

Date _____

GETTING TO KNOW YOU AS OUR PATIENT

PATIENT NAME	SOCIAL SECURITY NUMBER	HOME PHONE ()
Home Address	City, State, Zip	Birthdate / /
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated	<input type="checkbox"/> M <input type="checkbox"/> F	Drivers License and State
Primary Insurance Company _____ Group _____ Subscriber _____		
E-mail: _____		Cell phone: () _____

Responsible Party		
NAME	SOCIAL SECURITY NUMBER	HOME PHONE ()
Home Address	City, State, Zip	Birthdate / /
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated	Relationship to Patient	Drivers License and State
Responsible Person's Employer	Occupation	Work Phone ()
Business Address	City	State Zip
Spouse's Name	Social Security Number	Birthdate / /
Spouse's Employer	Spouse's Occupation	Spouse's Work Phone ()
Spouse's Business Address	City	State Zip

How did you hear about our Office?

(check only one)

Who selected this Office? Self Spouse Parent Employer

Where did you find the Phone Number to this Office? _____

 Referred by a friend Relative Insurance Plan Other _____ Internet Direct Mailing Sign by Building

If you were referred, whom may we thank for referring you? _____

CONSENT•I will answer all health questions to the best of my knowledge _____
Initial

After explanation by the doctor, I hereby authorize the performance of dental services upon the above named patients and whatever procedures that the judgement of the doctor may decide in order to carry out these procedures. I also authorize and request the administration of any anesthetics and x-rays as may be deemed necessary and advisable by the doctor.

Signature

Date

Relationship to Patient

TERMS AND CONDITIONS

This office depends upon reimbursement from the patient for the costs incurred in their case. The financial responsibility of each patient must be determined before treatment.

As a condition of treatment by this office, I understand financial arrangements must be made in advance. All emergency dental services, or any dental service performed without prior financial arrangements, must be paid for at the time the services are performed.

I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges will be paid by an insurance company.

Assignment of Insurance: I hereby authorize releases of any information needed and also authorize my insurance company to pay directly to this Office benefits accruing to me under my policy. I understand that the fee estimate listed for this dental care can only be extended for a period of 90 days from the date of the patient's examination. I also understand that in order to collect my debt, my credit history may be checked through the use of my Social Security Number or any other information I have given you. I agree that in the event that either this office or I institute any legal proceedings with respect to amounts owed by me for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorney's fees. I grant my permission to you, or your assignee, to telephone me at home or at my work to discuss matters related to this form. I have read the above conditions and agree to their content.

Signed _____ Date _____

There may be a charge for any missed appointments or appointments not cancelled 48 hours before the appointment time.

PATIENTS DENTAL HEALTH

Why have you come in to see us today? (e.g.: pain, checkup, etc.) _____

Previous Dentist _____ Last Visit _____ Date of last cleaning _____

Reasons for changing dentists: _____

What problems have you had with past dental treatment? _____

Are you nervous about seeing a dentist? Yes! No If yes, please tell us why: _____

How often do you brush? _____ Do you floss? Yes No How often? _____

(please circle each)

Y N I clench or grind my teeth during the day or while sleeping.	Y N My gums feel tender or swollen
Y N My gums bleed while brushing or flossing.	Y N I have problems eating.
Y N I like my smile.	Y N I have had orthodontics.
Y N I prefer tooth-colored fillings.	Y N I have had a facial or jaw injury.
Y N I avoid brushing part of my mouth due to pain.	Y N I want my teeth straight.
	Y N I want my teeth whiter.

What are your dental priorities? _____
(e.g.: apprentice, dental health, financial considerations, etc.)

PATIENTS MEDICAL HISTORY

I consider my health to be (please check one) Excellent Good Fair Poor

Do you or have you had any of the following? please circle Y for yes or N for no.

1. Y N Heart Disease	22. Y N Liver Disease	Doctor Notes Only:
2. Y N Heart Murmur/Mitral Valve Prolapse	23. Y N Jaundice	
3. Y N Stroke	24. Y N Hepatitis Type _____	
4. Y N Congenital Heart Lesions	25. Y N Diabetes	
5. Y N Rheumatic Fever	26. Y N Excessive Urination and/or Thirst	
6. Y N Abnormal Blood Pressure	27. Y N Infectious Mononucleosis (Mono)	
7. Y N Anemia	28. Y N Herpes	
8. Y N Prolonged Bleeding Disorder	29. Y N Arthritis	
9. Y N Tuberculosis or Lung Disease	30. Y N Sexually Transmitted/Venereal Disease	
10. Y N Asthma	31. Y N Kidney Disease	
11. Y N Hay Fever	32. Y N Tumor or Malignancy	
12. Y N Sinus Trouble	33. Y N Cancer/Chemotherapy	
13. Y N Epilepsy/Seizures	34. Y N Radiation Treatment	
14. Y N Ulcers	35. Y N History of Drug Addiction	
15. Y N Implants/Artificial Joints: <input type="checkbox"/> Hip <input type="checkbox"/> Knee <input type="checkbox"/> Other	36. Y N AIDS	
16. Y N I smoke or use tobacco. If yes, how much per day? _____ How many years? _____	37. Y N Immune Suppressed Disorder	
17. Y N I have consumed alcohol within the last 24 hours.	38. Y N Hearing Loss	
18. Y N I usually take an antibiotic prior to dental treatment.	39. Y N Fainting Spells	
19. Y N Have you ever taken Fen-Phen or Redux?	40. Y N Glaucoma	
20. Y N I have had major surgery: Year _____ Type of operation: _____ Year _____ Type of operation: _____	41. Y N History of Emotional or Nervous Disorders	

