

WELCOME!

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. If you have any questions or need assistance, please ask us. We will be happy to help.

PATIENT MEDICAL HISTORY					
Patient's Name: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>					For Office Use Only ID: <div style="border: 1px solid black; width: 80px; height: 20px;"></div>
Address: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>		Today's Date: <div style="border: 1px solid black; width: 100px; height: 20px;"></div>	Date of Last Visit: <div style="border: 1px solid black; width: 100px; height: 20px;"></div>	Date of Med. History: <div style="border: 1px solid black; width: 100px; height: 20px;"></div>	
City State Zip: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>		Email: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>			
Home Phone: <div style="border: 1px solid black; width: 100px; height: 20px;"></div>	Work Phone: <div style="border: 1px solid black; width: 100px; height: 20px;"></div>	Cell Phone: <div style="border: 1px solid black; width: 100px; height: 20px;"></div>	Birth Date: <div style="border: 1px solid black; width: 100px; height: 20px;"></div>	Social Security No.: <div style="border: 1px solid black; width: 100px; height: 20px;"></div>	Marital Status: <div style="border: 1px solid black; width: 100px; height: 20px;"></div>
Primary Dental Guarantor: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>		Home Phone: <div style="border: 1px solid black; width: 100px; height: 20px;"></div>	Work Phone: <div style="border: 1px solid black; width: 100px; height: 20px;"></div>	Cell Phone: <div style="border: 1px solid black; width: 100px; height: 20px;"></div>	
Secondary Dental Guarantor: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>		Home Phone: <div style="border: 1px solid black; width: 100px; height: 20px;"></div>	Work Phone: <div style="border: 1px solid black; width: 100px; height: 20px;"></div>	Cell Phone: <div style="border: 1px solid black; width: 100px; height: 20px;"></div>	
Physician Name: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>			Physician Phone: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>		
Pharmacy: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>			Pharmacy Phone: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>		

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?

Height:

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BP

Heart Rate:

Weight:

