

**Patient Information**

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Nickname: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Email (for appointment reminders) \_\_\_\_\_

Home Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Employer/School: \_\_\_\_\_

Dental Insurance Co: \_\_\_\_\_ Subscriber's Name: \_\_\_\_\_

Group #: \_\_\_\_\_ ID # (or SSN) \_\_\_\_\_

Referred to this office by: \_\_\_\_\_

If the patient is a minor:

Mother's Name: \_\_\_\_\_ Father's Name: \_\_\_\_\_

DOB: \_\_\_\_\_ DOB: \_\_\_\_\_

Mother's Employer: \_\_\_\_\_ Father's Employer: \_\_\_\_\_

Patient's Legal Guardian: \_\_\_\_\_ Person responsible for payment: \_\_\_\_\_

Other Children in the family (names/ages) \_\_\_\_\_

**Patient Health History**

<b><u>Yes</u></b>	<b><u>No</u></b>	
___	___	Is the patient allergic to anything? _____
___	___	Has the patient ever had a health problem? _____
___	___	Has the patient ever been hospitalized? (reason/date) _____
___	___	Is the patient currently taking medication? (medication/reason) _____
___	___	Does the patient premedicate for dental procedures? (medication name/dosage) _____
___	___	Does or did the patient suck a finger, thumb, or pacifier? _____
___	___	Does the patient have pain with chewing, yawning, or opening wide? _____
___	___	Does the patient's jaw make noise or have pain? _____

**Please check any of the following for which the patient has been treated:**

___ ADD	___ Cancer/Tumors	___ Heart Problems	___ Seizures
___ AIDS	___ Cerebral Palsy	___ Liver/GI Disease	___ Speech/hearing/vision problems
___ Anemia	___ Cleft Lip/Palate	___ Mental delays	___ Social concerns
___ Autism	___ Congenital birth Defect	___ Physical delays	___ Mild asthma / Severe asthma
___ Bleeding/Transfusions	___ Diabetes	___ Recurrent headache	
___ Blood Dyscrasias	___ Down Syndrome	___ Rheumatic Fever	

Please elaborate on any items checked or any other comments concerning medical health: \_\_\_\_\_

**Consent for Dental Treatment**

I request and authorize Dr. McCombs and his staff to examine and provide dental treatment on the patient's teeth. I further request and authorize the taking of dental X-rays as may be considered necessary by Dr. McCombs to diagnose and/or treat the patient. I will be responsible for any charges incurred on this patient for dental treatment.

Printed Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**NOTICE OF PRIVACY PRACTICES**

**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION.  
PLEASE REVIEW IT CAREFULLY.  
THE PRIVACY OF YOUR HEALTH 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 also 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 described in this Notice while it is in effect. This Notice takes effect January 1, 2007 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and 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 practice 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 these changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available 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 at 703-820-1011 during normal business hours.

**USES AND DISCLOSURES OF HEALTH INFORMATION**

We use and disclose health information about you for treatment, payment, and healthcare operations.

**Treatment:** We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

**Payment:** We may use and disclose your health information to obtain payment for services we provide to you.

**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, evaluating 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 or healthcare operations, you may give us authorization to use your health information or to 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 or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

**Persons Involved In Care:** We may use or disclose health information to notify, or assist in the notifications of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in 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.

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

**Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

**\*\* You may refuse to sign this acknowledgement \*\***

I, \_\_\_\_\_, have received a copy of this office's Notice of Privacy Practices.

Child's name, if under 18 years of age: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_