simplysmiles
FAMILY & COSMETIC DENTISTRY

PATIENT INFORMATION AND HEALTH HISTORY FORM

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. Sex: ❑ Male ❑ Female Nick Name _____
First Name _____ M.I. ____ Last Name _____
Date of Birth _____ Age ____ S.S. # _____ E-mail _____
Street _____ City _____ State ____ Zip _____
Home Tel. _____ Cell _____ Work _____ x _____
Referred by: _____ Dentist: _____ Physician: _____
Driver's Lic. # _____ DL Issuing State: _____
Employer & Address: _____
Relative / Friend not living with you: Name: _____ Relation: _____ Tel: _____

Who Will Be Responsible For Your Account

❑ Self ❑ Spouse ❑ Father ❑ Mother ❑ Other
Name _____ S.S. # _____ Birth Date _____ Age ____ Tel. _____
Street _____ City _____ State ____ Zip _____
Employer Bus. Tel. _____

Primary Dental Insurance Company

Employer _____
Bus. Address _____
Bus. Tel. _____
Insurance Company Name _____
Address _____
City _____ State ____ Zip _____ Tel. _____
Group # _____ Group Name _____
Insured Party _____ Relation: _____
Sex: ❑ Male ❑ Female Date of Birth _____
Address _____
City _____ State ____ Zip _____
Tel. _____ S.S. # _____
I.D. # _____

Additional / Secondary - Medical / Dental Insurance Company

Employer _____
Bus. Address _____
Bus. Tel. _____
Insurance Company Name _____
Address _____
City _____ State ____ Zip _____ Tel. _____
Group # _____ Group Name _____
Insured Party _____ Relation: _____
Sex: ❑ Male ❑ Female Date of Birth _____
Address _____
City _____ State ____ Zip _____
Tel. _____ S.S. # _____
I.D. # _____

List of Medications

Name or Medicine, Over the counter Medicine, Herbal Medicine, Vitamin or Street Drug	Dosage (mg)	How often is it Taken	Disease Being Treated or Reason for Taking	Prescribed by Doctor or Self Prescribed
_____	_____	_____	_____	❑ Doctor ❑ Self
_____	_____	_____	_____	❑ Doctor ❑ Self
_____	_____	_____	_____	❑ Doctor ❑ Self
_____	_____	_____	_____	❑ Doctor ❑ Self

Check any of the following medications you are ALLERGIC to:

❑ Penicillin	❑ Doxycycline	❑ Codeine	❑ Versed	❑ Aspirin	❑ Vicodin	❑ Dental Anesthetics
❑ Erythromycin	❑ Tetracycline	❑ Demerol	❑ Halcion	❑ Tylenol	❑ Lortab	❑ Latex
❑ Keflex	❑ Sulfa Drugs	❑ Valium		❑ Ibuprofen	❑ Darvocet	❑ Iodine

Any Others? _____

Dental History

Your Dentist _____ City _____ How Long? _____

Date of Last Cleaning? _____ Frequency of cleaning? _____

How often do you brush your teeth daily? _____ ❑ Manual ❑ Mechanical Do you floss? ❑ Yes ❑ No

Please check if you currently have or have had:

- ❑ Mouth discomfort
- ❑ Previous periodontal treatment
- ❑ Scaling / Root planing
- ❑ Gum surgery
- ❑ Gum Abscesses
- ❑ Bleeding Gums
- ❑ Loose or shifting teeth
- ❑ Bruise easily
- ❑ Grinding or clenching your teeth
- ❑ Clicking, popping or pain in jaw joints
- ❑ Orthodontic treatment
- ❑ Sensitive teeth (Hot, cold, or sweets)
- ❑ Mouth oder or bad taste
- ❑ Cold sores or fever blisters
- ❑ Other oral lesions / sores
- ❑ Bad dental experience
- ❑ Fear of dentist treatment
- ❑ Complications following dentist treatment

Have any immediate relatives lost all natural teeth?
❑ Yes ❑ No

Do you want to keep your teeth?
❑ Yes, no matter what it takes
❑ Yes, if it is not too much trouble
❑ Don't know
❑ Don't care

Are you happy with your smile?
❑ Yes ❑ No

Medical History

❑ Yes ❑ No Are you in good health? ..... Height _____ Weight _____

❑ Yes ❑ No Have there been any changes in your general health in the past year?

