EVERETT WATSON DDS
FOCUSED ON COMFORT • DEDICATED TO EXCELLENCE

Date paperwork was completed:_____

About You

Name: _____ Name Preference: _____
Last First MI

If child: Parent's name: _____

Birth Date: _____ ❑ M ❑ F Status: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed ❑ Other

Address: _____ City/State/Zip: _____

E-Mail Address: _____ Occupation: _____

Home #: _____ Cell #: _____

Work #: _____ Ext: _____ Whom may we thank for referring you?_____

Whom should we contact in case of an emergency: _____

Relation: _____

Home #: _____ Cell #: _____ Work# _____ Ext: _____

Person Responsible for this Account: _____

Insurance Information

Policy Holder's Name: _____ Relationship to patient: _____ Birth Date: _____
Last First MI

Address (if different from patient): _____ City/State/Zip _____

Phone #: _____ Ext: _____ Employed by: _____

Insurance Company: _____ Insurance Phone: _____

Insurance Address: _____ City/State/Zip: _____

Social Security Subscriber #: _____

Group # (plan, local, or policy#): _____ Other dependents under this plan _____

Does the patient have a secondary insurance plan? ❑ Yes ❑ No Insured's Name: _____

Relation to Patient: _____ Birth Date: _____

Insurance Company: _____ Insurance Phone: _____

Insurance Address: _____ City/State/Zip: _____

Group # (plan, local, or policy #): _____

Social Security Subscriber #: _____

Dental History

Reason for today's visit: _____

Are you in pain? ❑ Yes ❑ No How long? _____

Please check yes or no if any of the following applies:

❑ Y ❑ N Discomfort, clicking, popping, or locking of jaw
❑ Y ❑ N Sensitivity of teeth/gum to cold/heat/sweets when biting
❑ Y ❑ N Bad breath
❑ Y ❑ N Drymouth
❑ Y ❑ N Orthodontic treatment
❑ Y ❑ N Gag easily
❑ Y ❑ N Grinding/clenching teeth
❑ Y ❑ N Jaw pain (TMJ/TMD)
❑ Y ❑ N Blisters/sores on lips/mouth
❑ Y ❑ N Growth on lip or in mouth
❑ Y ❑ N Mouth breathing
❑ Y ❑ N Food collecting between teeth
❑ Y ❑ N Periodontal (gum) disease
❑ Y ❑ N Lip/Tongue piercing
❑ Y ❑ N Red/swollen/bleeding gums
❑ Y ❑ N Lost/broken filling or lost teeth
❑ Y ❑ N Need to chew on one side of mouth
❑ Y ❑ N Wear full/partial dentures
❑ Y ❑ N Headaches, neck aches or shoulder aches
❑ Y ❑ N Snore or have other sleeping disorders
❑ Y ❑ N Hold foreign object with your teeth (pencils, pipe, bite fingernails)
❑ Y ❑ N Other: _____

Do you require pre-medication? ❑ Yes ❑ No ❑ Don't know Name of medication: _____

Former Dentist's Name and Contact Info: _____

Date of Last Dental Visit: _____ Date of Last Dental Cleaning: _____ Date of Last Full Mouth X-Rays: _____

How often do you visit the dentist? _____ How often do you brush your teeth? _____
How often do you floss?_____ Have you ever or are you currently using topical fluoride? _____
What other dental aids do you use? (Interplak, toothpick; WaterPik) _____
Is there anything else about having dental treatment that you would like us to know? _____

Medical History

General health (please check): ❑ Excellent ❑ Good ❑ Fair ❑ Poor Date of last physical: _____
Do you smoke or use tobacco? ❑ Yes ❑ No If yes, how often?
Have you had any serious illnesses or operations in the last five years? ❑ Yes ❑ No If yes, please explain: _____
Are you currently under physician care or have you in the last two years? ❑ Yes ❑ No If yes, please explain: _____
Date of last visit: _____ Physician's Name/Phone #: _____

Please check yes or no if any of the following applies:

