

Rob E. Sable, D.D.S.,F.A.G.D.  
Patient Information Forms

Patient Name \_\_\_\_\_ Preferred Name \_\_\_\_\_

Date of Birth \_\_\_\_\_  Single  Married  Separated  Divorced  Widowed

Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone Home \_\_\_\_\_ Office \_\_\_\_\_ Cell \_\_\_\_\_

SS# \_\_\_\_\_ EMAIL \_\_\_\_\_ Referred by: \_\_\_\_\_

Is another member of your family or a relative in our practice?  Yes  No Name \_\_\_\_\_ Relationship \_\_\_\_\_

**Emergency**

Who would you like us to contact FIRST in case of an emergency?

Name \_\_\_\_\_ Address \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

**Financial**

Who is financially responsible for the payment of your account? \_\_\_\_\_

Relationship to patient \_\_\_\_\_

If different from the patient's, give daytime phone number. \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**PAYMENT IN FULL IS DUE AT THE TIME OF TREATMENT UNLESS PRIOR ARRANGEMENTS HAVE BEEN APPROVED.**

We will submit your insurance claim for you. However, we do not accept assignment.

**Insurance Information**

Insurance Co. Name \_\_\_\_\_ Group # \_\_\_\_\_ Insurance Co. Phone \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Subscriber's Name \_\_\_\_\_ Relation \_\_\_\_\_

Subscriber's D.O.B. \_\_\_\_\_ Subscriber's SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Subscriber's Employer \_\_\_\_\_

The information that I have given is true and correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence. I hereby authorize the doctor or designated staff to take x-rays, study models, bacteriological cultures, diagnostic casts, photographs, biopsies of oral tissue, and any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the above named patient's dental needs. Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I consent to the use of appropriate medication and therapy as deemed necessary. I fully understand that using anesthetic agents embodies a certain risk. I understand that I am responsible for the total fee for the services rendered.

**Patient/Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_**

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**MEDICAL/DENTAL HISTORY QUESTIONNAIRE/ (UPDATE)**

NAME \_\_\_\_\_

What is the best daytime phone # ? \_\_\_\_\_

- Are you now, or have been under the care of physician in the past two years? **YES/ NO**
- What is, or was the condition being treated? \_\_\_\_\_
- What is your physician's name and address? \_\_\_\_\_  
\_\_\_\_\_ phone# \_\_\_\_\_
  
- Have you had any serious illnesses or operations? **YES/ NO**  
If yes, describe \_\_\_\_\_
- Have you ever had a blood transfusion? **YES NO** If yes, about when? \_\_\_\_\_
- Are you pregnant? Or think you are **YES/ NO** Nursing? **YES/ NO**  
Taking birth control pills? **YES NO**
- Have you ever had abnormal bleeding with extractions, surgery or trauma? **YES NO**
- Do you smoke? **YES NO** If yes, how much? \_\_\_\_\_
- Do you use chewing tobacco? **YES NO**
- Do you consume more than 2 oz of liquor/day? **YES NO**
- Are you on Coumadin (blood thinner)? **YES NO**
- Are you taking medications? **YES NO**