<p>Y N Conditions</p> <p><input type="checkbox"/> <input type="checkbox"/> Abnormal Bleeding</p> <p><input type="checkbox"/> <input type="checkbox"/> Anemia</p> <p><input type="checkbox"/> <input type="checkbox"/> Angina Pectoris</p> <p><input type="checkbox"/> <input type="checkbox"/> Arthritis</p> <p><input type="checkbox"/> <input type="checkbox"/> Artificial Heart Valve</p> <p><input type="checkbox"/> <input type="checkbox"/> Artificial Joints</p> <p><input type="checkbox"/> <input type="checkbox"/> Asthma</p> <p><input type="checkbox"/> <input type="checkbox"/> Autoimmune Disease</p> <p><input type="checkbox"/> <input type="checkbox"/> Blood Transfusion</p> <p><input type="checkbox"/> <input type="checkbox"/> Bronchitis</p> <p><input type="checkbox"/> <input type="checkbox"/> Cancer</p> <p><input type="checkbox"/> <input type="checkbox"/> Chronic Obstructive Pulmonary Dis</p> <p><input type="checkbox"/> <input type="checkbox"/> Colitis</p> <p><input type="checkbox"/> <input type="checkbox"/> Congenital Heart Defect</p> <p><input type="checkbox"/> <input type="checkbox"/> Diabetes - Type I</p> <p><input type="checkbox"/> <input type="checkbox"/> Diabetes - Type II</p> <p><input type="checkbox"/> <input type="checkbox"/> Difficulty Breathing</p> <p><input type="checkbox"/> <input type="checkbox"/> Emphysema</p> <p><input type="checkbox"/> <input type="checkbox"/> Epilepsy</p> <p><input type="checkbox"/> <input type="checkbox"/> Fever Blisters</p> <p><input type="checkbox"/> <input type="checkbox"/> Frequent Headaches</p> <p><input type="checkbox"/> <input type="checkbox"/> Glaucoma</p>	<p>Y N Conditions</p> <p><input type="checkbox"/> <input type="checkbox"/> HIV+ AIDS</p> <p><input type="checkbox"/> <input type="checkbox"/> Heart Attack</p> <p><input type="checkbox"/> <input type="checkbox"/> Heart Surgery</p> <p><input type="checkbox"/> <input type="checkbox"/> Hepatitis</p> <p><input type="checkbox"/> <input type="checkbox"/> High Blood Pressure</p> <p><input type="checkbox"/> <input type="checkbox"/> Kidney Problems</p> <p><input type="checkbox"/> <input type="checkbox"/> Liver Disease</p> <p><input type="checkbox"/> <input type="checkbox"/> Low Blood Pressure</p> <p><input type="checkbox"/> <input type="checkbox"/> Mental Health Disorder</p> <p><input type="checkbox"/> <input type="checkbox"/> Mitral Valve Prolapse</p> <p><input type="checkbox"/> <input type="checkbox"/> Neurological Disease</p> <p><input type="checkbox"/> <input type="checkbox"/> Osteoporosis</p> <p><input type="checkbox"/> <input type="checkbox"/> Pace Maker</p> <p><input type="checkbox"/> <input type="checkbox"/> Radiation Therapy</p> <p><input type="checkbox"/> <input type="checkbox"/> Rheumatic Fever</p> <p><input type="checkbox"/> <input type="checkbox"/> Seasonal Allergies</p> <p><input type="checkbox"/> <input type="checkbox"/> Seizures</p> <p><input type="checkbox"/> <input type="checkbox"/> Shingles</p> <p><input type="checkbox"/> <input type="checkbox"/> Sickle Cell Disease</p> <p><input type="checkbox"/> <input type="checkbox"/> Sinus Problems</p> <p><input type="checkbox"/> <input type="checkbox"/> Sleep Apnea</p> <p><input type="checkbox"/> <input type="checkbox"/> Stroke</p>	<p>Y N Conditions</p> <p><input type="checkbox"/> <input type="checkbox"/> Substance Abuse</p> <p><input type="checkbox"/> <input type="checkbox"/> Sulfa Allergy</p> <p><input type="checkbox"/> <input type="checkbox"/> Thyroid Problems</p> <p><input type="checkbox"/> <input type="checkbox"/> Tuberculosis</p> <p><input type="checkbox"/> <input type="checkbox"/> Ulcers</p> <div style="border: 2px solid black; padding: 5px; margin-top: 10px;"><p>Y N Allergies</p><p><input type="checkbox"/> <input type="checkbox"/> Aspirin</p><p><input type="checkbox"/> <input type="checkbox"/> Codeine</p><p><input type="checkbox"/> <input type="checkbox"/> Dental Anesthetics</p><p><input type="checkbox"/> <input type="checkbox"/> Erythromycin</p><p><input type="checkbox"/> <input type="checkbox"/> Jewelry</p><p><input type="checkbox"/> <input type="checkbox"/> Latex</p><p><input type="checkbox"/> <input type="checkbox"/> Metals</p><p><input type="checkbox"/> <input type="checkbox"/> Penicillin</p><p><input type="checkbox"/> <input type="checkbox"/> Tetracycline</p><p>Other</p><p>_____</p><p>_____</p><p>_____</p></div>
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Medications:

Name of Previous Dentist: _____**Date of Last Dental Exam/Radiographs:** _____**Do you have dental insurance? If so, what insurance company:** _____**What is the reason for your dental visit today?**

_____**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:**

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NOTE: Both the doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request any insurance company to pay directly to the dentist or dental group any and all insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for the payment of all services rendered on my behalf or my dependent, as well as any and all costs that may be incurred in the collection of monies due on account, to include, but not limited to, attorney's fees, collection fees, and court costs.

Signature of Patient/Legal Guardian

Date: _____

Signature of Dentist: _____

Date: _____

LK DENTAL, LLC

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 REVIEW IT CAREFULLY.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 04/19/2017, 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, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.

Required by Law. We may use or disclose your health information when we are required to do so by law.

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

- o Prevent or control disease, injury or disability;
- o Report child abuse or neglect;
- o Report reactions to medications or problems with products or devices;
- o Notify a person of a recall, repair, or replacement of products or devices;
- o Notify a person who may have been exposed to a disease or condition; or
- o Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

National Security. We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else.

involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

Other Uses and Disclosures of PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

Your Health Information Rights

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to the additional requests.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

Amendment. You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or if you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Our Privacy Official: Lyndsay C. Kuzmak, DDS, MAGD
Address: 20 S. Center St. Westminster, MD 21157

Telephone: (410) 848-5656 Fax: (410) 848-6646
E-mail: LKDentalLLC@gmail.com

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Acknowledgment 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.

Print Name: _____

Signature: _____

Date: _____

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
 - ☐ Communications barriers prohibited obtaining the acknowledgement
 - ☐ An emergency situation prevented us from obtaining acknowledgement
 - ☐ Other (Please Specify)
-
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