BARRETT D STRAUB, DDS. SC.

PERSONAL CONTACT INFORMATION

Today's Date _____

Name _____ Date of Birth_____

Home Phone_____Work Phone _____ Cell_____

Email Address _____

Address _____

City_____ State_____ Zip_____

Person to be billed (if not yourself)_____

Emergency Contact_____Phone _____

Relationship _____

Your Employer _____

Occupation _____

How were you referred to our office? _____

DENTAL INSURANCE

DO YOU HAVE DENTAL INSURANCE? YES NO

Insured's Name _____ Birth Date _____

Name of Employer _____

Name of Insurance Company _____

Insurance ID # _____ Group Number _____

DO YOU HAVE DOUBLE INSURANCE COVERAGE? YES NO

Insured's Name _____ Birth Date _____

Name of Employer _____

Name of Insurance Company _____

Insurance ID # _____ Group Number _____

Assignment of Benefits
I authorize payment of dental benefits to the named provider for professional services rendered.

Signed _____
(Subscriber)

Release of Information
I authorize the release of any dental information necessary to process this claim.

Signed _____
(Patient or Guardian)

MEDICAL HISTORY

Date of last health care exam by a physician: _____

What was this exam for? _____

Have you been hospitalized in last 5 years? _____

If yes, reason: _____

Are you currently receiving care from a physician? YES NO

If yes, nature of care: _____

Please list contact information (name, phone, fax number) of all your treating physicians:

1. _____
2. _____
3. _____

For the following questions, circle YES or NO. Your answers are for our records only and will remain confidential. We may need to ask additional questions regarding your overall health.

Heart Murmur	NO	YES	Ever taken the drug Fen-Phen	NO	YES
Anemia	NO	YES	Venereal Disease	NO	YES
Diabetes Type I or II Insulin? Latest HbA1c reading:	NO	YES	Psychosis	NO	YES
Epilepsy	NO	YES	Enlarged Lymph Nodes	NO	YES
Hepatitis (any form)	NO	YES	Previous Biopsies	NO	YES
Asthma	NO	YES	Slow healing mouth sores	NO	YES
HIV Positive or AIDS related complex	NO	YES	Recurrent Illnesses	NO	YES
Emphysema or other Respiratory Illnesses, including COPD	NO	YES	Other infections	NO	YES
Heart Disease	NO	YES	Joint Replacement Date of Surgery:	NO	YES

Abnormal Heart Condition	NO	YES	Glaucoma	NO	YES
Do you have a Pacemaker	NO	YES	Abnormal Bleeding from cut	NO	YES
Have you ever had Heart Surgery	NO	YES	Liver Disease (including jaundice)	NO	YES
Previous Bacterial Endocarditis	NO	YES	Latex Sensitivity	NO	YES
Artificial Heart Valve or Heart Valve Surgery	NO	YES	HPV –Human Papilloma Virus	NO	YES
Heart Stent? When Placed?	NO	YES	Pain in Jaw Joints	NO	YES
Stroke	NO	YES	Cancer	NO	YES
Angina	NO	YES	Sleep Apnea	NO	YES
History of Seizures	NO	YES	Gastric Reflux	NO	YES

Are you required to Pre-medicate with antibiotics prior to dental treatment? NO YES

Women:
- Are you pregnant? NO YES
- If no, are you planning a pregnancy in the near future? NO YES
- Are you a nursing mother? NO YES
- Are you taking birth control pills? NO YES

Abnormal Blood Pressure NO YES

If yes, what is your normal BP reading?

BP Reading taken in our Office (Don't fill in): BP: _____O2%_____Pulse_____ Date:_____

Are you allergic to or have you had a reaction to:
- Local anesthetics NO YES
- Antibiotics NO YES
  - If yes, which one(s):
- Aspirin NO YES
- Codeine, valium, or other sedatives NO YES

Other: _____

Are you a smoker? NO YES

If yes, how much per day? _____

Do you use smokeless tobacco (chew)? NO YES

If yes, how much? _____

Do you consume grapefruit, grapefruit juice, or grapefruit extract? NO YES

Diet:

Food allergies_____

Sugar in your diet: HIGH MODERATE LOW

How many cans of soda do you drink per day? _____

Please list any medications you are currently taking. Please include both prescription and over the counter medications.

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

7. _____ 8. _____

Are you taking any of the following drugs? NO YES

Tagamet (Cimetidine), Cardizem (diltiazem), Calan, Isoptin (Verapamil), Serzone (nefazodone), Diflucan (fluconazole), Sporonox (itraconazole), Biaxin (clarithromycin)

Circle those you are taking or have recently taken.

Have you ever been treated with Bisphosphonate drugs? NO YES (Fosamax, Aredia, Zometa, Actonel, Boniva)

If so, which ones?

Currently being treated?