❑ Yes ❑ No Are you under the care of a physician? ..... Date of last visit _____

If so, for what are you being treated? _____

When was your last physical performed? Date _____

❑ Yes ❑ No Have you had any illness, operation or been hospitalized in the past five years?

If so, describe _____

❑ Yes ❑ No Do you have unhealed / recurrent injuries or inflamed areas, growths or sore spots in or around your mouth?

If so, describe _____

❑ Yes ❑ No Do you have a prosthetic joint or other metal implant? ..... If so, describe where _____

❑ Yes ❑ No Have you had a heart valve replacement or vascular graft? ..... If so, when? _____

❑ Yes ❑ No Has your physician ever told you to take antibiotics prior to having any type of dental procedure?

❑ Yes ❑ No Has your orthopedic surgeon ever told you to take antibiotics prior to having any type of dental prodedure?

❑ Yes ❑ No Has your dentist ever told you to take antibiotics prior to having any type of dental prodedure?

❑ Yes ❑ No Do you use any type of tobacco? ..... If so, how much? _____ ❑ per day ❑ week ❑ month

❑ Yes ❑ No I also use smokeless tobacco. ..... how much? _____ ❑ per day ❑ week ❑ month

❑ Yes ❑ No Have you ever used tobacco in the past? .. If so, how much? _____ ❑ per day ❑ week ❑ month

Quit ..... Month _____ Year _____

❑ Yes ❑ No Do you use any type of alcohol? ..... If so, how much? _____ ❑ per day ❑ week ❑ month

❑ Yes ❑ No Do you have any history of alcohol abuse?

❑ Yes ❑ No Do you have any history of substance abuse or do you currently use recreational drugs?

For women, check all that are appropriate: ❑ I am pregnant ❑ I am nursing ❑ I am taking birth control pills

❑ Yes ❑ No Have you ever taken, or are you currently taking any other following drugs orally (Check all that apply)?

❑ Fosamax ❑ Boniva ❑ Actonel ❑ Reclast ❑ Bonefos ❑ Didronel ❑ Skelid ❑ Zometa

❑ Yes ❑ No Have you every had chemotherapy for the treatment of any type of cancer?

❑ Yes ❑ No Have you ever been given any of the following drugs intraveniously (Check all that apply)?

❑ Aredia ❑ Bonefos ❑ Zometa ❑ Reclast

❑ Yes ❑ No Have you ever had radiation therapy to the head and neck area?

❑ Yes ❑ No Is there a family history of: ❑ Cancer ❑ Diabetes ❑ Heart Disease ❑ Anesthesia Problems

WOMEN NOTE: Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician / gynecologist for assistance regarding additional methods of birth control. By signing this form I agree to inform the office about my pregnancy status prior to xrays being performed

Medical Conditions

Check all of the following conditions that you may have had in the past or that currently apply to you.

❑ Heart attack
❑ Chest pain upon exertion
❑ Shortness of breath
❑ High blood pressure
❑ Low blood pressure
❑ Heart valve prosthesis
❑ Mitral valve prolapse
❑ Congenital heart lesion
❑ Rheumatic fever
❑ Heart murmur
❑ Damaged heart valve
❑ Irregular heartbeat
❑ Tachycardia
❑ Heart surgery
❑ Cardiac pacemaker
❑ Systemic Lupus Erythematosus

❑ Hepatitis A,B,C
❑ Liver disease or Jundice
❑ Received blood transfusion
❑ Anemia
❑ Leukemia
❑ Bleeding disorder
❑ Hemophilia
❑ Impaired liver function
❑ Gallbladder disease
❑ Active dialysis
❑ Kidney disease
❑ Impaired kidney function
❑ Esophageal reflux
❑ Hiatal hernia
❑ Stomach ulcer
❑ Anorexia or bulimia

❑ Irritable bowel syndrome
❑ Colitis
❑ Diabetes
❑ Low blood sugar
❑ Radiation therapy
❑ Chemotherapy
❑ History of cancer
❑ Sleep apnea
❑ Asthma
❑ Bronchitis
❑ Emphysema
❑ Sinus troubles
❑ Persistent cough
❑ Tuberculosis
❑ Joint replacement surgery
❑ Arthritis

❑ Connective tissue disorder
❑ Neurological disorders
❑ Stroke
❑ Headaches
❑ Migraines
❑ Epilepsy
❑ Seizures
❑ Mental health problems
❑ Recurrent infections
❑ Chronic fatigue
❑ Recent weight loss
❑ Glaucoma
❑ Wear contact lenses
❑ Severely impaired vision
❑ High cholesterol
❑ Thyroid condition
❑ Cancer, tumor or growths

If you have checked any of the above conditions or have any disease, problem or condition not listed above, please explain it below.

