Washington Periodontics
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Medical & Dental History Form

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

Title: _____ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date: _____ **SS#:** ___-__-____ **Prev. Visit:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ _____ _____ _____ _____ _____
Home Mobile Work Ext Fax Other

Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Are you active military or veteran? If yes, please list current duty station or date of seperation below: ◯ Yes ◯ No

Employment Information

The following is for: ◯ the patient ◯ the person responsible for payment ◯ both ◯ not applicable

Employer Name: _____ **Phone:** _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

In case of Emergency, whom should we contact? (name, phone number, and relationship to patient)

Spouse's Information

The following is for: ◯ the patient's spouse ◯ the person responsible for payment ◯ both ◯ neither-not applicable

Patient Name: _____ (Last) _____ (First) ___ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ **SS#:** ___-__-____ **DL#:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ (Home) _____ (Mobile) _____ (Work) _____ (Ext) _____ (Fax) _____ (Other)

Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) _____-____ (Zip Code)

Place of Employment:

Is your spouse active military or a veteran? If yes, please list current duty station or date of seperation below: ◯ Yes ◯ No

Dental Insurance Information

Name of Insured: _____ (Last) _____ (First) ___ (MI)

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Subscriber Date of Birth and Social Security Number

Member ID and Group Number

Please take a moment to let us know about your medical and dental history so we may serve you more effectively and in a way that watches out for your overall health and well-being.

Would you consider yourself to be in fairly good health? ◯ Yes ◯ No

Within the past year, have there been any changes in your general health? ◯ Yes ◯ No

If so, please explain.

What is the date (or approximate date) of your last medical exam?

Your Primary Care Physician's name, address, & phone number:

Your General Dentist's name, address, & phone number:

Pharmacy Name & Phone Number:

Please mark with a "x" to indicate Yes in response to the question (please explain any medical history and medications on page 4):

- [ ] Have you ever had complications following dental treatment?
- [ ] Are you currently under the care of a physician due to a specific condition?
- [ ] Have you been hospitalized within the last 5 years due to a surgery or illness?
- [ ] Are you currently taking any prescription or non-prescription medications?
- [ ] Do you use tobacco (smoking or chewing)?
- [ ] Do you require the use of corrective lenses (contacts or glasses)?
- [ ] Do you have any other conditions, diseases, etc., not listed above that we should be aware of?

Please mark with a "x" to indicate if you have any of the following:

- [ ] None

- [ ] Allergies
- [ ] Alzheimer's
- [ ] Amoxicillin Allergy
- [ ] Anemia
- [ ] Arthritis
- [ ] Artificial Joints
- [ ] Aspirin Sensitivity
- [ ] Asprin-prophylactic
- [ ] Asthma
- [ ] Bells Palsey
- [ ] Calcium Chan Blocker
- [ ] Cancer Medication
- [ ] Cancer
- [ ] Codeine Allergy
- [ ] Coumadin-Anti Coag.
- [ ] Diabetes
- [ ] Dilantin
- [ ] Emphezema
- [ ] Epilepsy
- [ ] Erythromycin Allergy
- [ ] Glaucoma
- [ ] Heart Disease
- [ ] Heart Murmur
- [ ] Hepatitis
- [ ] High Blood Pressure
- [ ] High Cholesterol
- [ ] HIV
- [ ] Hormone Replacement
- [ ] Insulin
- [ ] Joint Replacement
- [ ] Kidney Disease
- [ ] Liver Disease
- [ ] Migranes
- [ ] Morphine Allergy
- [ ] Multiple Sclerosis
- [ ] NSAID Sensitivity
- [ ] Oral Contraceptives
- [ ] Osteoporosis
- [ ] Other
- [ ] Pacemaker
- [ ] Penicillin Allergy
- [ ] Premed - Penicillin
- [ ] PreMed
- [ ] Premed-Amoxicillin
- [ ] Premed-clindamycin
- [ ] Premed-erythromycin
- [ ] Premed-Keflex
- [ ] Prostate problems
- [ ] Prozac
- [ ] Psychiatric History
- [ ] Psychiatric meds
- [ ] Pulmonary Disease
- [ ] Radiation Treatment
- [ ] Respiratory Problems
- [ ] Rheumatic Fever
- [ ] Rheumatism
- [ ] Sinus Problems
- [ ] Steroids
- [ ] Stomach Problems
- [ ] Stroke
- [ ] Sulfa Allergy
- [ ] Tetracycline Sensiti
- [ ] Thyroid Disease
- [ ] Ulcers

Do you have any other health issues or allergies?

Health Issues or Allergies:

_____

_____

_____

_____

Please list all medications you are currently taking (prescriptions and over the counter).

Medications - Prescription/Over the Counter:

_____

_____

_____

_____

_____

_____

WOMEN ONLY: Are you pregnant? ◯ Yes ◯ No

If Yes, when is the due date? _____

Do you anticipate becoming pregnant? ◯ Yes ◯ No

Are you taking hormone replacements? ◯ Yes ◯ No

How frequently do you brush your teeth?

