A B C

ADULT PATIENT INFORMATION

Date_____

Patient's name _____
Last First Middle

Residence _____
Street City Zip

Mailing Address _____
Street City Zip

How long at this address?_____ Home phone_____ Work phone _____

Previous Address (If less than 3 years) _____

Cell Phone_____ Birthdate_____ Social Security # _____

Email Address_____ Marital Status: Single__ Married__ Widowed__ Separated__ Divorced___

Employer_____ Occupation_____ No. years employed _____

Spouse's Name_____ Relationship to Patient_____

Employer_____ Occupation_____ No. years employed _____

Social Security # _____ Birthdate_____ Work Phone _____

Whom may we thank for referring you to our office? _____

DENTAL INSURANCE INFORMATION

Insured's Name_____ Insured's Social Security #_____

Insurance Company_____ Group No._____ Local No._____

Insurance Co. Address_____ Phone No. _____

Do you have dual coverage? Yes_____ No_____ If yes:

Insured's Name_____ Insured's Social Security #_____

Insurance Company_____ Group No._____ Local No._____

Insurance Co. Address_____ Phone No. _____

EMERGENCY INFORMATION

Name of nearest relative not living with you _____

Complete address _____
Street City Zip

Phone _____

I understand that, where appropriate, credit bureau reports may be obtained.

Signature _____

Updates (date & initial) _____

DENTAL HISTORY

Welcome! So that we may provide you with the best possible care, please complete this form. All information is completely confidential.

What is the reason for your visit today? _____

_____

Date of last Dental Visit: _____ Last Dental Cleaning: _____ X-Rays: _____

Previous Dentist's Name: _____
Address: _____
Phone: _____How frequently do you see the Dentist? _____

How often to you brush your teeth? _____ How often do you floss? _____
What other dental aids do you use? (Interplak, toothpick, etc) _____

Do you have any dental problems now? Yes No
If yes, please describe: _____

Any of your teeth sensitive to:

Y N Hot/Cold
Y N Sweets:
Y N Biting/Chewing
Y N noticed any bad odors/taste?
Y N Frequent cold sores/blisters?

Y N Do your gums bleed or hurt?
Y N Have your parents experienced gum disease/tooth loss
Y N Have you noticed any loose teeth or change in your bite
Y N Does food tend to get caught in between your teeth?
If so, where: _____

Have you ever:

Y N Orthodontic Treatment
Y N Oral Surgery
Y N Periodontal Treatment
Y N Mouth guard
Y N had a bite adjustment
Y N serious injury to the mouth/head?

Have you experienced

Y N Clicking/popping of jaw
Y N pain (joint/ear/side of face)
Y N difficulty opening/closing mouth
Y N Difficulty chewing
Y N Headache/neck ache/shoulder ache

Do you:

Y N Clench or grind your teeth?
Y N Bite your lips or cheeks regularly?
Y N Hold foreign objects with your teeth (pencils/fingernails)?
Y N Mouth breathe when awake or asleep?
Y N Have tired jaws, especially in the morning?
Y N Smoke or chew tobacco??
Y N Are you satisfied with your teeth's appearance?
Y N Would you like keep all of your teeth all of your life?
Y N Do you feel nervous about having dental treatment? If so, please explain: _____

_____

Y N Have you had an upsetting dental experience? If so, please explain: _____

_____

Y N Is there anything else about having dental treatment that you would like us to know? _____

_____

Signature: _____ Date: _____

MEDICAL HEALTH HISTORY

Do you have or have you had any of the following? Please circle all that apply

Physician Name: _____ Phone: _____

Heart/Vascular Problems:

Y N Chest Pain
Y N Shortness of Breath
Y N Blood Pressure Problem
Y N Heart Murmur
Y N Heart Valve Problem/Replacement
Y N Mitral Valve Prolapse
Y N Rheumatic Fever
Y N Pacemaker
Y N Stroke
Y N Easy Bruising
Y N Frequent Nose Bleeds
Y N Abnormal Bleeding
Y N Anemia
Y N Require a Blood Transfusion
Y N Premedication Required by Physician

Bone/Joint Problems:

Y N Arthritis
Y N Scoliosis
Y N Back/Neck pain
Y N Joint Replacement (ie: total hip, pins, implant)

Intestinal Problems

Y N Ulcers
Y N Weight Gain/Loss
Y N Special Diet
Y N Constipation/Diarrhea
Y N Kidney/Bladder Problems

Neurological:

Y N Frequent/Severe Headaches
Y N History of Head Injury
Y N Fainting/Seizures/Epilepsy
Y N Stroke
Y N Alzheimer's
Y N Nervous/Anxious
Y N Psychiatric/Physiological Care

Diabetes:

Y N Urinate more than 6 times a day
Y N Thirsty or Dry Mouth most of the time
Y N Family History of Diabetes
Y N Do you have Diabetes?

