StoneRidgeDental By Monarres
IMPLANT, COSMETIC, & PROSTHETIC DENTISTRY

Date: _____

We would like to extend a warm welcome and thank you for choosing our dental team for your dental care. We will always strive to provide you with the best possible dental care and attention. Please fill out this form in its entirety. If you have any questions or need assistance, please ask us. We are always happy to help you.

FOR YOUR WELLBEING AND SAFETY, PLEASE ANSWER ALL QUESTIONS THOROUGHLY

Patient Information (CONFIDENTIAL)

Name: _____ Cell Phone: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Date of Birth: _____ Age: _____ Sex: ☐M ☐F Social Security Number: _____

Check appropriate box: ☐Minor ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated

Patient's Employer/School: _____ Work Phone: _____

Occupation: _____ Years at Current Employer: _____

Email: _____ Emergency Contact: _____ Cell: _____

Whom may we thank for referring you? _____ or ☐Google ☐Facebook ☐TV

Preferred method of contact: ☐ Phone Call ☐ Text ☐ Email

Responsible Party if different than above **(ex: Parents, Spouse, Caregiver, Nursing home, P.O.A, etc.)**

Name of person responsible for this account: _____

Relationship to Patient: _____ Cell Phone: _____

Address: _____

Social Security Number: _____ Birth date: _____

Employer: _____ Work phone: _____

Is this person currently a patient in our office? ☐Yes ☐No

Dental Insurance Information: WE WORK WITH MOST **PPO PLANS** (NO HMO/MEDICAID/MEDICARE)

Name of Policy Holder: _____ Relationship to Patient: _____

Policy Holder's Birth date: _____ Member ID: _____ Employer: _____

Insurance Co: _____ Phone: _____ Group Number: _____

Insurance Address: _____ City: _____ State: _____ Zip code: _____

Do you have secondary dental insurance? ☐Yes ☐No If yes, please complete the following:

Name of Policy Holder: _____ Relationship to Patient: _____

Policy Holder's Birth date: _____ Member ID: _____ Employer: _____

Insurance Co: _____ Phone: _____ Group Number: _____

Insurance Address: _____ City: _____ State: _____ Zip code: _____

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Dental History

How can we improve your smile today? _____

Are you in any dental discomfort? _____

Previous dental provider: _____

Date of last dental care: _____ Date of last x-rays: _____

Have you had problems with any of the following?

Y ☐ N ☐ Bad Breath
Y ☐ N ☐ Bleeding Gums
Y ☐ N ☐ Broken Fillings
Y ☐ N ☐ Clicking/Popping Jaw
Y ☐ N ☐ Grinding/Clenching
Y ☐ N ☐ Hot/Cold Sensitivity
Y ☐ N ☐ Loose Teeth
Y ☐ N ☐ Difficulty Chewing
Y ☐ N ☐ Missing Teeth
Y ☐ N ☐ Sweets Sensitivity
Y ☐ N ☐ Sensitivity when biting
Y ☐ N ☐ Sores/Growths in mouth

How do you feel about the appearance of your teeth? _____

Have you experienced an adverse reaction during/in conjunction with a medical/dental procedure? Y☐ N☐

Any other important information about your dental health or previous treatment: _____

Medical History

Physician's Name: _____ Date of last Physician visit: _____ Phone: _____

Are you currently under physician care? If yes, describe: _____

Have you had any serious illnesses or operations? If yes, please describe: _____

Are you allergic to any medication? _____

Please list ALL medications you currently take: _____

_____

Have you ever used biphosphonate medication? (Brand names include Fosamax, Actonel, Atelvia, Didronel, and Boniva) Y☐ N☐

Women: Are you pregnant? Y ☐ N ☐ Nursing? Y ☐ N ☐ Taking birth control pills? Y ☐ N ☐

Please check **Yes** or **No** if you've had any of the following. **PLEASE DO NOT LEAVE ANY UNCHECKED:**

