PERSONAL INFORMATION of _____ Date _____

This personal information will help us to give you the most consideration of your time and feelings.
It is important to have complete answers. ALl information is, of course, confidential.

Are you aware of any particular dental problems? _____

_____

Are you having any discomfort or pain? _____

How long has it been since you last visited a dental office? _____

What was done for you at that time? _____

May we ask who recommended this office? _____

Your Name: _____ First name, husband (or wife) _____

Home address: _____ City _____ Zip _____

Home Phone: _____ Occupation _____ Social Sec. No. _____

Are you covered by any kind of dental insurance? Yes ❑ No ❑

If so, what insurance: _____

If married, occupation of your husband (or wife) _____

For what company does your husband (or wife) work? _____Phone _____Ext:_____

Is your husband (or wife) covered by any kind of dental insurance? Yes ❑ No ❑

If so, what insurance: _____

Your physician's name: _____ Address: _____

DOCTOR'S NOTES AND UP-DATES ON PERSONAL INFORMATION

DATE	

Health History

Has there been any problem in your general health within the past 5 years? (serious illness, hospitalization, surgery)

Yes ❑ No ❑

If so, what was the problem? _____

Have you had any form of Cancer? Yes ❑ No ❑ If so, what type or name?

_____

Date of last medical check-up _____ Attending physician _____

Date of last blood test _____ Attending physician _____

Under a physician's care now? Yes ❑ No ❑ If so, for what?

_____

What tablets, pills or liquids do you take? (That includes aspirin, vitamins, tonics, etc.) _____

_____

Does your physician require you to take special medication before dentistry? Yes No If so, what? _____

_____

Date and year of birth _____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING DISEASES OR PROBLEMS:

	Yes	No		Yes	No
Rheumatic fever, rheumatic heart disease _____	❑	❑	Tuberculosis, other lung ailments _____	❑	❑
Heart trouble, heart attack, high blood pressure, stroke	❑	❑	Persistent cough, cough up blood _____	❑	❑
Heart murmur, Mitral Valve prolapse _____	❑	❑	Diabetes _____	❑	❑
Pain in chest, shortness of breath, swollen ankles ____	❑	❑	Radiation treatment for a tumor or other growth ___	❑	❑
Blood disorders, anemia _____	❑	❑	Sores that did not heal within one week _____	❑	❑
Cold sores or herpes incident _____	❑	❑	Women: Are you pregnant? _____	❑	❑
Positive test for venereal disease within five years ____	❑	❑	Are you sensitive or allergic to: Penicillin _____	❑	❑
Positive test for aids virus _____	❑	❑	Codeine _____	❑	❑
Abnormal bleeding, prolonged healing, bruises easily	❑	❑	Novocaine _____	❑	❑
Asthma, hay fever _____	❑	❑	Aspirin _____	❑	❑
Low blood pressure _____	❑	❑	Other anesthetics _____	❑	❑
Fainting spells, seizures _____	❑	❑	Other drugs _____	❑	❑
Hepatitis, jaundice, liver disease _____	❑	❑	Do you have any disease, condition or problem **not**		
Arthritis _____	❑	❑	listed above that you think the doctor should know		
Have you had an orthopedic joint replacement _____	❑	❑	about?		
Have you had an organ transplant _____	❑	❑	_____		
Kidney troubles _____	❑	❑	_____		
			_____		

Patient's signature Date

DOCTOR'S NOTES AND UPDATES ON HEALTH HISTORY

DATE	

HIPAA Notice of Privacy Practices

Fairfield Family Dentistry
1140 Hicks Blvd.
Fairfield, Ohio 45014
(513) 829-8822

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. “Protected health information” is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and other outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician’s practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your healthcare with a third party. For example. We would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital administration

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food or Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers’ Compensation: Inmates: Required USes and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 154.500.

We are required by law to maintain the privacy of, and provide individuals with, the notice of our legal duties, and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices.

Print Name: _____ Signature _____ Date _____

Others to whom we may speak, concerning your medical history and account information

Name _____ Relation to patient _____

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law

Your may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization

Your Rights
Following is a statement of your rights with respect to your protected health information

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: physiotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If a physician believes it is in your best interest to permit use of disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health And Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**