DENTAL REGISTRATION AND HISTORY

(PLEASE PRINT)

Garrison Family Dentistry
129-D University Blvd.
Harrisonburg, VA 22801
540-434-5702

Date_____ Home Phone_____

PATIENT INFORMATION

Name_____ Soc. Sec. #_____
Last Name First Name Initial

Address_____

City_____ State_____ Zip_____

Sex ☐ M ☐ F Age_____ Birthdate_____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient Employed by_____ Occupation_____

Business Address_____ Business Phone_____

Whom may we thank for referring you?_____

In case of emergency who should be notified?_____ Phone_____

PRIMARY INSURANCE

Person Responsible for Account_____
Last Name First Name Initial

Relation to Patient_____ Birthdate_____ Soc. Sec. #_____

Address (If different from patient's)_____ Phone_____

City_____ State_____ Zip_____

Person Responsible Employed by_____ Occupation_____

Business Address_____ Business Phone_____

Insurance Company_____

Contract #_____ Group #_____ Subscriber #_____

Names of other dependents covered under this plan_____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with_____
Name of Insurance Company(ies)

and assign directly to Dr._____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____
Responsible Party Signature Relationship Date

GARRISON FAMILY
DENTISTRY

Health History Form

(Confidential)

Dental Information *Please mark (x) your responses to the following questions*

What is the reason for your dental visit today? Are you currently experiencing dental pain or discomfort?					
How do you feel about your smile?					
	Yes	No		Yes	No
Do your gums bleed when you brush or floss?.....	☐	☐	Do you get food stuck between your teeth?.....	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?....	☐	☐	Do you have clicking, popping or discomfort in your jaw?.....	☐	☐
Is your mouth dry?.....	☐	☐	Do you clinch or grind your teeth?.....	☐	☐
Do you feel that you have bad breath?.....	☐	☐	Do you have herpes, cold sores or ulcers in your mouth?....	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	Do you have missing teeth?.....	☐	☐
Have you ever had orthodontic (braces) treatment?.....	☐	☐	Do you wear full or partial dentures?.....	☐	☐
Have you had any problems with your previous treatments?...	☐	☐	Do you have any loose teeth?.....	☐	☐
Has fear or anxiety prevented you from seeing a dentist?.....	☐	☐	Do you have any broken teeth or missing fillings?.....	☐	☐
Has lack of insurance or finances prevented a dental visit?...	☐	☐	Have you ever had a serious injury to your head or mouth?.	☐	☐
When was your last dental exam? What was done at that time?					

DENTAL ROUTINE/HABITS	Yes	No		Yes	No
Do you have frequent snacks between meals?.....	☐	☐	Do you regularly drink soda, coffee or tea?.....	☐	☐
Is your home water supply fluoridated?.....	☐	☐	Do you use toothpaste with fluoride?.....	☐	☐
Do you brush twice a day for two minutes?.....	☐	☐	How often do you floss?		

Medical Information *Please mark (x) your response to indicate if you have or have not had any of the following diseases or problems*

	Yes	No		Yes	No
Have you had a serious illness, operation or been hospitalized in the past 5 years?.....	☐	☐	Has there been any change in your health within the past year?.....	☐	☐
Are you now under the care of a physician? Physician Name Phone Address			If yes, what was the change, illness or problem?		
Please list all prescription or over the counter medications, dietary supplements and vitamins you are taking:					

SOCIAL HISTORY	Yes	No		Yes	No
Do you use tobacco? (Smoking, snuff, chew, betel nut)..... If so, how many do you smoke in a day?	☐	☐	Do you drink alcoholic beverages?..... If so, how many beverages do you drink in a week?	☐	☐
Do you use controlled substances (recreational drugs)?.....	☐	☐			
If so, how interested are you in stopping any of the above? VERY / SOMEWHAT / NOT					

SLEEP STUDY SCREENING	Yes	No		Yes	No
Do you snore?.....	☐	☐	Do you wake up in the night gasping for breath?.....	☐	☐
Have you had a sleep study?.....	☐	☐	Do you wear a CPAP or other device?.....	☐	☐

