New Patient Information

Mark B. Griffiths, D.D.S.

Extraordinary Dentistry ~ Exceptional Service

We look forward to having you join our great family of friends and patients. The benefits of a healthy, beautiful smile are immeasurable and our goal is to allow you to obtain the healthy teeth and attractive smile you want and deserve. Please complete this form so we may provide the best care possible for you. All information is completely confidential.

PATIENT INFORMATION

Patient's Name_____ Date _____
Last First Middle

Address _____
Street City State Zip

Home Phone_____ Birthdate_____ Social Security # _____

Parent or guardian (if patient is a dependent) _____

Work Phone_____ Cell_____ Email _____

RESPONSIBLE PARTY INFORMATION

Name _____
Last First Middle

Residence _____
Street City State Zip

Mailing Address _____
Street City State Zip

How long at this address?_____ Home Phone_____ Work Phone _____

Previous Address (if less than 3 years)_____
Street City State Zip

Social Security #_____ Birthdate_____ Relationship to Patient _____

Driver's License #_____ Is this person currently a patient in our office? ☐ Yes ☐ No

Employer_____ Occupation_____ # Years Employed ___

Employer Address _____
Street City State Zip

GETTING TO KNOW YOU

What name do you go by? _____

Is a member of your family or relative a patient of our office? Name_____ Relationship _____

Whom may we thank for referring you to our office?_____

We value the confidence our patients and others place in our office and wish to recognize them for their referrals.)

Person to contact for emergency_____ Phone _____

Address _____
Street City State Zip

Name of nearest relative not living with you_____ Phone _____

Address _____
Street City State Zip

Confidential Health History Form

Today's Date _____

Patient Name: First _____ MI _____ Last _____ **Date of Birth** _____

I. Circle appropriate answer *(Leave blank if you do not understand the question)*

1. **Yes / No** **Is your general health good?**
   If NO, explain _____
2. **Yes / No** **Has there been a change in your health within the last year?**
   If YES, explain _____
3. **Yes / No** **Have you gone to the hospital or emergency room or had a serious illness in the last three years?**
   If YES, explain _____
4. **Yes / No** **Are you being treated by a physician now?**
   If YES, explain _____
   Date of last medical exam? _____ **Reason for exam** _____
5. **Yes / No** **Have you had problems with prior dental treatment?**
   If YES, explain _____
   Date of last dental exam _____ **Name of last treating dentist** _____
6. **Yes / No** **Are you in pain now?**
   If YES, explain _____

II. Have you experienced any of the following? *(Please circle Yes or No for each)*

Yes / No	Chest pain (angina)	Yes / No	Blood in stools	Yes / No	Frequent vomiting
Yes / No	Fainting spells	Yes / No	Diarrhea or constipation	Yes / No	Jaundice
Yes / No	Recent significant weight loss	Yes / No	Frequent urination	Yes / No	Dry mouth
Yes / No	Fever	Yes / No	Difficulty urinating	Yes / No	Excessive thirst
Yes / No	Night sweats	Yes / No	Ringing in ears	Yes / No	Difficulty swallowing
Yes / No	Persistent cough	Yes / No	Headaches	Yes / No	Swollen ankles
Yes / No	Coughing up blood	Yes / No	Dizziness	Yes / No	Joint pain or stiffness
Yes / No	Bleeding problems	Yes / No	Blurred vision	Yes / No	Shortness of breath
Yes / No	Blood in urine	Yes / No	Bruise easily	Yes / No	Sinus problems

