PATIENT INFORMATION

PATIENT'S NAME _____ (LAST / FIRST / MIDDLE) HOME PHONE _____

ADDRESS _____ CITY _____ ZIP _____

BIRTHDATE _____ AGE _____ ❑Male ❑Female SOCIAL SECURITY # _____

PATIENT'S EMPLOYER _____ OCCUPATION _____

ADDRESS _____ WORK PHONE _____

SPOUSE'S NAME _____ (LAST / FIRST / MIDDLE) HOME PHONE _____

SPOUSE'S EMPLOYER _____ OCCUPATION _____

ADDRESS _____ WORK PHONE _____

PARTY RESPONSIBLE FOR ACCOUNT _____ ADDRESS _____

IF MINOR: FATHER'S NAME _____ SS# _____ WORK PHONE _____ HOME PHONE _____

EMPLOYER _____ EMPLOYER ADDRESS _____

MOTHER'S NAME _____ SS# _____ WORK PHONE _____ HOME PHONE _____

EMPLOYER _____ EMPLOYER ADDRESS _____

DO YOU HAVE TITLE XIX? ❑ YES ❑ NO

DO YOU HAVE DENTAL INSURANCE? ❑ YES ❑ NO..... IF YES, COMPLETE THE FOLLOWING

PRIMARY INSURANCE _____ (SUBSCRIBER (PERSON WHO CARRIES INSURANCE)) _____ (INSURANCE COMPANY)

_____ (BIRTHDATE) _____ (SOCIAL SECURITY # OF SUBSCRIBER)

SECONDARY INSURANCE _____ (SUBSCRIBER (PERSON WHO CARRIES INSURANCE)) _____ (INSURANCE COMPANY)

_____ (BIRTHDATE) _____ (SOCIAL SECURITY # OF SUBSCRIBER)

OTHER THAN THE NAMES ABOVE, WHOM MAY WE CONTACT IN CASE OF EMERGENCY? _____

NAME _____ RELATIONSHIP _____ PHONE# _____

WHOM DO WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

DENTAL HISTORY

1. HAVE YOU NOTICED ANY OF THE FOLLOWING?
   - GRINDING OR CLENCHING TEETH..... ❑ YES ❑ NO
   - TEETH TENDER WHEN CHEWING..... ❑ YES ❑ NO
   - BLEEDING GUMS WHEN BRUSHING..... ❑ YES ❑ NO
   - BLEEDING GUMS WHEN FLOSSING..... ❑ YES ❑ NO
   - FOOD CATCHING BETWEEN TEETH..... ❑ YES ❑ NO
   - TEETH SENSITIVE TO HOT, COLD, OR SWEETS..... ❑ YES ❑ NO
   - SWELLING OR SORES IN MOUTH..... ❑ YES ❑ NO
   - PAIN IN TEETH OR JAWS..... ❑ YES ❑ NO
2. HAVE YOU EVER HAD YOUR TEETH STRAIGHTENED?..... ❑ YES ❑ NO
3. HAVE YOU HAD ANY SERIOUS TROUBLE ASSOCIATED WITH PREVIOUS DENTAL TREATMENT?..... ❑ YES ❑ NO
   IF YES, PLEASE EXPLAIN _____
4. HAVE YOU BEEN SATISFIED WITH YOUR PREVIOUS DENTAL CARE?..... ❑ YES ❑ NO
   IF NO, PLEASE EXPLAIN _____
5. ARE YOU SATISFIED WITH THE APPEARANCE OF YOUR TEETH?..... ❑ YES ❑ NO
   IF NO, PLEASE EXPLAIN _____
6. WOULD YOU LIKE TO KEEP YOUR NATURAL TEETH?..... ❑ YES ❑ NO
7. HAVE YOU EVER BEEN TREATED FOR PERIODONTAL DISEASE? (GUM DISEASE)..... ❑ YES ❑ NO
8. DO YOU USE ANY TOBACCO PRODUCTS?..... ❑ YES ❑ NO
9. HOW OFTEN DO YOU BRUSH YOUR TEETH? _____
10. HOW OFTEN DO YOU FLOSS YOUR TEETH? _____
11. APPROXIMATE DATE OF LAST DENTAL TREATMENT _____
12. APPROXIMATE DATE OF LAST DENTAL CLEANING _____
13. DO YOU HAVE ANY DENTAL CONCERNS YOU WOULD LIKE EVALUATED TODAY?..... ❑ YES ❑ NO
    IF YES, PLEASE EXPLAIN _____
14. PREVIOUS DENTIST _____ CITY _____ ST _____ PHONE _____

