CruseDentalCenter

Cruse Dental Center complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística.
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn.

Patient Information

Name: ______________________
Last Name First Name Middle Initial

Address: ______________________

City: ____________ State:_____ Zip: _______

SS #: ____________ Sex: Male Female

DOB:________ Age:___ Preferred Name:________

Home Phone: ________ Cell Phone: ________

Work Phone: ________ Add'l Phone: ________

Email: ______________________

Minor Single Married Other: ________

Mother/Guardian Name: ______________

Father/Guardian Name: ______________

In Case of Emergency: ______________

Phone:____________ Relationship: ________

Names of Other Family Members Seen Here:________

____

____

Referred By: ______________________

Dental History

Why have you come to the dentist today? ________

____

Do you need to be pre-medicated (antibiotics) before dental treatment? Yes No

Are you currently in pain? Yes No

Have you ever had a serious / difficult problem associated with any previous dental work? Yes No

Have you ever had gum treatment? Yes No

Do your gums Bleed? Yes No

How often do you: Brush__________ Floss__________

Have you lost any teeth? Yes No

If Yes, Why? ______________________

Medical History

Your current physical health is: Good Fair Poor

Primary Care Physician: ______________________

Are you currently under the care of a physician? Yes No

If yes, Please Explain: ______________________

Do you smoke or use tobacco in any other form? Yes No

Are you taking any prescription / Over-the-counter drugs? Yes No

Please list all medications you are currently taking:

____

____

____

Have you ever had any of the following diseases or medical problems? Please circle the appropriate letter beside each.

1. Y N Abnormal Bleeding
2. Y N Alcohol / Drug Abuse
3. Y N Anemia
4. Y N Arthritis
5. Y N Artificial Bones / Joints / Valves
6. Y N Asthma
7. Y N Autism/ASD
8. Y N Blood Transfusion
9. Y N Cancer / Chemotherapy
10. Y N Congenital Heart Defect
11. Y N Diabetes
12. Y N Difficulty Breathing
13. Y N Emphysema
14. Y N Epilepsy
15. Y N Fainting Spells
16 .Y N Frequent Headaches
17 .Y N Glaucoma
18 .Y N Hay Fever
19 .Y N Heart Attack
20. Y N Heart Murmur
21 .Y N Heart Surgery
22. Y N Hemophilia
23. Y N Hospitalized for Any Reason
24. Y N Hepatitis
25. Y N Herpes/Fever Blisters
26. Y N High Blood Pressure
27. Y N HIV+ / AIDS
28. Y N Kidney Problems
29. Y N Liver Disease
30. Y N Low Blood Pressure
31. Y N Mitral Valve Prolapse
32. Y N Pacemaker
33. Y N Psychiatric Problems
34. Y N Radiation Treatment
35. Y N Rheumatic/ Scarlet Fever
36. Y N Seizures
37. Y N Shingles
38. Y N Sickle Cell Disease/Traits
39. Y N Sinus Problems
40. Y N Stroke
41. Y N Thyroid Problems
42. Y N Tuberculosis (TB)
43. Y N Ulcers
44. Y N Venereal Disease

Have you ever had any other serious illness not listed above? If so what:

____

Are you allergic to any of the following?

Y N Aspirin
Y N Codeine
Y N Dental Anesthetics
Y N Erythromycin
Y N Latex
Y N Penicillin
Y N Sulfa/Sulfur
Y N Tetracycline
Y N Other

Please list any other drugs that you are allergic to: ______________

____

For Women: Are you taking birth control pills? Yes No

Are you pregnant? Yes No Week #: _______

Are you nursing? Yes No

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail. **By signing this information sheet, I authorize the Dentist to do the dental work deemed necessary.**

X ______________________
PATIENT SIGNATURE (PARENT OR GUARDIAN)

Date: ______________________

Revised 10/23/2015

CruseDentalCenter

Office Policy

The Cruse Dental Center supplies a staff of dentists, hygienists, and other professionals who work very hard to provide quality dental care to each patient. To ensure that each patient is well informed of our policies upon entering our office, it has become necessary to place the following policies in writing:

- A **current** Insurance/Medicaid card is required by each patient at each visit. Anyone 18 years or older must present a picture ID at each visit.
- **For the safety of your children, parents/guardians are required to accompany any child 17 years or younger to the dental visit. Once the patient is called to the operatory, the parent/guardian should have a seat in the waiting area out front. If it is necessary for the parent to be present in the operatory, only one parent will be allowed in the room and no other persons may accompany the child.**
- It is important that each patient receive proper dental care. Therefore, it is important that each patient keep his/her scheduled treatment time. **If it is necessary to change/cancel your reserved treatment time, we request notification of at least 24-48 hours prior to the appointment**. Notification of a change/cancellation in the scheduled treatment time must be made during normal business hours: Monday-Thursday, 8:30am-5:00pm and Friday 8:00am-2:00 pm. **Failure to provide proper notification will result in a Broken Appointment. Once a patient reaches 3 Broken Appointments, the family will be placed in our Inactive Files.**
- Each patient will receive a call to confirm his/her reserved treatment time; therefore, it is necessary to notify the office of any phone number changes as they occur. **If a message is left for the patient to call back and confirm, and the patient does not call back within the appropriate time frame, the reserved appointment may be given to another patient on our waiting list.**
- At the time of each visit, please notify the administrative staff if there have been any changes to personal information or if the Dental Van has seen the patient recently.
- **All forms requested require 24-48 hour notice for the staff to prepare.**

Authorization and Agreement to Terms

Please read the above information carefully. By signing this form, you are agreeing that you are responsible for and adhere to all said terms stated above.

