4233 Montgomery Blvd NE
Suite 120W
Albuquerque, NM 87109
Phone: (505) 323-7966
Fax: (505) 884-8716

HonestTooth
Family Dentistry

E-Mail: honesttooth@gmail.com
Web: www.honesttooth.com

Patient Information and Medical Release

First Name: _____ Middle Name: _____ Last Name: _____

DOB: _____ SSN: _____ GENDER: ☐ - Male ☐ - Female

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

Home Phone: _____ Cell Phone: _____ Email: _____

Reason for Visit: ☐-Cleaning ☐-Exam ☐-Other_____

How would you like to be reminded of future appointments? ☐ - Email ☐ - Text Message ☐- Phone

Insurance Information **(** ☐ - Uninsured)

Policy Holder Name: _____ Policy Holder Employer: _____

Policy Carrier: _____ Policy Group Number: _____

Policy Holder SSN:_____ Policy Holder DOB:_____

Previous Dental Information

Previous Dentist: _____ Date of Last Dental Appointment: _____

Were X-rays taken at the last appointment? Yes ☐ No ☐

Are records in the possession of the patient? Yes ☐ No ☐

Can the records be obtained by the patient? Yes ☐ No ☐

Were the records requested from previous office? Yes ☐ No ☐

This Form serves as a Medical Release and Honest Tooth Family Dentistry has my permission to obtain any of my previous medical or dental records.

Patient Signature: _____ Date: _____

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Medical History Form

First Name:_____ Middle Name:_____ Last Name:_____

Dental History (Please check all that apply):

☐-Bad Breath	☐-Dry Mouth	☐-Jaw Pain
☐-Bleeding Gums	☐-Food Collection between Teeth	☐-Mouth Breathing
☐-Blisters on Lips	☐-Grinding Teeth	☐-Tooth Pain
☐-Cigarette Smoking	☐-Gums Swollen or Tender	☐-Tooth Sensitivity

Medical History (Please check all that apply):

Primary Physician Name: _____ Phone: _____ Date of Last Exam: _____

☐-Anemia	☐-Diabetes	☐-High Blood Pressure	☐-Scarlet Fever
☐-Arthritis	☐-Dizziness	☐-Kidney Disease	☐-Shortness of breath
☐-Artificial Heart Valve	☐-Emphysema	☐-Liver Disease	☐-Sinus Problems
☐-Back Problems	☐-Fainting	☐-Low Blood Pressure	☐-Stroke
☐-Bleeding abnormally	☐-Glaucoma	☐-Nervous Problems	☐-Swollen Ankles
☐-HIV/Hepatitis	☐-Headaches	☐-Pace Maker	☐-Thyroid Disease
☐-Cancer Type: _____	☐-Heart Murmur	☐-Psychiatric Care	☐-Tuberculosis
☐-Chemotherapy/ Radiation	☐-Heart Problems	☐-Weight Loss/Gain	☐-Tumor
☐-Circulatory Problems	☐-Hepatitis Type: ___	☐-Respiratory Disease	☐-Venereal Disease
☐-Cough persistent, blood	☐-Herpes	☐-Rheumatic Fever	☐-Ulcer

Do you wear contact lenses? Yes ☐ No ☐ Are you taking Birth Control pills? Yes ☐ No ☐

Are you Pregnant? Yes ☐ No ☐ Are you Nursing? Yes ☐ No ☐

Please list all medications you are currently taking: _____

Please list any allergies or sensitivities: _____

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PRIVACY ACT

NOTICE OF PRIVACY PRACTICES THIS NOTICE DESCRIBES HOW HEALTH INFORMATIONABOUT 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. 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 let us know.

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. Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety of others 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 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 or fax to the address and/or fax at the end of this notice. If you request copies, we will charge you $0. 10 for each page, $ 2.00 per hour for staff time to 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 in that format. If you prefer, we will prepare a summary or an explanation of 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 disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities. Restriction: You have the right to request that we place additional restrictions on

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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. Your request must specify the alternative means or location. 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.

QUESTIONS AND CONCERNS

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 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. 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. I acknowledge that I was given the opportunity to read and understand the privacy practices outlined on this form. I authorize the disclosure of my health information as outlined on this form.

Signature: _____ Date: _____