❑ Y ❑ N	Heart Murmur	❑ Y ❑ N	Abnormal Bleeding	❑ Y ❑ N	Thyroid Disease
❑ Y ❑ N	Rheumatic Fever	❑ Y ❑ N	On Blood Thinner	❑ Y ❑ N	Cortisone Treatment
❑ Y ❑ N	Mitral Valve Prolapse	❑ Y ❑ N	Respiratory Disease	❑ Y ❑ N	Rapid Weight Gain/Loss
❑ Y ❑ N	Artificial Heart Valves	❑ Y ❑ N	Sinus Problems	❑ Y ❑ N	Severe/Frequent Headaches
❑ Y ❑ N	Artificial Joints	❑ Y ❑ N	Asthma	❑ Y ❑ N	Psychiatric Care
❑ Y ❑ N	Arthritis, Rheumatoid	❑ Y ❑ N	Tuberculosis	❑ Y ❑ N	Nervousness
❑ Y ❑ N	Cosmetic Surgery/Implants	❑ Y ❑ N	Persistent Cough	❑ Y ❑ N	Tobacco Habit
❑ Y ❑ N	Congenital Heart Defects	❑ Y ❑ N	Pacemaker/Heart Surgery	❑ Y ❑ N	Alcohol Dependency
❑ Y ❑ N	AIDS/HIV Positive	❑ Y ❑ N	Heart Problems	❑ Y ❑ N	Circulatory Problems
❑ Y ❑ N	Hepatitis, Type		Describe _____	❑ Y ❑ N	Stomach Ulcer
❑ Y ❑ N	Stroke	❑ Y ❑ N	Back Problems	❑ Y ❑ N	Glaucoma
❑ Y ❑ N	Cancer	❑ Y ❑ N	Diabetes	❑ Y ❑ N	Anaphylaxis
❑ Y ❑ N	Leukemia	❑ Y ❑ N	Kidney Disease	❑ Y ❑ N	Skin Rash
❑ Y ❑ N	Anemia	❑ Y ❑ N	Liver Disease	❑ Y ❑ N	Epilepsy
❑ Y ❑ N	Radiation Treatment	❑ Y ❑ N	Chemical Dependency	❑ Y ❑ N	Dementia
❑ Y ❑ N	Tumor or Growth	❑ Y ❑ N	High Blood Pressure	❑ Y ❑ N	Other _____
❑ Y ❑ N	Chemotherapy	❑ Y ❑ N	Low Blood Pressure		_____

Women: Are you pregnant? ❑ Y ❑ N Due date: _____ Nursing? ❑ Y ❑ N
Taking Birth Control Pill? ❑ Y ❑ N Type: _____

Allergies: ❑ Latex ❑ Anesthetics ❑ Penicillin ❑ Sulfa ❑ Codeine ❑ Metal ❑ Food ❑ Pollen
❑ Other, please list: _____

Medication: Please list **all** medications you are currently taking and the correlating diagnoses: _____
_____

Signature of Patient, Parent or Guardian: _____ Date: _____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Relationship to Patient: _____
History review:_____
_____

Dentist signature:_____ Date: _____

Consent

- I agree to the treatment, diagnostics, and procedures done by the dentist for proper dental care.
- I agree to proper use and disclosure of my records or my child's records to conduct treatment, obtain payment, or other healthcare activities that are related to treatment or payment.
- I agree to the disclosure of my records or my child's records to the following persons. These individuals are involved in my care or my child's care or payment regarding that care. This will be effective until I revoke in writing
- I agree to payment directly to the dentist or dental group of insurance benefits that are otherwise payable to me. I understand that my dental benefits may cover less than the exact bill for services. In this event, I am financially responsible for payment of the remaining balance. By signing below, I agree that all previous agreements are revoked as I agree to be the responsible party for payment of services moving forward.

Patient's or Guardian's Signature: _____ Date: _____

My Smile Profile

Patient Name: _____ Date: _____

Please take a few minutes to let us know your smile a little bit better and how we could help make it even more beautiful by answering the following questions:

Are you satisfied with the appearance and functions of your teeth? ❑ Yes ❑ No

Please comment: _____

_____

_____

Would you like your smile to be better, brighter, or different? ❑ Yes ❑ No

Please comment: _____

_____

_____

If you had a magic wand and could change anything you wanted about your smile, what would it be?

_____

_____

Would you like to keep all of your teeth your whole life?

