Patient Name _____ Date of Birth _____

Home Address _____ Home Phone _____

_____ Cell Phone _____

E-Mail _____ Work Phone _____

Employer _____ SSN# _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	Yes	No	If yes, please explain: _____
Have you ever been hospitalized or had a major operation?	Yes	No	If yes, please explain: _____
Have you ever had a serious head or neck injury?	Yes	No	If yes, please explain: _____
Are you taking any medications, pills, or drugs?	Yes	No	If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux?	Yes	No	_____
Are you on a special diet?	Yes	No	_____
Do you use tobacco?	Yes	No	
Have you ever taken Fosamax,Boniva, Actonel or any Other medications containing bisphosphonates?	Yes	No	

Women: Are you

Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics sulfa drugs

Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive	Yes	No	Cortisone Medicine	Yes	No	Hemophilia	Yes	No	Renal Dialysis	Yes	No
Alzheimer's Disease	Yes	No	Diabetes	Yes	No	Hepatitis A	Yes	No	Rheumatic Fever	Yes	No
Anaphylaxis	Yes	No	Drug Addiction	Yes	No	Hepatitis B or C	Yes	No	Rheumatism	Yes	No
Anemia	Yes	No	Easily Winded	Yes	No	Herpes	Yes	No	Scarlet Fever	Yes	No
Angina	Yes	No	Emphysema	Yes	No	High Blood Pressure	Yes	No	Shingles	Yes	No
Arthritis/Gout	Yes	No	Epilepsy or Seizures	Yes	No	Hives or Rash	Yes	No	Sickle Cell Disease	Yes	No
Artificial Heart Valve	Yes	No	Excessive Bleeding	Yes	No	Hypoglycemia	Yes	No	Sinus Trouble	Yes	No
Artificial Joint	Yes	No	Excessive Thirst	Yes	No	Irregular Heartbeat	Yes	No	Spina Bifida	Yes	No
Asthma	Yes	No	Fainting Spells/Dizziness	Yes	No	Kidney Problems	Yes	No	Stomach/Intestinal Disease	Yes	No
Blood Disease	Yes	No	Frequent Cough	Yes	No	Leukemia	Yes	No	Stroke	Yes	No
Blood Transfusion	Yes	No	Frequent Diarrhea	Yes	No	Liver Disease	Yes	No	Swelling of Limbs	Yes	No
Breathing Problem	Yes	No	Frequent Headaches	Yes	No	Low Blood Pressure	Yes	No	Thyroid Disease	Yes	No
Bruise Easily	Yes	No	Genital Herpes	Yes	No	Lung Disease	Yes	No	Tonsillitis	Yes	No
Cancer	Yes	No	Glaucoma	Yes	No	Mitral Valve Prolapse	Yes	No	Tuberculosis	Yes	No
Chemotherapy	Yes	No	Hay Fever	Yes	No	Pain in Jaw Joints	Yes	No	Tumors or Growths	Yes	No
Chest Pains	Yes	No	Heart Attack/Failure	Yes	No	Parathyroid Disease	Yes	No	Ulcers	Yes	No
Cold Sores/Fever Blisters	Yes	No	Heart Murmur	Yes	No	Psychiatric Care	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disorder	Yes	No	Heart Pace Maker	Yes	No	Radiation Treatments	Yes	No	Yellow Jaundice	Yes	No
Convulsions	Yes	No	Heart Trouble/Disease	Yes	No	Recent Weight Loss	Yes	No	Human Papilloma Virus	Yes	No

High Cholesterol Y N

Have you ever had any serious illness not listed above? Yes No If yes, please explain:

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

We require 48 hours (two business days) advance notice to cancel or change your appointment to avoid $75 broken appointment fee per half hour of scheduled appointment time.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

HIPAA NOTICE OF PRIVACY PRACTICES

PAUL M, LEE, DDS, PC

If you have questions about this Notice please contact: our privacy contact who is Cathleen Pannell

This is a synopsis of the HIPAA Practices as conducted by our office. You may read the notice in it's entirety by asking the privacy contact.

Your Protected health information may be used and disclosed by the dentist, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills.

We will use and disclose your protected health information to provide, coordinate, or manage your dental care and any related services. This includes the coordination and management of your health care with a third party (your insurance company). We will also disclose protected health information to other dentists who may be treating you to ensure that the dentist has the necessary information to diagnose or treat you.

Your health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity and undertaking ulilization and review activities.

We may use your protected health information, as necessary, to provide you with information about treatment alternatives or other services that may be of interest to you. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. You may contact our Privacy Contact to request that these materials not be sent to you.

You have the right to inspect and copy your protected health information.

You have the right to request a restriction of your protected health information.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location.

You have the right to have your dentist amend your protected health information.

You have the right to receive an accounting of disclosures we have made, if any, of your protected health information.

You may complain to the Secretary of Health and Human services if youu believe your privacy rights have been violated by us.

Paul M. Lee, D.D.S., P.C.
Family and Cosmetic Dentistry

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Please read the following statements carefully.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person mentioned in our Notice. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I have had full opportunity to read and consider the contents of this Consent for and Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Name of Patient _____

Signature of Patient _____ Date_____

I give permission for _____, my _____
(NAME) (RELATIONSHIP TO PATIENT)

to communicate with Dr. Lee's office on my behalf.

Signature of Patient _____ Date_____