

CONFIDENTIAL HEALTH HISTORY

Patient Name: _____ **Today's**

Date _____

Patient Date of Birth _____ **Patient SS #** _____

Patient Phone Number

Patient Email Address: _____

Patient Address _____

City _____ **State** _____ **Zip Code** _____

Referring Dentist: _____ **Phone**
Number _____

Primary Physician: _____ **Phone**
Number _____

Check off the appropriate answer. (Leave blank if you do not understand the question)

1. Is your general health good? **Yes** **No**
If No, please explain _____

2. Has there been a change in your health within the last 12 months? **Yes** **No**
If Yes, please explain _____

3. Have you gone to the hospital or emergency room or had a serious illness in the last three years? **Yes** **No**
If Yes, please explain _____

4. Are you being treated by a physician now? **Yes** **No**
If Yes, please explain _____
Date of last medical exam? _____ Reason for exam _____

5. Have you had any problems with prior dental treatments? **Yes** **No**
If Yes, please explain _____

6. Have you had problems with anesthesia? **Yes** **No**
If Yes, please explain _____

HAVE YOU HAD OR DO YOU HAVE ANY OF THE FOLLOWING?

Heart Disease..... **Yes** **No**

High Blood Pressure..... **Yes** **No**

Heart Defects..... **Yes** **No**

- Heart Murmurs..... Yes No
- Angina..... Yes No
- Mitral Valve Prolapse..... Yes No
- Rheumatic Fever..... Yes No
- Open Heart Surgery..... Yes No
- Artificial Heart Valves..... Yes No
- Heart Attack..... Yes No
- Stroke..... Yes No
- Chronic Sinus Problems..... Yes No
- Asthma, Emphysema, Bronchitis..... Yes No
- Tuberculosis..... Yes No
- Seizures, Epilepsy, Fainting..... Yes No
- Stomach Problems, Ulcers..... Yes No
- Arthritis/Joint Pain..... Yes No
- Artificial Joint Surgery/Implants..... Yes No
- Diabetes/ High Blood Sugar..... Yes No
- Hepatitis, Jaundice, Liver Disease..... Yes No
- Thyroid Disease..... Yes No
- Kidney or Bladder Disease..... Yes No
- Hemophilia, Anemia, Sickle Cell..... Yes No
- Abnormal Bleeding after Surgery..... Yes No
- Osteoporosis or Osteopenia..... Yes No
- Tumors or Cancer..... Yes No
- Chemotherapy or Radiation Therapy..... Yes No
- Sexual Transmitted Disease..... Yes No
- HIV/AIDS..... Yes No
- Psychiatric Problems..... Yes No
- Drug Addiction..... Yes No
- Excessive Use or Alcohol/Alcoholism..... Yes No
- Developmental Disability..... Yes No
- Cosmetic Surgery..... Yes No
- Transplants..... Yes No
- TMJ or Limited Jaw Opening..... Yes No
- Injury to Face, Jaws, or Neck..... Yes No
- Numbness in any part of your face/mouth..... Yes No
- Frequent Severe Headaches..... Yes No

ARE YOU AWARE OF HAVING ANY ALLERGIC REACTION OR ADVERSE REACTION TO ANY OF THE FOLLOWING?

- | | | | | | |
|------------------|------------------------------|-----------------------------|---------------|------------------------------|-----------------------------|
| Aspirin | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tylenol | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Darvon | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Codeine | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Vicodin | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Penicillin | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Amoxicillin | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Clindamycin | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Valium | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Versed | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Fentanyl | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Nitrous Oxide | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Local Anesthetic | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Latex | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Food | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Metal | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Other Allergies or Drug Reactions: _____

ARE YOU TAKING OR HAVE YOU TAKEN ANY OF THE FOLLOWING IN THE LAST TWELVE MONTHS?

