all that apply

___ Aspirin ___ Barbiturates ___ Codeine ___ Dental Anesthetics ___ Erythromycin
___ Jewelry/Metals ___ Latex ___ NSAIDS (anti-inflammatory) ___ Penicillin
___Sedatives (valium or other tranquilizers) ___ Sulfa Drugs ___ Tetracycline
___ Other _____

Our office HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.
I affirm that the information I have given is correct to the best of my knowledge, and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary services I may need. I assign the Doctor all insurance benefits. I understand that I am responsible for payment of services rendered, any deductible, and co-payment that my insurance does not cover. I have been offered a copy of the **Notice of Privacy Practices**.

Signature: _____ Date: _____
(parent or guardian if minor)

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACESS 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 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 this Notice while it is in effect. This Notice takes effect 1/1/2003, 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 the changes in our privacy practices and the new terms of our Notice 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 the 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 dentist, physician, or other healthcare provider providing treatment to you.

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

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include 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 healthcare operations, you may give us written 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 was in effect. Unless you give us a written authorization, we cannot use or

disclose your health information for any reason except those described in this Notice. By state law, your authorization is valid for 90 days.

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 information to a family member, friend, or other person to the extent necessary to help you with your healthcare or with payment, but only if you agree.

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, of 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 to 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 in 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 communications without your written authorization.

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

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. We may disclose your health information to the extent necessary to avert a serious threat to your health 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 authorize federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution 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 you with appointment reminders (such as voicemail messages, postcards).

PATIENTS RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. 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.

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 means or to alternative locations. You must make your request in writing. Your request must specify the alternative means or 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.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices, or if you have questions/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 alternative locations, 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 Health and Human Services. We will provide you with the address to file your complaint upon request. We support your right to the privacy of your health information. We 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.