DENTAL PATIENT INFORMATION FORM

Welcome to our Dental office, Dr. Nolan R. Behr

5770 Flintridge Drive, Suite 200, Colorado Springs, CO 80918 (719) 591-2050 Fax: (719)597-3211

Patient's Name_____Male___Female___Todays Date_____

Nickname/Preferred Name (if any)_____Birth Date_____SS#_____-___-_____

Billing Address:_____City/State_____Zip:_____

Home Phone:_____Cell Phone:_____Work Phone:_____

Email Address:_____Best time/phone # to reach you is?_____

Can we leave a message?_____

EMPLOYMENT

Employer:_____Job Title:_____

Address:_____City/State_____Zip:_____

May we call you at work?_____

DENTAL INSURANCE

Subscriber's Name_____

Relationship to Patient_____Birth Date_____

Employer_____Group #_____

SSN/Insurance ID_____

Insurance Company_____

Insurance Phone#_____

SECONDARY INSURANCE (if applicable)

Subscribers Name:_____

Relationship to patient _____Birth Date___

Employer_____Group#_____

SSN/Insurance ID_____

Insurance Company_____

Insurance Phone#_____

I authorize Nolan R. Behr Family Dentistry to release any patient record information needed to process benefit claims for myself or for my dependents and to submit claims on my (or their) behalf. I also Authorize insurance payments to be issued from my insurance company directly to Nolan R. Behr, DDS.

X Signature (patient, parent or guardian)_____

I authorize Nolan R. Behr, DDS staff to discuss my dental and account information with my spouse, guardian, parent or significant other.

X Signature (patient, parent or guardian)_____

PATIENT MEDICAL HISTORY

Patient's Name:

For Office Use Only
ID:

Address: | **Today's Date:** | **Date of Last Visit:** | **Date of Med. History:**

City State Zip: | **Email:**

Home Phone: | **Work Phone:** | **Cell Phone:** | **Birth Date:** | **Social Security No.:** | **Marital Status:**

Primary Dental Guarantor: | **Home Phone:** | **Work Phone:** | **Cell Phone:**

Secondary Dental Guarantor: | **Home Phone:** | **Work Phone:** | **Cell Phone:**

Physician Name: | **Physician Phone:**

Pharmacy: | **Pharmacy Phone:**

For Office Use Only
Medical Alerts:

Sex:

If female please answer the following:

Y N
- ☐ ☐ Are you taking Birth Control Pills?
- ☐ ☐ Are you pregnant? If Yes, # of weeks ☐
- ☐ ☐ Are you nursing?

Please answer the following:

Y N
- ☐ ☐ Do you smoke or use tobacco?

For Office Use Only
BP ☐ Heart Rate: ☐

Height: ☐

Weight: ☐

Y	N	Conditions
☐	☐	Abnormal Bleeding
☐	☐	Alcohol Abuse
☐	☐	Allergies
☐	☐	Anemia
☐	☐	Angina Pectoris
☐	☐	Arthritis
☐	☐	Artificial Bones
☐	☐	Artificial Heart Valve
☐	☐	Asthma
☐	☐	Blood Transfusion
☐	☐	Cancer- Chemotherapy
☐	☐	Colitis
☐	☐	Congenital Heart Defect
☐	☐	Cosmetic Surgery
☐	☐	Diabetes
☐	☐	Difficulty Breathing
☐	☐	Drug Abuse
☐	☐	Emphysema
☐	☐	Epilepsy
☐	☐	Fainting Spells
☐	☐	Fever Blisters
☐	☐	Frequent Headaches

Y	N	Conditions
☐	☐	Glaucoma
☐	☐	Hay Fever
☐	☐	Heart Attack
☐	☐	Heart Surgery
☐	☐	Hemophilia
☐	☐	Hepatitis A
☐	☐	Hepatitis B
☐	☐	High Blood Pressure
☐	☐	HIV+ AIDS
☐	☐	Kidney Problems
☐	☐	Liver Disease
☐	☐	Low Blood Pressure
☐	☐	Mitral Valve Prolapse
☐	☐	Pace Maker
☐	☐	Pneumocystitis
☐	☐	Psychiatric Problems
☐	☐	Radiation Therapy
☐	☐	Rheumatic Fever
☐	☐	Seizures
☐	☐	Shingles
☐	☐	Sickle Cell Disease
☐	☐	Sinus Problems