**If yes, please list all medications & dosages on the back of this form**

**Check (√) if you have or had any of the following:**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> alcohol/drug abuse       | <input type="checkbox"/> epilepsy/seizures     | <input type="checkbox"/> other                           |
| <input type="checkbox"/> anemia                   | <input type="checkbox"/> glaucoma              | <input type="checkbox"/> pacemaker                       |
| <input type="checkbox"/> arthritis                | <input type="checkbox"/> heart attack          | <input type="checkbox"/> psychiatric care                |
| <input type="checkbox"/> artificial heart valve   | <input type="checkbox"/> heart murmur          | <input type="checkbox"/> radiation therapy               |
| <input type="checkbox"/> artificial joints        | <input type="checkbox"/> hepatitis, type___    | <input type="checkbox"/> rheumatic fever                 |
| <input type="checkbox"/> asthma                   | <input type="checkbox"/> high blood pressure   | <input type="checkbox"/> sinus                           |
| <input type="checkbox"/> bruise easily            | <input type="checkbox"/> HIV/AIDS              | <input type="checkbox"/> stroke                          |
| <input type="checkbox"/> cancer                   | <input type="checkbox"/> hypoglycemia          | <input type="checkbox"/> subacute bacterial endocarditis |
| <input type="checkbox"/> chemotherapy             | <input type="checkbox"/> kidney disease        | <input type="checkbox"/> swollen neck glands             |
| <input type="checkbox"/> cold sores/blisters      | <input type="checkbox"/> liver disease         | <input type="checkbox"/> thyroid condition               |
| <input type="checkbox"/> cortisone therapy        | <input type="checkbox"/> lupus                 | <input type="checkbox"/> tuberculosis                    |
| <input type="checkbox"/> diabetes                 | <input type="checkbox"/> mitral valve prolapse | <input type="checkbox"/> ulcers                          |
| <input type="checkbox"/> diet(special/restricted) | <input type="checkbox"/> nervous/anxious       | <input type="checkbox"/> venereal disease                |

**Check (√) if you are allergic to or have reacted adversely to any of the following:**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> aspirin                      | <input type="checkbox"/> codeine/other narcotics | <input type="checkbox"/> local anesthetics |
| <input type="checkbox"/> barbiturates(sleeping pills) | <input type="checkbox"/> iodine                  | <input type="checkbox"/> latex             |

antibiotics (PLEASE CIRCLE) penicillin    sulfa    erythromycin    tetracycline

**OTHER PLEASESPECIFY** \_\_\_\_\_

**Check (√) if you are having problems with any of the following:**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> bleeding gums       | <input type="checkbox"/> grinding teeth                | <input type="checkbox"/> sensitivity to hot or cold     |
| <input type="checkbox"/> periodontal disease | <input type="checkbox"/> jaw pain                      | <input type="checkbox"/> sensitivity when chewing       |
| <input type="checkbox"/> dry mouth           | <input type="checkbox"/> clicking or popping jaw       | <input type="checkbox"/> sores or growths in your mouth |
| <input type="checkbox"/> mouth breathing     | <input type="checkbox"/> food collection between teeth |   |

**Patient signature** \_\_\_\_\_ **date** \_\_\_\_\_



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**HIPAA Notice of Privacy Practice**

**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 Disclosure of Protected Health Information**

Your protected health information may be used and disclosed by your physician, our office staff and others 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 health care 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 admission.

**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 school 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 and 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 164.500.

**Other Permitted and Required Uses and Disclosures** will be made only with your consent, authorization or opportunity to object unless required by law.

**You may revoke this authorization** (above mentioned), 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; psychotherapy 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.

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**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 physician believes it is in your best interest to permit use and 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 any 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.**

**PLEASE SIGN THE ENCLOSED ACKNOWLEDGEMENT OF RECEIPT AND SEND BACK TO THE OFFICE OR BRING IT TO YOUR NEXT APPOINTMENT.**

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Please initial all that apply:

\_\_\_\_\_ I consent to receiving communication regarding my care via email.

\_\_\_\_\_ I consent to receiving communication on my voicemail at HOME, CELL OR  
WORK.

\_\_\_\_\_ I consent to have my care discussed with my spouse.

\_\_\_\_\_ I consent to have my care discussed with my immediate family  
members\_\_\_\_\_.

\_\_\_\_\_ I DO NOT want my care discussed with anyone other than myself.

By signing below you agree that you have been given the opportunity to review HIPPA's privacy practices.  
You may revoke your above designation(s) at any time via written request. Thank you for allowing our doctor  
the opportunity to assist in your care.

Patient's Signature:\_\_\_\_\_ Date:\_\_\_\_\_