ALLERGIES..... ☐ NO KNOWN ALLERGIES			
☐ Aspirin	☐ Local Anesthetics	☐ Penicillin or other antibiotics	☐ Barbiturates (Sleeping Pills)
☐ Sulfates or Sulfa Drugs	☐ Codeine or other narcotics	☐ Metals (i.e nickel)	☐ Latex
☐ Gluten intolerance ☐ Celiacs Disease ☐ Artificial Dyes ☐ Other:			
☐ Environmental (Seasonal, Animals, Food) - Please list:			
☐ Other			

ARTIFICIAL JOINT REPLACEMENT	Yes	No		Yes	No
Have you had an orthopedic total joint replacement?..... (Hip, knee, elbow, finger)	☐	☐	Has your doctor told you you need to take antibiotics prior to a dental visit?.....	☐	☐
Date of surgery:			Treating physician:		

BISPHOSPHONATES	Yes	No
Are you taking or scheduled to take an antiresorptive agent (like Fosamax, Actonel, Atelvia, Boniva, Reclast, Prolia) for osteoporosis or Paget's disease?	☐	☐
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?.....	☐	☐

MEDICAL/SURGICAL HISTORY	Yes	No	
Do you have any Heart problems?.....	☐	☐	☐Heart Attack ☐Artificial valve ☐Pacemaker ☐High Blood Pressure ☐Murmur ☐Mitral Valve Prolapse ☐Circulation problems ☐A-Fib
Has your doctor told you you need to take antibiotics prior to a dental visit?	☐	☐	☐_____ ☐_____
Do you have any Breathing problems?.....	☐	☐	☐ Asthma ☐Persistent cough ☐Respiratory disease ☐Shortness of Breath ☐COPD ☐Tuberculosis ☐Cough up blood ☐_____
Do you have any Blood problems?.....	☐	☐	☐ HIV+/AIDS ☐ Hepatitis ☐Anemia ☐Hemophilia ☐Transfusion ☐_____
Do you have any Head, Ear, Eyes or Nose problems?	☐	☐	☐ Sinus Infections ☐Glaucoma ☐Migraines ☐Tonsillitis ☐_____
Do you have any Digestive problems?.....	☐	☐	☐ GERD ☐History of bulimia or anorexia ☐_____
Do you have any Endocrine problems?.....	☐	☐	☐ Diabetes ☐ Thyroid disorder ☐_____
Do you have any Nervous System problems?.....	☐	☐	☐ Stroke ☐Epilepsy ☐_____
Do you have any Psychiatric problems?.....	☐	☐	☐ Anxiety ☐ Bipolar ☐ Depression ☐ ADD/ADHD ☐_____
Do you have Chronic pain?.....	☐	☐	☐Back problems ☐Cortisone injections ☐Swelling of feet
Do you have a history of Cancer?.....	☐	☐	☐Treatment with Radiation/Chemotherapy
Do you have other Systemic Diseases?.....	☐	☐	☐Kidney disease ☐Liver Disease ☐Jaundice ☐Rheumatic Fever ☐Scarlet Fever ☐Arthritis/Rheumatism ☐_____
Do you have other Health concerns not listed?.....	☐	☐	Please list:

WOMEN ONLY	Yes	No		Yes	No
Are you pregnant? ..... Number of weeks: _____	☐	☐	Are you taking birth control pills or hormonal replacement?	☐	☐
Are you nursing (breastfeeding/pumping)?.....	☐	☐			

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature: _____ **Date:** _____

GARRISON FAMILY DENTISTRY

CONSENT FOR USE AND DISCLOSURE OF 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 STATEMENTS 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 other 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: Susan or Jenifer

Telephone: 540-434-5703 Fax: 540-574-4944

E-mail: dentist4u3@gmail.com

Address: 129 University Blvd., Suite D, Harrisonburg VA 22801

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 took 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 heath 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: _____

GARRISON FAMILY DENTISTRY

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}

_____
{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)

_____

_____

_____

This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).

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 4/19/2003, 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.

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 or the 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 to the address at the end of this Notice. If you request copies, we will charge you $0._____ for each page, $_____ 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 or our business associates disclosed your health information for purposes, 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 location 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 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.

Contact Officer: C.M. Garrison, D.D.S. P.C.
Telephone: 540-434-5702
Fax: 540-574-4944
E-mail: dentist4u1@gmail.com
Address: 129 University Blvd., Suite D Harrisonburg, VA 22801