_____

_____

Please check below any changes you would make in your smile:

❑ Whiten all visible front teeth	❑ Whiten a single tooth	❑ Close spaces between teeth
❑ Straighten teeth	❑ Lengthen teeth	❑ Shorten teeth
❑ Rebuild chipped teeth	❑ Repair uneven edges	❑ Eliminate crowding
❑ Eliminate dark or stained fillings	❑ Reduce gum showing in smile	❑ Repair gum recession

Please help us make your visit more pleasant by answering the following questions:

Have you ever had an upsetting dental experience? ❑ Yes ❑ No

If yes, please describe: _____

_____

Do you feel nervous about having dental treatment done? ❑ Yes ❑ No

If so, what is your biggest concern? _____

_____

_____

Notice of Privacy Practices

Everett Watson, DDS

Protecting Your Confidential Health Information is Important to Us

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.

OUR PROMISE

Dear Patient:

This notice is not meant to alarm you. Quite the opposite! It is our desire to communicate to you that we are taking seriously Federal law (HIPAA—Health Insurance Portability and Accountability Act) enacted to protect the confidentiality of your health information. We do not ever want you to delay treatment because you are afraid your personal health history might be unnecessarily made available to others outside our office.

Why do you have a privacy policy?

Very good question!

The Federal government legally enforces the importance of the privacy the importance of the privacy of health information largely in response to the rapid evolution of computer technology and its use in healthcare. The government has appropriately sought to standardize and protect the privacy of the electronic exchange of your health information. This has challenged us to review not only how your health information is used within our computers but also with the Internet, phone, faxes, copy machines, and charts. We believe this has been an important exercise for us because it has disciplined us to put in writing the policies and procedures we follow to protect your health information when we use it. We want you to know about these policies and procedures which we developed to make sure your health information will not be shared with anyone who does not require it. Our office is subject to State and Federal law regarding the confidentiality of your health information and in keeping with these laws, we want you to understand our procedures and your rights as our valuable patient. We will use and communicate your health information only for the purposes of providing your treatment, obtaining payment, conducting health care operations, and as otherwise described in this notice.

How your Health Information may be used to Provide Treatment

We will use your health information within our office to provide you with dental care. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care between hygienist, dental assistant, dentist, and business office staff. In addition, we may share your health information with physicians, referring dentists, clinical and dental laboratories, or other health care personnel providing you treatment.

To Obtain Payment

We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically. WE will be sure to only work with companies with similar commitment to the security of your health information.

To Conduct Health Care Operations

Your health information may be used during performance evaluations of our staff. Some of our best teaching opportunities use clinical situations experienced by patients receiving care at our office. As a result, health information may be included in training programs for students, interns, associates, and business and clinical employees. It is also possible that health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine processes of certification, licensing, or credentialing activities.

In Patient Reminders

Because we believe regular care is very important to your oral and general health, we will remind you of scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you or your family.

These communications are an important part of our philosophy of partnering with our patients to be sure they receive the best preventive and restorative care modern dentistry can provide. They may include postcards folding postcards, letters, telephone reminders or electronic reminders such as email (unless you tell us that you do not want to receive these reminders).

To Business Associates

We have contracted with one or more third parties (referred to as a business associate) to use and disclose your health information to perform services for us, such as billing services. We will obtain each business associate's written agreement to safeguard your health information.

NOTICE OF PRIVACY PRACTICES

Federal law generally permits us to make certain uses or disclosures of health information without your permission. Federal law also requires us to list in the Notice each of these categories of uses or disclosures. The listing is below.

As Required by Law

We may use or disclose your health information as required by any statute regulation, court order, or other mandate enforceable in a court of law.

Abuse or Neglect

We may disclose your health information to the responsible government agency if (a) the Privacy Official reasonably believes that you are a victim of abuse, neglect, or domestic violence, and (b) we are required or permitted by law to make the disclosure. We will promptly inform you that such a disclosure has been made unless the Privacy Official determines that informing you would be in your best interests.

Public Health and National Security

We may be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public health or national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic or the understanding of new side effects of a drug treatment or medical device.

For Law Enforcement

As permitted or required by State of Federal law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstances, if you are the victim of a crime or in order to report a crime.