III. Have you had or do you have any of the following? *(Please circle Yes or No for each)*

Yes / No	Heart disease	Yes / No	Cosmetic surgery	Yes / No	Eating disorders
Yes / No	Family history of heart disease	Yes / No	Surgeries	Yes / No	Osteoporosis
Yes / No	Heart attack	Yes / No	Hospitalization	Yes / No	Thyroid disease
Yes / No	Artificial joint	Yes / No	Diabetes	Yes / No	Asthma
Yes / No	Stomach problems or ulcers	Yes / No	Family history of diabetes	Yes / No	Hepatitis
Yes / No	Heart defects	Yes / No	Tumors or cancer	Yes / No	Sexual transmitted disease
Yes / No	Heart murmurs	Yes / No	Chemotherapy	Yes / No	Herpes
Yes / No	Rheumatic fever	Yes / No	Radiation	Yes / No	Canker or cold sores
Yes / No	Skin disease	Yes / No	Arthritis, rheumatism	Yes / No	Anemia
Yes / No	Hardening of arteries	Yes / No	Emphysema or other lung disease	Yes / No	Liver disease
Yes / No	High blood pressure	Yes / No	Kidney or bladder disease	Yes / No	Eye disease
Yes / No	Seizures	Yes / No	Stroke	Yes / No	Transplants
				Yes / No	Tuberculosis

This information will not be released unless specifically authorized by patient.

Yes / No AIDS/HIV Yes / No Anxiety Yes / No Depression Yes / No Treatment for emotional condition

IV. Are you allergic to or have you had a reaction to any of the following? *(Please circle Yes or No for each)*

Yes / No	Aspirin	Yes / No	Valium	Yes / No	Tetracycline
Yes / No	Darvon	Yes / No	Demerol	Yes / No	Vicodin
Yes / No	Codeine	Yes / No	Penicillin	Yes / No	Percodan
Yes / No	Latex	Yes / No	Food	Yes / No	Nitrous oxide
Yes / No	Local anesthetic (Novocain or Xylocaine)	Yes / No	Erythromycin	Yes / No	Metal

Others _____

V. Are you taking or have you taken any of the following in the last three months? *(Please circle Yes or No for each)*

Yes / No Recreational drugs
Yes / No Over-the-counter medicines
Yes / No Weight loss medications
Yes / No Cortico - Steroids
Yes / No Tobacco in any form
Yes / No Alcohol
Yes / No Bisphosphonate (Fosamax)
Yes / No Antibiotics
Yes / No Supplements
Yes / No Aspirin

Please list all medications you are currently taking _____

VI. Women only *(Please circle Yes or No for each)*

Yes / No **Are you or could you be pregnant? If YES, what month?** _____
Yes / No **Are you nursing?**
Yes / No **Are you taking birth control pills?**

VII. All patients *(Please circle Yes or No for each)*

Yes / No **Do you have or have you had any other diseases or medical problems NOT listed on this form?**
If YES, explain _____

Yes / No **Have you ever been pre-medicated for dental treatment?**
If YES, why _____

Yes / No **Have you ever taken Fen-Phen?**
If YES, when _____

Yes / No **Is there any issue or condition that you would like to discuss with the dentist in private?**

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment.

I authorize the dentist to contact my physician.

Patient's Signature _____ Date _____

Physician's Name _____ Phone Number _____

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient (Parent or Guardian)	Date	Signature of Dentist	Date

Medical updates

I have reviewed my Health History and confirm that it accurately states past and present conditions.

Date	Patient Signature	Changes to Health History	Dentist Initials

Patient Name

DENTAL HISTORY

Medical Alert _____

What is the reason for today's visit? _____

_____ Date: _____

Date of last dental visit _____ Last dental cleaning _____ Last full mouth X-rays _____

What was done at your last dental visit? _____

If you wish us to obtain your previous dental records, please provide the following:

Previous dentist's name _____ Telephone _____

Address _____

How often do you have dental examinations? _____

How often do you brush your teeth? _____ How often do you floss? _____

What other dental aids do you use? ☐ Electric toothbrush ☐ Toothpick ☐ Water irrigator ☐ Other _____

Do you have any dental problems now? ☐ Yes ☐ No

If yes, please describe: _____

_____

Are any of your teeth sensitive to:

Hot or cold? ☐ Yes ☐ No

Sweets? ☐ Yes ☐ No

Biting or chewing? ☐ Yes ☐ No

Have you noticed any mouth odors or bad tastes? ☐ Yes ☐ No

Do you frequently get cold sores, blisters or any other oral lesions? ☐ Yes ☐ No

Do your gums bleed or hurt? ☐ Yes ☐ No

Have your parents experienced gum disease or tooth loss? ☐ Yes ☐ No

Have you noticed any loose teeth or change in your bite? ☐ Yes ☐ No

Does food tend to become caught in between your teeth? ☐ Yes ☐ No

If yes, where? _____

Do you:

Clench or grind your teeth while awake or asleep? ☐ Yes ☐ No

Bite your lips or cheeks regularly? ☐ Yes ☐ No

Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails) ☐ Yes ☐ No

Mouth breathe while awake or asleep? ☐ Yes ☐ No

Have tired jaws, especially in the morning? ☐ Yes ☐ No

Smoke, chew tobacco? ☐ Yes ☐ No

Are you interested in stopping smoking? ☐ Yes ☐ No

Have you ever had:

Orthodontic treatment? ☐ Yes ☐ No

Oral surgery? ☐ Yes ☐ No

Periodontal treatment? ☐ Yes ☐ No

Your teeth ground or the bite adjusted? ☐ Yes ☐ No

A bite plate or mouth guard? ☐ Yes ☐ No

A serious injury to the mouth or head? ☐ Yes ☐ No

If so, please describe, including cause: _____

_____

Have you experienced:

Clicking or popping of the jaw? ☐ Yes ☐ No

Pain? (joint, ear, side of face) ☐ Yes ☐ No

Difficulty in opening or closing the mouth? ☐ Yes ☐ No

Difficulty in chewing on either side of the mouth? ☐ Yes ☐ No

Headaches, neck or shoulder aches? ☐ Yes ☐ No

Sore muscles (neck, shoulders)? ☐ Yes ☐ No

Are you satisfied with the appearance of your teeth? ☐ Yes ☐ No

Would you like to improve your smile? ☐ Yes ☐ No

Would you be interested in teeth whitening? ☐ Yes ☐ No

Do you feel nervous about having dental treatment? ☐ Yes ☐ No

If so, what is your biggest concern? _____

_____

Have you ever had an upsetting dental experience? ☐ Yes ☐ No

If yes, please describe: _____

_____

Is there anything else about having dental treatment that you would like us to know? ☐ Yes ☐ No

If yes, please describe. _____

_____

Mark B. Griffiths, D. D. S., Inc.
General & Cosmetic Dentistry
3565 Fourth Ave. San Diego, CA 92103
(619) 298-6257

Acknowledgment of Receipt of Privacy Practices Notice and Dental Material Fact Sheet

This document acknowledges that you have received a cop of:

1. Notice of Privacy Practices
2. Dental Material Fact Sheet

This document is not a contract, authorization, release or consent form. This document will remain in your records.

From time to time we apprise our clients of events that may be of interest to them via email or mail. Please check below if you do NOT wish to be notified of such events.

_____

I, _____, acknowledge that I have received a copy of the Notice of Privacy Practices and the Dental Material Fact Sheet.

Patient's Signature_____ Date_____

If the patient is a minor, a parent or legal guardian must sign.

Parent or Legal Guardian_____ Date_____

Relationship to Patient _____

Consent for Treatment

I understand the information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify Dr. Griffiths of any change in my health or dedication.

I hereby authorize Dr. Griffiths or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) _____'s dental needs. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I agree to use the anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand I can ask for a complete recital of any possible complications. I understand it is my responsibility to advise your office of any changes in the information contained on he registration, insurance and medical/dental history form.

_____

Signature of Patient (Parent or Responsible Party) Today's date

Relationship to Patient _____

Witnessed by _____

Doctor's signature _____ Date _____

Mark B. Griffiths, D.D.S.

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 is in effect. This Notice takes effect (MM/DD/YR), 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 changes 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 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 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 a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and 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.

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.

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 of protected health information of 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 practicably 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. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.___ for each page, $___ per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

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.

Restriction: 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 payments 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 Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.