Y☐ N☐ AIDS/HIV Positive
Y☐ N☐ Anaphylaxis
Y☐ N☐ Anemia
Y☐ N☐ Arthritis, Rheumatism
Y☐ N☐ Artificial Heart Valves
Y☐ N☐ Artificial Joints
Y☐ N☐ Asthma
Y☐ N☐ Atrial Fibrilation
Y☐ N☐ Atopic (Allergy Prone)
Y☐ N☐ Back Problems
Y☐ N☐ Blood Disease
Y☐ N☐ Cancer
Y☐ N☐ Chemical Dependency
Y☐ N☐ Chemotherapy
Y☐ N☐ Circulatory Problems
Y☐ N☐ Cortisone Treatments
Y☐ N☐ Cough (persistent)
Y☐ N☐ Cough up blood
Y☐ N☐ Diabetes
Y☐ N☐ Epilepsy
Y☐ N☐ Excessive Bleeding
Y☐ N☐ Fainting
Y☐ N☐ Food Allergies
Y☐ N☐ Glaucoma
Y☐ N☐ Headaches
Y☐ N☐ Heart Murmur
Y☐ N☐ Heart Problems
Describe: _____
Y☐ N☐ High Cholesterol
Y☐ N☐ Hemophilia/Abnormal Bleeding
Y☐ N☐ Herpes
Y☐ N☐ Hepatitis
Y☐ N☐ High Blood Pressure
Y☐ N☐ Jaw Pain
Y☐ N☐ Kidney Disease
Y☐ N☐ Liver Disease
Y☐ N☐ Material Allergies
(latex, wool, metal, chemicals)
Y☐ N☐ Mitral Valve Prolapse
Y☐ N☐ Nervous Problems
Y☐ N☐ Pacemaker/Heart Surgery
Y☐ N☐ Psychiatric Care
Y☐ N☐ Rapid Weight Change
Y☐ N☐ Radiation Treatment
Y☐ N☐ Respiratory Disease
Y☐ N☐ Rheumatic/Scarlet Fever
Y☐ N☐ Shingles
Y☐ N☐ Shortness of Breath
Y☐ N☐ Skin Rash
Y☐ N☐ Spina Bifida
Y☐ N☐ Stroke
Y☐ N☐ Surgical Implants
Y☐ N☐ Swelling of feet or ankles
Y☐ N☐ Thyroid disease
Y☐ N☐ Tobacco Habit
Y☐ N☐ Tonsillitis
Y☐ N☐ Tuberculosis
Y☐ N☐ Ulcers/Colitis
Y☐ N☐ Venereal Disease
Y☐ N☐ Vaping
Y☐ N☐ Other: _____

Height: _____
Weight: _____

Authorization and Release

I confirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform the office of any changes in my medical status. I understand this information will be used by the dentist to help determine appropriate and healthful treatment.

I understand that I am responsible for payment of services rendered and also responsible for any co-payment and deductible that my insurance (if any) does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electric. By signing below, I have read and understand all of the above.

Signature: _____ Date: _____

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights - You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your rights have been violated

Your Choices - You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures - We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get a copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a small fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list of the times we've shared your health information for the previous six years, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Ave, S.W., Washington, DC 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

We never share your information unless you give us written permission for marketing purposes, sale of your information, and most sharing of psychotherapy notes. In the case of fundraising, we may contact you, but you can tell us not to contact you again.

Our Uses and Disclosures / How do we typically use or share your health information?

We typically use or share your health information in the following ways:

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as preventing disease, helping with product recalls, reporting adverse reactions to medications, reporting suspected abuse, neglect, or domestic violence, and/or preventing or reducing a serious threat to anyone's health or safety.

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Revision date: 7/20/2017

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.

You may refuse to sign this acknowledgement*

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

Patient Name (printed)

Signature

Date

Authorization To Release Information

Purpose: this form is used to obtain authorization to release information regarding yourself covered under the Privacy Act to people other than you.

I authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself.

--- ---
Name (printed) Relationship

--- ---
Name (printed) Relationship

--- ---
Name (printed) Relationship

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
[ ] Communication barriers prohibited obtaining the acknowledgement

[ ] An emergency situation prevented us from obtaining acknowledgement

[ ] Other (Please specify)
