DePalma Dental
Experience The Difference

Eaglesoft Medical History

Patient Name: Birth Date: Date Created: 2/23/2021

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medic;ition that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	Yes No	If yes
Have you ever been hospitalized or had a major operation?	Yes No	If yes
Have you ever had a serious head or neck injury?	Yes No	If yes
Are you taking any medications, pllls, or drugs?	Yes No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	Yes No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes No	If yes
Are you on a special diet?	Yes No	
Do you use tobacco?	Yes No	

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Do you use controlled substances?	Yes No	If yes
Other?	☐	If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive	Yes No	Cortisone Medicine	Yes No	Hemophilia	Yes No	Radiation Treatments	Yes No
Alzheimer's Disease	Yes No	Diabetes	Yes No	Hepatitis A	Yes No	Recent Weight Loss	Yes No
Anaphylaxis	Yes No	Drug Addiction	Yes No	Hepatitis B or C	Yes No	Renal Dialysis	Yes No
Anemia	Yes No	Easily Winded	Yes No	Herpes	Yes No	Rheumatic Fever	Yes No
Angina	Yes No	Emphysema	Yes No	High Blood Pressure	Yes No	Rheumatism	Yes No
Arthritis/Gout	Yes No	Epilepsy or Seizures	Yes No	High Cholesterol	Yes No	Scarlet Fever	Yes No
Artificial Heart Valve	Yes No	Excessive Bleeding	Yes No	Hives or Rash	Yes No	Shingles	Yes No
Artificial Joint	Yes No	Excessive Thirst	Yes No	Hypoglycemia	Yes No	Sickle Cell Disease	Yes No
Asthma	Yes No	Fainting Spells/Dizziness	Yes No	Irregular Heartbeat	Yes No	Sinus Trouble	Yes No
Blood Disease	Yes No	Frequent Cough	Yes No	Kidney Problems	Yes No	Spina Bifida	Yes No
Blood Transfusion	Yes No	Frequent Diarrhea	Yes No	Leukemia	Yes No	Stomach/Intestinal Disease	Yes No
Breathing Problems	Yes No	Frequent Headaches	Yes No	Liver Disease	Yes No	Stroke	Yes No
Bruise Easily	Yes No	Genital Herpes	Yes No	Low Blood Pressure	Yes No	Swelling of Limbs	Yes No
Cancer	Yes No	Glaucoma	Yes No	Lung Disease	Yes No	Thyroid Disease	Yes No
Chemotherapy	Yes No	Hay Fever	Yes No	Mitral Valve Prolapse	Yes No	Tonsillitis	Yes No
Chest Pains	Yes No	Heart Attack/Failure	Yes No	Osteoporosis	Yes No	Tuberculosis	Yes No
Cold Sores/Fever Blisters	Yes No	Heart Murmur	Yes No	Pain in Jaw Joints	Yes No	Tumors or Growths	Yes No
Congenital Heart Disorder	Yes No	Heart Pacemaker	Yes No	Parathyroid Disease	Yes No	Ulcers	Yes No
Convulsions	Yes No	Heart Trouble/Disease	Yes No	Psychiatric Care	Yes No	Venereal Disease	Yes No
Yellow Jaundice	Yes No						

Have you ever had any serious illness not listed Yes No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X _____ Date:_____

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DENTAL HISTORY

Name: _____ **Date of Birth:** _____ **Referred by:** _____

How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Previous Dentist: _____ **How long have you been a patient** _____ **Months / Years**

Date of most recent dental exam _____ / _____ / _____ **Date of most recent x-rays** _____ / _____ / _____

Date of most recent treatment: (other than a cleaning) _____ / _____ / _____

I routinely see my dentist every: ☐ 3 months ☐ 4 months ☐ 6 months ☐ 12 months ☐ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE CIRCLE YES OR NO TO THE FOLLOWING:

PERSONAL HISTORY

Are you fearful of dental treatment? If yes, how fearful, on a scale of 1 (least) to 10 (most)? _____ YES / NO

Have you had an unfavorable dental experience? _____ YES / NO

Have you ever had complications from past dental treatment? _____ YES / NO

Have you ever had trouble getting numb or had any reactions to local anesthetic? _____ YES / NO

Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age? _____ YES / NO

Have you had any teeth removed or missing that never developed or lost teeth due to injury/facial trauma? YES / NO

GUM AND BONE

Do your gums bleed or are they painful when brushing or flossing? _____ YES / NO

Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____ YES / NO

Have you ever noticed an unpleasant taste or odor in your mouth? _____ YES / NO

Is there anyone with a history of periodontal disease in your family? _____ YES / NO

Have you ever experienced gum recession? _____ YES / NO

Have you had any teeth become loose on their own (without injury), or do you have difficulty eating an apple? YES / NO

Have you experienced a burning or painful sensation in your mouth not related to your teeth? _____ YES / NO

TOOTH STRUCTURE

Have you had any cavities within the past 3 years? _____ YES / NO

Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? YES / NO

Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? _____ YES / NO

Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth? YES / NO

Do you have grooves or notches on your teeth near the gum line? _____ YES / NO

Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? _____ YES / NO

Do you frequently get food caught between any teeth? _____ YES / NO

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DENTAL HISTORY CONTINUED

BITE AND JAW JOINT

Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)_____ YES / NO

Do you feel like your lower jaw is being pushed back when you bite your back teeth together? _____ YES / NO

Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, protein bars, or other hard, dry foods? YES / NO

In the past 5 years, have your teeth changed (become shorter, thinner or worn) or has your bite changed? YES / NO

Are your teeth becoming more crooked, crowded, or overlapped? _____ YES / NO

Are your teeth developing spaces, or becoming more loose? _____ YES / NO

Do you have trouble finding your bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together? _____ YES / NO

Do you place your tongue between your teeth or close your teeth against your tongue? _____ YES / NO

Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____ YES / NO

Do you clench or grind your teeth together in the daytime or make them sore? _____ YES / NO

Do you have any problems with sleep (i.e. restlessness or grinding) wake up with a headache or tooth pain? YES / NO

Do you wear or have you ever worn a bite appliance? _____ YES / NO

SMILE CHARACTERISTICS

Is there anything about the appearance of your teeth that you would like to change (shape, color, size)? YES / NO

Have you ever whitened (bleached) your teeth? _____ YES / NO

Have you felt uncomfortable or self conscious about the appearance of your teeth? _____ YES / NO

Have you been disappointed with the appearance of previous dental work? _____ YES / NO

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

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Referral Information

Whom may we thank for referring you to our practice?

- Another patient, friend
- Another Doctor
- Newspaper Ad
- Phone Book
- Work
- TV Commercial
- Internet Search
- Other

Name of person or office referring you to our practice:

_____

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Date: 2/23/2021 Time 01:51 PM

PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name:

Responsible Party (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Soc Sec: Drivers Lic:

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: Address 2:

City: State / Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: Age: Soc Sec: Drivers Lic:

E-mail: ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg:

Section 3

Pre Med

Emergency Contact

Primary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Secondary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

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FINANCIAL POLICY AND CANCELLATION POLICY

FINANCIAL POLICY AND DENTAL INSURANCE EXPLANATION

Thank you for choosing DePalma Dental, LLC as your dental care provider! We are committed to providing the best dental care and service possible. It is also our goal to effectively communicate with our patients on all levels. With this in mind, please read the information regarding our policy on appointments and dental insurance benefits. If you have any further questions, please do not hesitate to ask.

CANCELLATION POLICY / RESERVED APPOINTMENT TIMES:

It has always been our contention that your time is valuable. We have a theory about scheduling - you deserve our undivided attention. For this reason, we do not double-book like other practices and we also do not accept walk-ins.

When we schedule a dental visit, that time is yours. It belongs to you. We understand that sometimes you are unable to make an appointment after you schedule it, however, when that appointment is cancelled within 48 hours of the appointment, it does not allow us enough time to replace it with someone who is also in need of our services.

Please note if you fail to keep an appointment or cancel one within 48 hours you will be sent a warning letter the first time. If this occurs a second time, there will be a charge of $50.00 made to your account. We will consider exceptions on an individual basis. Please sign below stating that you understand our cancellation policy and will work together with our office to continue providing you with prompt care.

INSURANCE

The insurance you have is a contract between you, your employer (if applicable) and the insurance company. Your employer has selected the level of insurance coverage you have. Covered services vary from plan to plan. Insurance companies base the amounts that they will pay for your dental treatments on restricted fee schedules related to your premium payments and geographical locations. Dental insurance is designed to defray the cost of your dental treatment. It is not intended as a total payment for services and should not be used to determine the type or amount of treatment you receive.

Please understand:
You must provide our office with a valid insurance card.
You must understand the terms of YOUR insurance coverage including but not limited to

1. Waiting periods for certain treatments
2. Changes in your plan terms/benefits (insurances do not tell us if there is a change)
3. Limitations and exclusions on certain treatment
4. Other benefits used in other dental offices

DO YOU ACCEPT MY INSURANCE?

If your insurance plan allows you the freedom to choose your own doctor, then you can use your benefits in our office. We are happy to file your claim for you.

HOW MUCH WILL THEY PAY?

Please call your insurance company to find out what your out-of-network benefits are and what they will cover for an out-of-network provider.

INSURANCE DIDN'T PAY NOW WHAT?

Ultimately, you are responsible for all charges incurred in our office. We file your primary insurance claim as a courtesy to you. We will try to submit the claim again if other information or questions are asked by the insurance company.

If you have any questions about our financial policy or have any uncertainty regarding insurance coverage, please ask now.

I have read and understand the above financial and cancellation policy and agree to comply with its terms.

Print Name: _____ Signature: _____ Date: _____

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Notice of Privacy Practices - DePalma Dental, LLC

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, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 11/06/2013, 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 protected health information 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 AND DISCLOSE HEALTH INFORMATION ABOUT YOU We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. 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 and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.
Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.
Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.
Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or 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 protected health information 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 and 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 look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure. If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.
Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. 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 the additional requests.
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 to the Privacy Official. 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. 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, 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 Request a Restriction. You will receive notifications of breaches of your unsecured protected health information as required by law.
Electronic 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).
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 if you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at 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 the U.S. Department of Health and Human Services upon request.

I acknowledge that I received a copy of DePalma Dental, LLC Notice of Privacy Practices.

Patient Name: _____ **Signature:** _____ **Date:** _____

I agree to your sharing any relevant information regarding my dental care to the following people:

1) _____

2) _____