Eating Disorder/Dieting

Y N Bulimia/Anorexia
Y N Taking Medication for Weight Loss
Y N Do you Drink Alcohol
If so, How Much? _____
Y N History of Drug Abuse
Y N Hepatitis, Jaundice, Liver Trouble
Y N Do you use Tobacco?
If so, How much? _____
Smoking or smokeless? _____
Y N Cancer/Tumor
Y N Chemotherapy/Radiation Therapy
If so, when? _____
Y N Glaucoma
Y N Do you wear contact lenses?
Y N Hearing impaired/Deaf?
Y N Do you wear hearing aids?
Y N Herpes?
Y N HIV-Positive/AIDS

Allergy Problems

Y N Hay Fever
Y N Sinus Problems
Y N Skin Rash
Y N Asthma
Y N Persistent Cough/Swollen Glands

Are you allergic, or reacted adversely to the following?

Y N Local Anesthetic
Y N Antibiotics (Penicillin, Erythromycin, Sulfa)
Y N Barbiturates/Sedatives/Sleeping Pills
Y N Codeine/Demerol/Narcotics
Y N Aspirin/Acetaminophen/Tylenol
Y N Skin reaction to Metals?
Y N Rubber Dam?
Other? _____

Surgeries or hospitalization in the last 24months? If so, please describe. _____

_____

Any Disease, condition or problem not listed that you feel we should know about? If so please describe____

_____

Women:

Y N Are you taking Contraceptives/hormones

Y N Are you Pregnant?
If so, expected delivery date:_____
Y N Are you Nursing
Y N Have you reached menopause?

List Current Medications (Prescription, vitamins, etc)

_____

_____

Signature: _____ **Date:** _____

Korsmo Family Dental
2520 N. Alder Street
Tacoma, WA 98406
253-759-5414

Acknowledgement of Receipt of Statement of Privacy Practices

I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of Lars Korsmo, DDS. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Lars Korsmo, DDS reserves the right to change the privacy practices that are described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed to me.

ADDITIONAL DISCLOSURE AUTHORITY In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below.		
ANY MEMBER OF MY IMMEDIATE FAMILY	YES	NO
SPOUSE ONLY	YES	NO
OTHER (PLEASE SPECIFY)	YES	NO

Name of Patient

Signature of Responsible Party

Date

Relation to Patient

OFFICE USE ONLY BELOW THIS LINE

Record of Acknowledgement not obtained		
Provided Prior to Treatment	**Yes** **No**	
Date Provided:		
Reason for Denial		Needed more time to review Statement of Privacy Practices
		Wanting to consult with another person before signing
		Unable to sign
		Reason not given
		Other (explain)

STATEMENT OF PRIVACY PRACTICES

Our office is dedicated to protect the privacy rights of our patients and the confidential information entrusted to us. The commitment of each employee to ensure that your health information is never compromised is a principal concept of our practice. We may, from time to time, amend our privacy policies and practices but will always inform you of any changes that might affect your rights.

Protecting Your Personal Healthcare Information

We use and disclose the information we collect from you only as allowed by the Health Insurance Portability and Accountability Act and the state of Washington. This includes issues relating to your treatment, payment, and our health care operations. Your personal health information will never be otherwise given to anyone- even family members- without your written consent. You, of course, my give written authorization for us to disclose your information to anyone you choose, for any purpose.

Our offices and electronic systems are secure from unauthorized access and our employees are trained to make certain that the confidentiality of your records is always protected. Our privacy policy and practices apply to all former, current, and future patients, so you can be confident that your protected health information will never be improperly disclosed or released.

Collecting Protected Health Information (PHI)

We will only request personal information needed to provide our standard of quality health care, implement payment activities, conduct normal health practice operations, and comply with the law. This may include your name, address, telephone number(s), Social Security Number, employment date, medical history, health records, etc. While most of the information will be collected from you, we may obtain information from third parties if it is deemed necessary. Regardless of the source, your personal information will always be protected to the full extent of the law.

Disclosure of your Protected Health Information

As stated above, we may disclose information as required by law. We are obligated to provide information to law enforcement and governmental officials under certain circumstances. We will not use your information for marketing purposes without your written consent. We may use and/or disclose your health information to communicate reminders about your appointments including voicemail messages, answering machines, and postcards.

Any breach in the protection of your personal health information, including unauthorized acquisition, access, use, or disclosure will be fully investigated, addresses, and mitigated as established by the HIPAA Privacy Rule. You have a right to and will be provided all information relating to any breach involving your PHI.

Your Rights as our Patient

You have a right to request copies of your healthcare information; to request copies in a variety of formats; and to request a list of instances in which we, or our business associates have disclosed your protected information for uses other than stated above. All such requests must be in writing. We may charge for your copies in an amount allowed by law. If you believe your rights have been violated, we urge you to notify us immediately. You can also notify the U.S. Department of Health and Human Services.

Please ask if you have any questions about your privacy rights or the protection of your health information.

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patients) _____'s dental needs.
2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. 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.
4. I give consent to the doctor's (or designated staff's) use and disclosure of any oral, written, or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, paying, and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.
5. I agree to be responsible for payment of all services rendered on my behalf of my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates I understand that a 1 ½% late charge may be applied

Patient Signature: _____ Date: _____

Parent/Responsible Party's Signature: _____ Date_____

Relationship to patient: _____