◯ 3 (+) a day ◯ Twice a day ◯ Once a day ◯ Weekly ◯ Seldom

How frequently do you floss your teeth?

◯ 1 (+) a day ◯ 2 - 6 weekly ◯ 1 - 6 monthly ◯ Seldom ◯ Never

Please mark with a "x" to indicate Yes in response to the question:

☐ Do your gums bleed when you brush or floss?

☐ Do your teeth experience sensitivity to cold or hot temperatures?

☐ Are any of your teeth currently causing you pain?

☐ Do you grind your teeth (either consciously or during sleep)?

☐ Are any of your teeth loose, or are you concerned about any teeth loosening?

☐ Do you currently have any dental implants, dentures, or partials?

If any of the previous questions are marked, please explain:

_____

_____

_____

If you could change anything about your mouth, teeth, or smile, what would it be?

_____

_____

_____

☐ **To the best of my knowledge, all of the preceding information is true and correct. If I ever have a change in my health, I will inform the office at my next detal appointment without fail.**

FINANCIAL AGREEMENT AND AUTHORIZATION

For any accounts that are 90 days overdue, we have the discretion of sending these accounts to an attorney. If this account is placed in the hands of an attorney for collection, I agree to pay attorney fees of 33 and 1/3% of unpaid balance owing, plus all court costs, and interest. Interest is charged at a rate of 1.5% per month, (18% APR), beginning 30 days after the monies have become due or expenses have been incurred. I further agree to pay returned check charges of $25 per returned check and $75 per appointment cancelled without 72 hours notice. Any professional/courtesy discount is contingent upon the execution of the payment terms outlined above and may be reversed at the discretion of the practice if the account goes into default.

This agreement is reaffirmed each time services are received by me or another person on my account, including, but not limited to, any child, stepchild, or parents within my family who receive services from the above-named provider or any other provider within the practice.

The following applies to those patients who have Delta Dental Insurance:
If at your first appointment we are unable to verify your dental insurance or cannot obtain a list of benefits, full payment is due at the time services are rendered. We are not responsible for the accuracy of information provided to us by either the patient or insurer. Patients are to pay their deductible and estimated co-payments at the time treatments is rendered. While filing insurance claims is a service we extend to our patients, we must emphasize that as dental providers, our relationship is with our patients, not the insurance company. If a full payment is not received from your insurance carrier within 60 days, the balance becomes your responsibility. The insurance information we receive is limited only to covered procedures. We sincerely encourage you to contact your insurance company to obtain list of procedures and limitations not covered. Upon receipt of an insurance payment, any balance due will be billed to you. If you have deposited an excessive co-payment, it will be refunded to you. Ultimately, you, not your insurance company, are responsible for payment of all fees for services rendered by this office. We look to you for payment of any monies not paid by your insurance company.

☐ * **By checking this box, I acknowledge that I have read, understand, and agree to the above Financial Agreement and authorization. This will serve as my electronic signature.**

STATEMENT 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.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 3/31/2013, 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, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice 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.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative.

If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.

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

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

o Prevent or control disease, injury or disability;

o Report child abuse or neglect;

o Report reactions to medications or problems with products or devices;

o Notify a person of a recall, repair, or replacement of products or devices;

o Notify a person who may have been exposed to a disease or condition; or

o Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

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 security activities. We may disclose to correctional institution or law enforcement official having lawful custody the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

Other Uses and Disclosures of PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

Your Health Information Rights

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. 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 the additional requests.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the

Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.
Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have

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. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.
Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.
Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).
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 if 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 with the U.S. Department of Health and Human Services 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.

Our Privacy Official: Dr. Christine Karapetian

Telephone: 703-569-4040 Fax: 703-569-7334

Address: 9004 Crownwood Court, Suite A Burke, VA 22015

E-mail: info@washingtonperio.com

ADDITIONAL DISCLOSURE AUTHORIZATION: In addition to the allowable disclosures described in the Statement of Privacy Practices. I hereby specifically authorize disclosure of my Protected Healthcare Information to the person(s) identified below. (I understand that the default answer is "No". Without indicating "Yes" in answer to each individual question, personal protected (PHI) cannot be shared with anyone unless otherwise allowed by HIPPA rules.)

Spouse Only ◯ Yes ◯ No

Any member of my immediate family (Spouse, Children, Children's Spouses): ◯ Yes ◯ No

Any member of my extended family (Parents, Grandchildren): ◯ Yes ◯ No

Limited Disclosure to Emergency Contact ◯ Yes ◯ No

Other:

Name of Patient: *

Signature _____ **Date** _____

Patient's Personal Representative:

Representative's Telephone Number:

Signature _____ **Date** _____

Response Date: ____/____/_____