Y	N	Conditions
☐	☐	Stroke
☐	☐	Thyroid Problems
☐	☐	Tuberculosis
☐	☐	Ulcers
☐	☐	Venereal Disease
☐	☐	Yellow Jaundice

Y	N	Allergies
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Dental Anesthetics
☐	☐	Erythromycin
☐	☐	Jewelry
☐	☐	Latex
☐	☐	Metals
☐	☐	Penicillin
☐	☐	Tetracycline

Other

_____

_____

_____

Medications:

Y N

☐ ☐ **Is there any disease, condition, or problem that you think this office should know about that is not covered above? If yes, please describe below...**

Notes:

Signature: _____ **Date:** _____

(If Under 18, Parent or Guardian Signature Required)

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DENTAL HISTORY

Name of previous dentist_____Last dental visit_____

Date of last dental xrays_____How often do you brush?_____Floss_____

Whiten Teeth?_____Other?_____

ARE YOU CONCERNED WITH ANY OF THE FOLLOWING?

___Prevention of decay___Appearance of smile___Color of your teeth___Mouth odor

___Chipped/worn teeth___Replacing missing teeth___replacing old mercury/silver fillings

___Recurring/untreated gum disease Other?_____

PLEASE CHECK ALL THAT APPLY

___Dry Mouth/Sjogrens Disease ___TMJ soreness/pain ___Dental implants

___Tooth sensitivity ___Jaw clicking/popping ___Active tooth Decay

___Bleeding gums ___Grind/clench teeth

___Does food catch between your teeth?

___Periodontal treatment/disease

___Sore/tired jaw muscles

___Do you wear a night guard?

___Chronic headaches

___Removable denture/partial/bridge

Have you had trouble associated with any previous dental treatment?_____

Do you require pre-medication for dental appointments? ___YES ___NO

IF YES, PLEASE LIST ASSOCIATED CONDITION:_____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGMENT

I, _____, HAVE RECEIVED A COPY OF THIS OFFICE'S NOTICE OF PRIVACY PRACTICES.

_____

PRINTED NAME DATE

SIGNATURE_____

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

___Communication barriers prohibited obtaining the acknowledgment

___An Emergency situation prevented us from obtaining acknowledgement

___Other (please specifiy)

_____

_____

_____

Nolan R. Behr, DDS

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 read and review carefully. The privacy of your health information is important to us.

To our Valued Patients,

We are dedicated to protect the privacy rights of our patients and the confidential information entrusted to us. The commitment of each employee to ensure that your health information is never compromised is a principle concept of our practice. We may, from time to time, amend our privacy policies and practices, but will always inform you of any changes that might affect your rights.

We use and disclose the information we collect from you only as allowed by the Health Insurance Portability and Accountability Act. This includes issues relating to your treatment, payment, and our dental care operations. You may give written authorization for us to disclose your information to anyone you choose, for any purpose, but it will never otherwise be given to anyone - even family members - without your written consent. Guardians of minor children will be consulted.

Our offices and elecronic systems are secure from unauthorized access and our employees are trained to apply to all current and former patients, so you can be confident that your protected health information will never be improperly disclosed or released.

We will only request personal information needed to provide our standard of quality dental care, implement payment activites, conduct normal dental practice operations and comply with the law. This may include your name, address, telephone number(s), Social Security number, employment data, medical history, health records, etc. While most of the information will be collected from you, we may obtain information from third parites if it is deemed necessary. Regardless of the source, the information will always be protected to the full extent of the law.

As stated above, we may disclose information as required by law. This includes issues in which we reasonably believe you may be a victim of abuse, neglect, domestic violence or other crimes. We are also obligated to provide information to law enforcement officials under certain circumstances. We will not use your information for marketing purposes without your written consent.

We may use and/or disclose your health information to communicate reminders about your appointments including voicemail messages, answering machines and postcards.

You have a right to get copies of your healthcare information; to obtain copies in a variety of formats; and to a list of instances in which we, or our business associates, have disclosed your protected information for uses other than stated above. We may charge for your copies in an amount allowed by law. If you believe your rights have been violated, we urge you to notify us immediately. You can, also, notify the U.S. Department of Human Services.

We thank you for being a patient at our practice. Please let us know if you have any questions concerning your privacy rights and the protection and the protection of your personal health information.