____
Patient Name

_______________________________ _________________
Responsible Party Date

_______________________________ _________________
Cruse Dental Center Representative Date

CRUSE DENTAL CENTER
NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that the information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your ***Notice of Privacy Practices*** containing a more complete description of the uses and disclosures of my health information. I understand that Cruse Dental Center has the right to change its ***Notice of Privacy Practices*** from time to time and that I may contact the office at any time at the address listed below to obtain a current copy of the ***Notices of Privacy Practices*****:**

1098 Herrington Road, Suite 20
Lawrenceville, GA 30044

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

You agree, in order for us to service our account or to collect any amounts you may owe, we may contact you by telephone at any number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or e-mails, using any e-mail address you provide to us. Methods of contact may include pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable. I have read this disclosure and agree that the Lender/Creditor may contact me as described above.

Patient Name: ________________________________

Relationship to Patient: ________________________________

Signature: ________________________________

Date: ________________________________

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:

Revised 6/2013

NOTICE OF PRIVACY PRACTICES

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.

Cruse Dental Center is required by law to maintain the privacy of your health information, to follow the terms of this Notice, and to provide you with this notice of its legal duties and privacy practices with respect to your health information. We will not use or disclose medical information about you without your written authorization, except as described in this Notice.

Use or Disclosure of your Health Information: *This law permits Cruse Dental Center to use or disclose your health information for the following purposes:*

- **Treatment, Payment and Regular Health Care Operations**: Information obtained by the dental office will be used to dispense and provide prescription goods and services to you, bill your insurance carrier, and to record and monitor the services provided to you. Information will also be provided to you upon your request.

- **As and When Required By Law:** We may use and disclose your health information to Public Health Officials, Law Enforcement, Health Oversight activities (for audits, investigations, etc.). Judicial and Administrative, Deceased Person Information, Workers Compensation Programs, Food and Drug Administration (FDA for reporting of adverse drug events and quality issues), if there is a serious threat to your health or safety, in times of National Security, if you are in the Military or a Veteran of the Armed Forces when requested, or if you become an inmate in a correctional institution.

- **Personal Communication**: We may contact you to provide appointment reminders, and other information about treatment alternatives of other heath-related benefits and services that may be of interest to you as well as communicate with individuals involved in your care or payment of your care.

- **Disclosure to our Business Associates:** There are some services provided by us through contracts with business associates. When these services are contracted, we may disclose health information about you to our business associates so that they can perform the job we have asked them to do. To protect your health information, we require the business associate to appropriately safeguard the health information.

- **Victims of Abuse, Neglect or Domestic Violence**: We may disclose our health information to a government authority, such as social services or protective services agency, if we reasonably believe you are a victim of abuse, neglect, or domestic violence.

- **Marketing Communication:** We may obtain your written authorization prior to using your health information to send you and marketing materials. We may communicate with you about products or services relating to your treatment, care, or alternative treatments, or providers without authorization.

- **When Cruse Dental Center May Not Use or Disclose Your Health Information**: Except as described in this Notice of Privacy Practices, Cruse Dental Center will not use or disclose your health information without your written authorization. If you do authorize Cruse Dental Center to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time. If your state law provides additional restrictions upon any of the foregoing uses and disclosures, we must follow the state law.

- **You Have the Following Rights with Respect to your Health Information:** You have the right to request restrictions or certain uses and disclosures of your health information. To make such a request, you must complete the **Restriction of the Use of Patient Information Form** and the request will apply only to the location providing services. Cruse Dental Center is not required to agree to the restrictions that you requested.

- You have the right to inspect and copy your health information as long as the dental office maintains health information. Your health information usually will include prescription and billing records. To inspect or copy your health information, you must complete a **Request to Inspect Medical Records Form** and submit the request to Cruse Dental Center. We may charge you a fee for the copying, mailing, or for other supplies that are necessary to grant your request.

- You have the right to request that Cruse Dental Center amend your health information that is incorrect or incomplete. To request an amendment, you must complete a **Request to Amend Medical Records Form** to Cruse Dental Center. We are not required to change your health information and will provide you with information about the procedure for addressing any disagreement with the denial.

- You have the right to receive an accounting of disclosure of your health information we have made for the purposes other than treatment, payment, healthcare operations, information provided to you, and certain government functions. To request an accounting, you must complete a **Request for Accounting and Disclosure Form** to Cruse Dental Center. We will notify you of the time period but may not be longer than six weeks. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time.

- You must request communications of your health information by alternative means or alternate locations. For example, you may request that we contact you about medical matters only in writing or at a different residence or post office box. To request confidential communication of your health information, you must complete a **Request for Alternative Communication** to Cruse Dental Center and will be good only for the location providing services. Your request must state how or when you would like to be contacted. We will accommodate all reasonable requests.