Recreational Drugs	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tobacco in any form	<input type="checkbox"/> Yes <input type="checkbox"/> No
Weight Loss Medication	<input type="checkbox"/> Yes <input type="checkbox"/> No	Steroids	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bisphosphonates	<input type="checkbox"/> Yes <input type="checkbox"/> No	Alcohol	<input type="checkbox"/> Yes <input type="checkbox"/> No

INSURANCE:

Dental Insurance Plan: _____

Group Number /ID Number: _____

Medical Insurance Plan: _____

Group Number/ID Number: _____

LIST OR ATTACH ALL OF YOUR CURRENT MEDICATIONS:

WOMEN ONLY:

Are you or could you be pregnant? If Yes, what month? _____ Yes No

Are you nursing? Yes No

Are you taking birth control pills? Yes No

ALL PATIENTS:

Do you have or have you had any other diseases or medical problems NOT listed on this form?

Yes No

If Yes, please explain _____

PHYSICIAN INFORMATION

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potential medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment.

I authorize this office to contact my physician.

Signature of Patient: (Parent or Guardian) _____ Date _____

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any changes in my health and/or medication. Further, I will not hold my dentist or any other member of his staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient: (Parent or Guardian) _____ Date _____

Signature of Doctor _____ Date _____

Mid-Hudson Oral and Maxillofacial Practice P.C.

Patient Name: _____

NOTICE OF EXCLUSIONS FROM INSURANCE BENEFITS

There are items and services for which your Insurance plan is not expected to pay.

__ Your insurance plan does **not** pay for all of your health care costs. Your insurance plan only pays for covered benefits. **Some items and services are not plan benefits and your insurance plan will not pay for them.**

__ When you receive an item or service that is **not** a plan benefit, **you are responsible to pay for it.**

The purpose of this notice is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you will have to pay for them yourself. **Before you make a decision, you should read this entire notice carefully.** Ask us to explain if you don't understand why your insurance plan won't pay.

_ **1. Because it does not meet the definition of any insurance plan benefit:**

_ **2. Because of the following exclusion from your insurance plan benefits:**

-Services in connection with the care, treatment, filling, removal or replacement of teeth or structures directly supporting teeth are not covered.

The official insurance plan program provisions are contained in your insurance contract and plan benefit booklet. Contact your insurance company for more information.

I hereby acknowledge that I have been informed that my insurance is not expected to fully cover charges related to my dental surgery. I understand that I will be required to pay for non-benefit charges.

Signature

Date

MID-HUDSON ORAL AND MAXILLOFACIAL PRACTICE, P.C.

NOTICE 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.
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 (04/14/03), 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 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.

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 health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

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

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 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 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, or letters).

PATIENT 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. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge you \$0.75 for each page, \$12.00 per hour for staff to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information for a fee. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purpose, 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 locations 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.

Electronic Notice: If you receive this notice on our Web site or by electronic mail (e-mail), you are entitled to receive this notice in written form.

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 you disagree with a decision we made about access to your health information or in response you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by 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 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

Contact Officer: Practice Administrator **Telephone:** 845-340-1962 **Fax:** 845-340-7970
Address: 117 Mary's Avenue Suite 104 Kingston, NY 12401

MID-HUDSON ORAL AND MAXILLOFACIAL PRACTICE, P.C.

HIPPA PRIVACY FORM #1
HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____
Address: _____
Telephone: _____ E-mail: _____
Patient Number: _____ Social Security Number: _____

SECTION B: TO THE PATIENT PLEASE READ THE FOLLOWING STATEMENT CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of either important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Practice Administrator **Telephone:** 845-340-1962 **Fax:** 845-340-7970
Address: 117 Mary's Ave Suite 104 Kingston, NY 12401

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we look in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ **Date:** _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____
Relationship to Patient: _____

MID-HUDSON ORAL AND MAXILLOFACIAL PRACTICE, P.C.

HIPPA PRIVACY FORM #2

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement. By signing below, I hereby acknowledge that I have been provided with a copy of this office's Notice of Privacy Practices. Therefore, I have been advised of how my protected health information may be used and disclosed by the office and how I may obtain access to and control this information. In addition, by signing below, I hereby consent to the use and disclosures of my health information for treatment purposes, payment activities and healthcare operations of the office as described in the Notice

**ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES**

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices.

(Please Print Name) or Personal Representative

(Signature)

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify) _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Includes completed Consent in the patient's chart

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ **Date:** _____