Do you take Antacids? NO YES If Yes, how often? _____

Do you take any herbal supplements? NO YES If Yes, which ones? _____

Do you take any diet pills or vitamins? NO YES If Yes, which ones? _____

Miscellaneous Notes:

_____

_____

_____

_____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor or hygienist of any change to my health or medications.

_____ _____ _____

Print Name Patient Signature Date

_____ _____

Doctor Signature Date

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if my medications change, I will inform the dentist at the next appointment without fail.

DATE	ADDITIONS/CHANGES	SIGNATURE	DDS/RDH INITIAL

SMILE EVALUATION

Rate the appearance of your smile on a scale from 1 to 10 (10 being the highest): _____

Please ✓ the statements below that apply to you.

O I wish the color of my teeth were whiter

O I wish my teeth were straighter

O I wish I had a broader smile

O I feel my teeth are too large or too small (circle that which applies)

O I think my gums show too much when I smile

O My smile shows too much space between some of my teeth

O I sometimes hesitate to smile due to the appearance of my smile

O I would like to know what my cosmetic options are to improve the appearance of my smile

O Other: _____

OCCLUSAL/TMD QUESTIONAIRE

Please mark a ✓ next to any symptom you currently are experiencing or have experiencing in the past.

O Headaches

O TMJ Joint Pain

O TMJ Joint Noises (Clicking or Popping)

O Limited opening of your mouth

O Clenching or Grinding of your teeth

O Facial Pain

O Snoring at night

Notes:

_____
_____
_____
_____
_____
_____

PATIENT INTERVIEW

DO NOT FILL OUT – TO BE FILLED OUT BY DOCTOR STRAUB

What prompted you to seek dental treatment at this time?

_____
_____

How long since your last dental exam? _____

Are you experiencing any discomfort or problems with your mouth?

_____
_____
_____

Do your gums ever bleed when brushing or flossing? _____

How often do you brush? _____ Floss? _____

Have you had your wisdom teeth removed? _____
Have you had other adult teeth removed? _____
If so, have they been replaced? _____

Dental History

_____
_____

Rate your own overall oral health as: Good Fair Poor Comments: _____

Are you apprehensive or fearful about receiving dental treatment?

_____
_____
_____

Do you feel you'd benefit from Sedation Dentistry? YES NO

Other:

_____
_____
_____
_____
_____
_____
_____
_____

Barrett D Straub DDS, SC / Straub Dentistry

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.

We are required by law to maintain the privacy of protected health information (referred to as PHI from here forward), to provide individuals with notice of our legal duties and privacy practices with respect to PHI, and to notify affected individuals following a breach of unsecured PHI. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect September, 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 PHI 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 OR DISCLOSE YOUR HEALTH INFORMATION

The following categories describe the ways that we may use and disclose your health information. 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 or disclose your health information in the provision, coordination or management of your health care. Our communications to you may be by telephone, cell phone, e-mail, or by mail. For example we may use your information to call and remind you of an appointment or to refer your care to another physician. If another provider requests your health information and they are not providing care and treatment to you we will request an authorization from you before providing your information.

Payment. We may use or disclose your health information to obtain payment for your health care services. For example, we may use your information to send a bill for your health care services to your insurer.

Healthcare Operations. We may use or disclose your health care information for activities relating to the evaluation of patient care, evaluating the performance of health care providers, business planning and compliance with the law. For example, we may use your information to determine the quality of care you received. If the activities require disclosure outside of our health care organization we will request your authorization before disclosing that information.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family, 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:
Prevent or control disease, injury or disability; report child abuse or neglect; report reactions to medications or problems with products or devices; notify a person of a recall, repair, or replacement of products or devices; notify a person who may have been exposed to a disease or condition; or 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 PHI 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 inspect or obtain copies of your health information, with limited exceptions. You must make your request in writing using the contact information listed at the end of this Notice.
You have the right to request that the information be provided in an electronic form or format (e.g., PDF saved onto CD). If the form and format are not readily producible, we will work with you to provide it in a reasonable electronic form or format. In addition, we may charge you a reasonable fee to cover our expenses for copying your health information.

Disclosure Accounting. You have the right to request a list of the disclosures of your health information that we have made in compliance with federal and state law. This list will include the date of each disclosure, who received the disclosed health information, a brief description of the health information disclosed, and why the disclosure was made. For some types of disclosures, the list will also include the date and time the request for disclosure was received and the date and time the disclosure was made. You must make your request in writing using the contact information provided at the end of this Notice. We must comply with your request for a list within 60 days, unless you agree to a 30-day extension, and we may not charge you for the list, unless you request such list more than once per year.

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 using the contact information provided at the end of this Notice. 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 using the contact information provided at the end of this Notice. 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 using the contact information provided at the end of this Notice, 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 PHI as required by law.

Paper Copy of this 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). Submit your written request using the contact information provided at the end of this Notice.

Complaints. If you believe your privacy rights have been violated, you may file a complaint in writing using the contact information provided at the end of this Notice. We request that you file your complaint in writing so that we may better assist in the investigation of your complaint. You may also file a complaint with the Secretary of the Department of Health and Human Services. 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.

If you want more information about our privacy practices or have questions or concerns, please contact us.

Patience D Frankl, Privacy Officer
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