_____

_____

PLEASE READ CAREFULLY AND SIGN STATING YOU UNDERSTAND
PARENT/GUARDIAN MUST SIGN FOR MINOR CHILD

CONSENT TO FEES

I understand:

- I am responsible for 100% of all dental fees
- **All estimates quoted are just that, *only estimates,* and cannot be a guarantee**
- **of payment from the insurance company. You will be billed for any remaining balance after insurance makes their final payment on your account.**
- **All fees, including estimated co-pays and deductibles are due on the day of service**.
- Some plans base benefits on a *fee schedule* or *usual and customary charges* and not the actual fee amounts charged by this office. *Some insurance companies also downgrade services for fillings and crowns. For this reason, the amount paid by my insurance company may be less than originally quoted and the difference will be my responsibility.*
- After 60 days if there is no response from the insurance company after being properly billed, the balance is my responsibility.
- A late charge will be added to my account if unpaid for more than 30 days.
- Any balance left unpaid for 60 days will be turned over to an outside collection agency.
- There will be a $35.00 insufficient check fee charged for any returned checks.
- I will be responsible for all collection costs, court costs, attorney fees, interest, etc.

Appointment Policy

We are committed to bringing you the very best professional and personal care that we can, and we also place value on your time. **Please be aware that by making an appointment, you are stating that you will be present for that appointment, just as we are stating that we will be here to serve you.** We consider an appointment written in our schedule as a bond of trust and therefore should not be broken. Please give us advanced notice (a minimum of 48 hours) when you cancel an appointment so that we can use that time for the benefit of our other patients. There will be a $35.00 cancellation fee charged to your account after your first missed appointment or cancellation without 48 hour notice. Insurance does not cover this charge and this fee will have to be paid at the return of your following appointment. Your initialing below indicates that we will have mutual respect for each other's time.

Initial: _____

PATIENT NAME: _____

_____ _____
SIGNATURE DATE

Should your check be returned for insufficient funds, you expressly authorize your account to be electronically debited or bank drafted for the amount of the check plus any applicable fees. The use of a check is your acknowledgement and acceptance of this policy and it's terms and conditions.

Brian S. Kruger, DDS
2788 N. Mount Juliet Rd., Mount Juliet, TN 37122
PHONE: (615) 758-4746
FAX: (615) 773-2592
Office Contact: Teresa

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient name_____

Patient number _____

Patient address _____

Patient phone number _____

I authorize the professional office of my dentist named above to release health information identifying me [including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services] under the following terms and conditions:

1. Detailed description of the information to be released:

2. To whom may the information be released [name(s) or class(es) of recipients]:

3. The purpose(s) for the release (if the authorization is initiated by the individual, it is permissible to state "at the request of the individual" as the purpose, if desired by the individual):

4. Expiration date or event relating to the individual or purpose for the release:

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to the office contact person listed at the top of this form.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

[For marketing authorizations, include, as applicable: We will receive direct or indirect remuneration from a third party for disclosing your identifiable health information in accordance with this authorization.]

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Dated Patient signature

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient Print Name

Source of Authority

Effective date of notice: January 1, 2008

NOTICE OF PRIVACY PRACTICES

Brian S. Kruger DDS
2788 N. Mount Juliet Rd., Mount Juliet, TN 37122
PHONE: (615) 758-4746
FAX: (615) 773-2592
Office Contact: Teresa

Signature:

Date:

A copy can be provided for you if needed

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.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; examining your teeth; prescribing medications and faxing them to be filled; referring you to another doctor or clinic for other health care or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or dental care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we usually will not ask you for special written permission.

We will ask for special written permission in the following situations:

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

when a state or federal law mandates that certain health information be reported for a specific purpose;
for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;

disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
uses or disclosures for health related research;
uses and disclosures to prevent a serious threat to health or safety;
uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
disclosures of de-identified information;
disclosures relating to worker's compensation programs;
disclosures of a "limited data set" for research, public health, or health care operations;
incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information;

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your dental care.

APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours.

If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this Notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address, fax or E Mail shown at the beginning of this Notice.
ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E mail to your personal E Mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30 day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to

ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

- get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our Web site.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or E mail shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this Notice.