21. Y N Do you have any other medical problem or medical history NOT listed on this form? _____

<p>Are you allergic to any of the following? Please circle Y for yes or N for no</p> <p>44. Y N Aspirin</p> <p>45. Y N Ibuprofen</p> <p>46. Y N Sulfa Drugs/Sulfites/Sulfides</p> <p>47. Y N Penicillin</p> <p>48. Y N Codeine</p> <p>49. Y N Latex, Metals, Plastics</p> <p>50. Y N Local Anesthetics (Novocaine)</p> <p>51. Y N Other Medications - Which ones? _____</p>	<p>Please list all medications you are currently taking:</p> <p>Medicine _____ Condition _____</p> <p>Medicine _____ Condition _____</p> <p>Medicine _____ Condition _____</p> <p>Medicine _____ Condition _____</p> <p>Physician's Name _____ Phone _____</p> <p>Address _____ Fax _____</p>
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In the event of an emergency please contact:

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Initial medical/dental health reviewed by:

X _____ / _____ / _____ X _____ / _____ / _____
Doctor's Signature Date Patient's Signature Date

Periodic medical/dental health reviewed by:

X _____ / _____ / _____ X _____ / _____ / _____
Doctor's Signature Date If patient is a minor: Parent/Guardian's Signature Date

GETTING TO KNOW YOU AS OUR PATIENT



GISPERT FAMILY DENTISTRY

189 Christiana Road New Castle, DE. 19720 302.322.1000

CANCELATION POLICY; Patient Agreement

- When you make an appointment with us, you are reserving time, facilities, equipment, doctors and staff members exclusively to treat you. Missed appointments adversely affect and delay treatment and/or prevent others from receiving necessary care; therefore, please provide us with **AT LEAST 2 WORKING DAYS** notice in the event that you cannot keep your appointment to avoid a cancellation fee (\$50). This fee must be paid in full prior to rescheduling the appointment.
- When you make an appointment for an extensive time, we may ask for a reservation fee. With 2 working days notice, we will gladly reschedule your appointment and reapply your reservation fee. If you do not give us sufficient notice, your reservation fee will be forfeited. Messages left on weekends are not sufficient.
- We realize in most cases when you are late, it is due to circumstances beyond your control. We will do our best to accommodate you; however, if sufficient treatment time is not left, your appointment may be rescheduled regardless of whether or not you are reached by our office.
- **Multiple missed appointments can result in an administrative discharge from our practice.**
- In the event of a dental emergency, we try to provide same day emergency care as our schedule permits. Please call our office as early in the day as possible as it gives us greater ability to schedule your visit. Should you need us after hours, please call our office and leave a voicemail and we will get back to you asap.

I have read and understand this agreement and will abide by its guidelines;

Patient Signature (Or Guardian)

Date



**GISPERT FAMILY
DENTISTRY**

189 Christiana Road New Castle, DE. 19720 302.322.1000

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____ have received a copy of this office's Notice of Privacy Practice.

Please Print Patients Name

Date of Birth

Signature of Patient or Guardian

Today's Date



189 Christiana Road New Castle, DE. 19720 302.322.1000

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. 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's in effect. This notice takes effect April 14, 2003 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. We reserve the right to make the change in our privacy practices 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 the 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 using the information listed at the end of this Notice.

Uses and disclosures of health information:

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

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 qualification 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 written 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 written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family & Friends: We must disclose your health information to you as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you 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.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Require 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.

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 institutions or law enforcement officials having lawful custody of protected health information of an inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters.)

Patient rights:

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practically do so. (You must make a request in writing to obtain access to your health information. 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.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. 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 these additional requests.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payment will be handled under the alternative means or location you request.

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.

Electronic Notice: If you receive this Notice on our website or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

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 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.

Contact Officer: Ignacio V. Gispert, D.M.D. Telephone: 302-322-2303



GISPERT FAMILY DENTISTRY

189 Christiana Road New Castle, DE. 19720 302.322.1000

HIPPA

Patient's Name: _____ Today's Date: _____

DOB: _____

Many of our patients allow family members such as their spouse, parents or others to call and request information including appointment days and times, treatment plan information, payment information, and updates on care.. Under the requirements for HIPPA, we are not allowed to give this information to anyone without the patients' written consent. If you wish to have your protected health information released to a family member you must review, fill-in, and sign this form. You have the right to revoke this consent, in writing except where we have already made disclosures in reliance on your prior consent. This consent will remain in force until revoked or requested in writing by you, our patient.

If you wish to *NOT* have health information disclosed to anyone, please initial here _____.

I authorize Gispert Family Dentistry to release information about my care including appointment days/time, treatment plan information, care updates and billing information to the following individuals:

1. _____ DOB _____ Relation to Patient: _____

2. _____ DOB _____ Relation to Patient: _____

3. _____ DOB _____ Relation to Patient: _____

Signature of Patient/Guardian: _____