Family, Friends and Caregivers

We may share your health information with those you tell us will be helping you with your home hygiene, treatment, medications, or payment. We will be sure to ask your permission first. IN the case of an emergency, where you are unable to tell us what you want, we will use our best judgment when sharing your health information only when it will be important to those participating in providing your care.

Workers' Compensation Purposes

We may disclose your health information as required or permitted by State or Federal workers' compensation laws.

Judicial and Administrative Proceedings

We may disclose your health information in an administrative or judicial proceeding in response to a subpoena or a request to produce documents. We will disclose your health information in these circumstances only if the requesting party first provides written documentation that the privacy of your health information will be protected.

Incidental Uses and Disclosures

We may use or disclose your health information in a manner which is incidental to the uses and disclosures described in this Notice.

Health Oversight Activities

We may disclose your health information to a government agency responsible for overseeing the health care system or health-related government benefit program.

To Avert a Serious Threat to Health or Safety

We may use or disclose your health information to reduce a risk of serious and imminent harm to another person or to the public.

To the U.S. Department of Health and Human Services (HHS)

We may disclose your health information to the HHS, the government agency responsible for overseeing compliance with federal privacy law and regulations regulating the privacy and security of health information.

For Research

We may use or disclose your health information for research, subject to conditions. "Research" means systematic investigation designed to contribute to generalized knowledge.

In Connection with your Death or Organ Donation

We may disclose your health information to a coroner for identification purposes, to a funeral director for funeral purposes, or to an organ procurement organization to facilitate transplantation of one of your organs.

If applicable State law does not permit the disclosure described above, we will comply with the stricter State law.

Authorization to Use or Disclose Health Information

Other than is stated above or where Federal, State, or Local law requires us, we will not disclose your health information other than with your written authorization. You may revoke that authorization in writing at any time.

PATIENT RIGHTS

You have the following rights related to your health information:

Restrictions

You have the right to request restrictions on the use or disclosure of your health information for treatment, payment, or health care operations in addition to the restrictions imposed by federal law. Our office is not required to agree to your request, but we will endeavor to honor reasonable requests. We generally are not required to agree to a requested restriction. Our office with honor your request that we do not disclose your health information to a health plan for payment or healthcare operation purposes if the health information relates solely to a health care item or service for which you have paid us out-of-pocket in full.

Confidential Communications

You have the right to request that we communicate with you by alternative means or at an alternative location. You may, for example, request that we communicate your health information only privately with no other family members present or through mailed communications that are sealed. We will honor your reasonable requests for confidential communications.

Inspect and Copy your Health Information

You have the right to read, review, and copy your health information, including your complete chart, x-rays, and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable cost-based fee to duplicate and assemble your copy. If there will be a charge, we will first contact you to determine whether you wish to modify or withdraw your request.

Amend your Health Information

You have the right to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe the information to be changed and your reason for the change.

Your request may be denied if the health information record in questions was not created by our office, is not part of our records, or if the records containing your health information are determined to be accurate and complete. If we deny your request, we will provide you with a written explanation of the denial.

Accounting of Disclosures of your Health Information

You have the right to ask us for a description of how and where your health information was disclosed. Our documentation procedures will enable us to provide information on health information disclosures that we are required to disclose to you. Please let us know in writing the time period for which you are interested. Thank you for limiting your request to no more than six years at a time. We will provide the first accounting during any 12-month period without charge. We may charge a reasonable, cost-based fee for each additional accounting during the same 12-month period. IF there will be a charge, the Privacy Official will first contact you to determine whether you wish to modify or withdraw your request.

Request a Paper Copy of this Notice

You have the right to obtain a copy of this Notice of Privacy Practices directly from our office at any time. Stop by or give us a call and we will mail or email you a copy.

We are required by law to maintain the privacy of your health information and to provide to you or your personal representative with this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our Notice. If we change our privacy practices we will be sure all of our patients receive a copy of the revised Notice. You have the right to express complaints to us or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information. We will not retaliate against you for submitting a complaint. Please let us know of your concerns or complaints in writing by submitting your complaint to our Privacy Officer.

Patient Name/Guardian (printed) _____

Date _____

Patient/Guardian Signature _____

Date _____