OVER PLEASE

MEDICAL HISTORY

1. HOW WOULD YOU DESCRIBE YOUR PRESENT HEALTH? ❑ EXCELLENT ❑ GOOD ❑ FAIR ❑ POOR ❑ UNCERTAIN

2. DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING? PLEASE INDICATE BY CHECKING (✔).

	YES	NO		YES	NO		YES	NO
HEART PROBLEMS OF ANY TYPE	❑	❑	HEPATITIS	❑	❑	RECREATIONAL DRUG USE	❑	❑
HEART MURMUR	❑	❑	LIVER DISEASE	❑	❑	SINUS PROBLEMS	❑	❑
RHEUMATIC FEVER	❑	❑	TUBERCULOSIS	❑	❑	FREQUENT HEADACHES	❑	❑
ARTIFICIAL HEART VALVE	❑	❑	CANCER	❑	❑	FREQUENT FEVER	❑	❑
ARTIFICIAL JOINT	❑	❑	RADIATION TREATMENT OR			BLOOD TRANSFUSION	❑	❑
HIGH BLOOD PRESSURE	❑	❑	CHEMOTHERAPY	❑	❑	NIGHT SWEATS	❑	❑
STROKE	❑	❑	ULCER	❑	❑	SWOLLEN LYMPH NODES	❑	❑
CIRCULATORY PROBLEMS	❑	❑	EXCESSIVE BLEEDING OR BRUISING	❑	❑	(ARMPIT, NECK, GROIN)		
ALLERGIES TO ANESTHETICS	❑	❑	KIDNEY DISEASE	❑	❑	UNEXPLAINED WEIGHT LOSS	❑	❑
ALLERGY TO LATEX RUBBER	❑	❑	NERVOUS PROBLEMS	❑	❑	AIDS OR ARC (AIDS RELATED COMPLEX)	❑	❑
EMPHYSEMA	❑	❑	ARTHRITIS	❑	❑	POSITIVE HIV BLOOD TEST	❑	❑
ASTHMA	❑	❑	EPILEPSY OR SEIZURES	❑	❑	THYROID CONDITION	❑	❑
DIABETES OR HYPOGLYCEMIA	❑	❑	CHEMICAL/ALCOHOL DEPENDENCY	❑	❑	IMPLANTS OF ANY TYPE	❑	❑

3. IS THERE ANYTHING ABOUT YOUR HEALTH THAT WE SHOULD KNOW? (CURRENT TREATMENT, IMPENDING SURGERY, MAJOR ILLNESS, ETC.) .... ❑ YES ❑ NO

IF YES, PLEASE DESCRIBE: _____

_____

4. HAVE YOU BEEN UNDER A MEDICAL DOCTOR'S CARE IN THE PAST TWO YEARS? ❑YES ❑ NO IF YES, FOR WHAT REASON?

_____

5. MEDICAL DOCTOR: _____ LAST PHYSICAL EXAM DATE: _____

6. ARE YOU TAKING ANY OVER-THE-COUNTER OR PRESCRIPTION MEDICATIONS NOW? ..... ❑ YES ❑ NO

NAME OF MEDICATION	CONDITION BEING TAKEN FOR

7. ARE YOU SENSITIVE OR ALLERGIC TO ANY DRUGS OR MEDICATIONS? ..... ❑ YES ❑ NO

NAME OF MEDICATION	REACTION EXPERIENCED

8. ARE YOU ALLERGIC TO ANY METALS OR JEWELRY? ..... ❑ YES ❑ NO

9. **FEMALES:** ARE YOU PREGNANT? ❑ YES ❑ NO ARE YOU NURSING? ❑ YES ❑ NO USING BIRTH CONTROL PILLS/IMPLANTS? ❑ YES ❑ NO

I, the undersigned, affirm the information given on this form to be accurate. This information will be utilized for evaluation and treatment by my doctor. I consent to photographic images to be taken for record keeping which may be used by Mosier Dental for educational purposes.

DATE _____ SIGNATURE _____ DR. INITIAL _____
(PATIENT, OR PARENT IF MINOR)

Mosier Dental Associates, P.C.

Notice of Privacy Practice

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW CAREFULLY, THE PRIVACY OF YOUR HEALTH AND 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 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 descried in this notice while it is in effect 01/01/2017, 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.

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 that is providing treatment to you.

Payment: We may use and disclose your health information and personal information to obtain payment for services rendered.

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, evaluations 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 of healthcare operations, you give us written authorization to use your health information or 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 of disclosures permitted by your authorization, we cannot use or disclose your health information for any reason except those described in this notice.

To Family and Friends: We must disclose your health information to you and you alone, unless otherwise noted.

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 such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on determination using 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.

Mosier Dental Associates, P.C.

Acknowledgement of Receipt of Privacy Practices

I have received a copy of this office's notice of Privacy Practices. I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers, (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations.

_____

Patient Signature

_____

Date

Mosier Dental Associates, P.C.
1816 Beaver Avenue
Des Moines, Iowa 50310
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Fax (515)277-3576
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Patient Name: _____ Birthdate: _____

I, give consent to receive dental treatment, deemed necessary by Dr. Brian J. Mosier. These procedures include, but are not limited to; Examinations, Oral Prophylaxis (cleanings), Fluoride Treatments, Sealants, Restorations (amalgam or composite fillings and crowns), Endodontic Treatments (root canal therapy) and the use of local anesthetics. I understand that the use of local anesthetics carries a small risk for swelling, bruising, allergic reaction, changes in pain perception, or prolonged anesthesia. This consent shall be considered in effect until rescinded or revoked.

_____ _____

(signature) (date)