

NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT

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

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

I have received, read, and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosure of my health insurance information. I understand that this organization has 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 _____

PATIENT SIGNATURE _____ DATE _____

I authorize the office to disclosure my dental information

on my answering machine	_____ YES	_____ NO
to my spouse/children	_____ YES	_____ NO
send recall postcards	_____ YES	_____ NO

FOR OFFICE USE ONLY

I attempted to obtain the patients signature in acknowledgement on this *Notice of Privacy Practices Acknowledgement*, but was unable to do so as documented below.

DATE _____ INITIALS _____ REASON _____

Informed Consent for General Dental Procedures

You, the patient, have the right to accept or accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment.

Do not consent to treatment unless and until you discuss potential benefits, risks, and complications with your dentist and all of your questions are answered. By consenting to the treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

It is very important that you provide your dentist with accurate information before, during, and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialists, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.

Please read and initial the items below and sign at the bottom of the form.

1. Treatment to be Provided

I understand that during my course of treatment that the following care may be provided:

Examinations _____ Preventative Services _____ Restorations _____

Crowns _____ Bridges _____ Other _____ Patient Initials _____

2. Drugs and Medications

I understand that antibiotics, analgesics, and other medications can cause allergic reactions causing redness and swelling of tissues; pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). Patient Initials _____

3. Changes in Treatment Plan

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the dentist to make any/all changes and additions as necessary. Patient Initials _____

4. I give permission to the dental office to bill my dental insurance provider for the treatment provided, if applicable. Patient Initials _____

Patient Signature

Date

Health History Form

Email:	Today's Date:
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As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name:	Home Phone:	Business/Cell Phone:
Last First Middle	()	()
Address:	City:	State: Zip:
Mailing address		
Occupation:	Height:	Weight: Date of Birth: Sex: M F
SS# or Patient ID:	Emergency Contact:	Relationship: Home Phone: Cell Phone:
		() ()
If you are completing this form for another person, what is your relationship to that person?		
Your Name	Relationship	
Do you have any of the following diseases or problems: (Check DK if you Don't Know the answer to the the question) Yes No DK		
Active Tuberculosis.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Persistent cough greater than a 3 week duration.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Cough that produces blood.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Been exposed to anyone with tuberculosis.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.		

Dental Information

For the following questions, please mark (X) your responses to the following questions.

Yes No DK	Yes No DK
Do your gums bleed when you brush or floss?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you have earaches or neck pains?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Are your teeth sensitive to cold, hot, sweets or pressure?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you have any clicking, popping or discomfort in the jaw?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Is your mouth dry?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you brux or grind your teeth?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Have you had any periodontal (gum) treatments?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you have sores or ulcers in your mouth?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Have you ever had orthodontic (braces) treatment?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you wear dentures or partials?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Have you had any problems associated with previous dental treatment?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you participate in active recreational activities?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Is your home water supply fluoridated?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Have you ever had a serious injury to your head or mouth?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Do you drink bottled or filtered water?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Date of your last dental exam:
If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY	What was done at that time?
Are you currently experiencing dental pain or discomfort?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Date of last dental x-rays:
What is the reason for your dental visit today?	
How do you feel about your smile?	

Medical Information

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

Yes No DK	Yes No DK
Are you now under the care of a physician?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Have you had a serious illness, operation or been hospitalized in the past 5 years?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Physician Name: Phone: Include area code ()	If yes, what was the illness or problem?
Address/City/State/Zip:	Are you taking or have you recently taken any prescription or over the counter medicine(s)?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Are you in good health?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	If so, please list all, including vitamins, natural or herbal preparations and/or dietary supplements:
Has there been any change in your general health within the past year?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
If yes, what condition is being treated?	
Date of last physical exam:	

Medical Information

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

(Check DK if you Don't Know the answer to the question)		Yes	No	DK
Do you wear contact lenses?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Date: _____ If yes, have you had any complications?				
Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax*, Actonel*, Atelvia, Boniva*, Reclast, Prolia) for osteoporosis or Paget's disease?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia*, Zometa*, XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Date Treatment began: _____				
Allergies. Are you allergic to or have you had a reaction to:				
To all yes responses, specify type of reaction.		Yes	No	DK
Local anesthetics		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin or other antibiotics		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Barbiturates, sedatives, or sleeping pills		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sulfa drugs		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Codeine or other narcotics		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you use controlled substances (drugs)?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you use tobacco (smoking, snuff, chew, bidis)?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If so, how interested are you in stopping? Circle one: VERY / SOMEWHAT / NOT INTERESTED				
Do you drink alcoholic beverages?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, how much alcohol did you drink in the last 24 hours?				
If yes, how much do you typically drink in a week?				
WOMEN ONLY Are you:				
Pregnant?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Number of weeks:				
Taking birth control pills or hormonal replacement?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nursing?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Metals		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Latex (rubber)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Iodine		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hay fever/seasonal		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Animals		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Food		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

			Yes No DK						Yes No DK						Yes No DK		
Artificial (prosthetic) heart valve.....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Autoimmune disease.....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Previous infective endocarditis			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid arthritis			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis, jaundice or liver disease.....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Damaged valves in transplanted heart			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Systemic lupus erythematosus.....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Congenital heart disease (CHD)						Asthma			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fainting spells or seizures			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unrepaired, cyanotic CHD			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neurological disorders			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Repaired (completely) in last 6 months.....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema.....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If yes, specify:					
Repaired CHD with residual defects			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus trouble			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sleep disorder			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.</i>						Tuberculosis.....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you snore?.....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						Cancer/Chemotherapy/ Radiation Treatment.....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mental health disorders.....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular disease.....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain upon exertion.....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent Infections			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Angina.....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic pain			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Type of infection:					
Arteriosclerosis.....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes Type I or II			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney problems.....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Congestive heart failure.....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eating disorder			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Night sweats			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Damaged heart valves			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Malnutrition			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis.....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal disease.....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Persistent swollen glands in neck.....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur.....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	G.E. Reflux/persistent heartburn			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Severe headaches/migraines.....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low blood pressure			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Severe or rapid weight loss			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure.....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sexually transmitted disease ..			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other congenital heart defects.....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Excessive urination			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>																	
Name of physician or dentist making recommendation:												Phone: <i>Include area code</i> ()					
Do you have any disease, condition, or problem not listed above that you think I should know about? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>																	
Please explain:																	

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian:

Date:

Signature of Dentist:

Date:

FOR COMPLETION BY DENTIST

Comments:
