AUSTIN IMPLANTS &PERIODONTICS

Answers to the following questions are for our records only and will be kept confidential. Date _____

Patient Information

Your Name _____ Preferred Name _____ SS# _____ - _____ - _____

Birth Date _____ / _____ / _____ Age _____ Height _____ Weight _____ Sex: ☐M ☐F Driver's License # _____

Address _____ City _____ State _____ ZIP _____

Home Phone ( ) Cell Phone ( ) Email _____@_____

Occupation _____ Employer _____ Work Phone ( )

Spouse's Name _____ Parent/Guardian for Minor Patient _____

Emergency Contact _____ Phone ( ) Relationship _____

Responsible Party (if different from patient)

Name _____ Relationship to Patient: ☐ Spouse ☐ Parent ☐ Guardian

Address _____ City _____ State _____ ZIP _____

Home Phone ( ) Cell Phone ( ) Email _____@_____

Employer _____ Work Phone ( )

Dental Insurance

Policyholder's Name _____ Birth Date _____ / _____ / _____ SS# _____ - _____ - _____

Insurance Company _____ ID# _____ Group No. _____

Health History

For your safety and to assist us in accurately diagnosing and treating you, please carefully review this form completely and fill out areas which pertain to you. **All information is private and confidential.**

Dental History

Who referred you to our office? _____

Your general dentist (if different from referring dentist):

Dr. _____

How long have you been a patient there? _____

When was your last cleaning? _____

How often do you go for cleanings?

☐ 3 months ☐ 6 months ☐ not as often as I should

Have you ever had gum surgery before? ☐ YES ☐ NO

Have you had jaw surgery for orthodontics? ☐ YES ☐ NO

Are you dissatisfied with the appearance of your teeth or gums? ☐ YES ☐ NO

If yes, explain: _____

Have you had teeth (other than wisdom teeth) removed? ☐ YES ☐ NO

Have these missing teeth affected your chewing? ☐ YES ☐ NO

Have you ever declined needed dental treatment? If so, for what reason(s)?

☐ Time ☐ Fear ☐ Finances ☐ other: _____

Check any of the following if you have or recently had:

☐ teeth sensitivity to:
- ☐ heat
- ☐ cold
- ☐ sweets
- ☐ biting/chewing

☐ loose/loosening teeth

☐ snoring

☐ diagnosed with sleep apnea

☐ use a sleep appliance such as a CPAP

☐ been told you grind/clench your teeth

☐ are aware that you grind/clench your teeth

☐ wear an occlusal/night guard

☐ been recommended to use an occlusal/night guard

☐ food catching between teeth

☐ gums bleed when brushing/flossing

☐ swollen gums

☐ bad breath or bad taste

☐ jaw pain

☐ unable to open or close jaw

☐ clicking of jaws

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MEDICAL HISTORY

Any health problems or medications that you are taking may have an effect on your oral and periodontal health, so please review this portion carefully and completely fill out which areas that pertain to you. **All information is private and confidential.**

List your current physician(s):

_____ Type _____ Phone ( ) How long? _____

_____ Type _____ Phone ( ) How long? _____

Date of last physical exam including bloodwork _____ Findings _____

Have there been any changes in your general health last year?	☐ YES	☐ NO	If YES, please explain: _____
Are you under a physician's care other than for routine checkups?	☐ YES	☐ NO	If YES, please explain: _____
Have you ever been hospitalized or had a major operation in past 10 years?	☐ YES	☐ NO	If YES, please explain: _____
Have you ever had excessive bleeding that required treatment?	☐ YES	☐ NO	If YES, please explain: _____
Have you had complications from prior sedation/anesthesia?	☐ YES	☐ NO	If YES, please explain: _____
Have you taken cortisone or steroids within the last 6 months?	☐ YES	☐ NO	If YES, please explain: _____
Do you have family members with diabetes?	☐ YES	☐ NO	If YES: ☐ mom's side ☐ dad's side ☐ siblings
Do you currently use tobacco products (smoke, chew, dip)	☐ YES	☐ NO	If YES: How much? _____ How long? _____
Even if not current, have you ever used tobacco in the past?	☐ YES	☐ NO	If YES, when did you quit? ☐ <10 years ☐ > 10 years ago
Do you consume alcohol?	☐ YES	☐ NO	If YES: ☐ occasionally ☐ 5-7 per week ☐ > 7 per week
Have you had a history of alcohol or illicit drug abuse?	☐ YES	☐ NO	If YES, please explain: _____
Have you ever had Botox® or dermal fillers around the mouth/lips?	☐ YES	☐ NO	If YES, how often: _____
Do you or have you ever taken medication for osteoporosis?	☐ YES	☐ NO	If YES, which one? _____
			Route: ☐ oral ☐ shot ☐ IV infusion
			Frequency: ☐ daily ☐ every ___ months

For females: Are you

Pregnant/Trying? ☐ YES ☐ NO Taking oral contraceptives? ☐ YES ☐ NO Nursing? ☐ YES ☐ NO Post-menopause? ☐ YES ☐ NO

For males: Are you

Taking erectile dysfunction meds? ☐ YES ☐ NO Being treated for enlarged prostate? ☐ YES ☐ NO Taking testosterone supplements? ☐ YES ☐ NO

Please list all medications you are taking including over-the-counter drugs, or supplements:

_____

_____

_____

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Tetracycline	☐ Clindamycin	☐ Versed	☐ Tylenol	☐ Codeine	☐ Ibuprofen
☐ Local anesthetics	☐ Amoxicillin	☐ Doxycycline	☐ Sulfa drugs	☐ Valium	☐ Halcion	☐ Norco/Lortab	☐ Latex

☐ Other(s) _____ If yes, what sort of reaction? _____

Do you have, or have had, any of the following? (circle where applicable)

Cardiovascular disease	☐ No ☐ Yes	Artificial joints	☐ No ☐ Yes	Chronic sinus infections	☐ No ☐ Yes
Heart attack	☐ No ☐ Yes	Thyroid disorders	☐ No ☐ Yes	HIV/AIDs	☐ No ☐ Yes
Chest pain	☐ No ☐ Yes	Diabetes: Type I or Type 2	☐ No ☐ Yes	Kidney disease/failure	☐ No ☐ Yes
High blood pressure	☐ No ☐ Yes	Anemia	☐ No ☐ Yes	Dialysis	☐ No ☐ Yes
Heart murmur	☐ No ☐ Yes	Hepatitis A / B / C	☐ No ☐ Yes	Osteoporosis or osteopenia	☐ No ☐ Yes
Congenital heart defect	☐ No ☐ Yes	Liver disease	☐ No ☐ Yes	Osteoarthritis	☐ No ☐ Yes
Artificial heart valve	☐ No ☐ Yes	Jaundice	☐ No ☐ Yes	Rheumatoid arthritis	☐ No ☐ Yes
Rheumatic fever	☐ No ☐ Yes	Tumors or growths	☐ No ☐ Yes	Acid reflux	☐ No ☐ Yes
Pacemaker	☐ No ☐ Yes	Cancer	☐ No ☐ Yes	GI disorders	☐ No ☐ Yes
Heart arrhythmia	☐ No ☐ Yes	Head and neck radiation	☐ No ☐ Yes	Glaucoma	☐ No ☐ Yes
Stroke	☐ No ☐ Yes	Current chemotherapy	☐ No ☐ Yes	Epilepsy/seizures	☐ No ☐ Yes
Shortness of breath	☐ No ☐ Yes	Tuberculosis	☐ No ☐ Yes	Psychiatric disorders	☐ No ☐ Yes
Emphysema/COPD	☐ No ☐ Yes	Sexually transmitted diseases	☐ No ☐ Yes	Anxiety	☐ No ☐ Yes
Asthma	☐ No ☐ Yes	Oral herpes	☐ No ☐ Yes	Depression	☐ No ☐ Yes
Autoimmune disorders	☐ No ☐ Yes	Immunosuppression	☐ No ☐ Yes	Dementia/Alzheimer's	☐ No ☐ Yes

If you need to specify or clarify any of the above conditions: _____

Do you have any medical condition/diseases not listed on above that we should know about? ☐ No ☐ Yes: _____

I attest that to the best of my knowledge, the information provided above is accurate and complete. I understand that providing incorrect or omitting information can be dangerous to my (or the patient's) health. If I ever have any changes in my health or to medications, it is my responsibility to inform the office.

_____ _____

Patient, Parent, or Guardian's Signature Date Doctor's Signature Date

AUSTIN IMPLANTS &PERIODONTICS

PATIENT ADVISORY AND ACKNOWLEDGMENT

RECEIVING DENTAL TREATMENT DURING THE COVID-19 PANDEMIC

Dear Patient:

You have presented to the office today seeking examination and/or treatment, either elective, urgent, or emergent, for a dental condition.

Please be advised of the following:

- While our office complies with all regulatory body (TSBDE, State Health Department, OSHA, and CDC) infection control guidelines to prevent the spread of the SARS CoV-2, we cannot make any guarantees.

- Our staff are symptom-free and, to the best of their knowledge, have not been exposed to the virus. However, since we are a place of public accommodation, other persons (including other patients) could be infected, with or without their knowledge.

- I have answered and will continue to answer all screening questions prior to arrival for any appointment honestly and candidly in order to help prevent the spread of the virus.

_____ _____

Signature of patient/responsible party Date

_____

Printed name of patient/responsible party

AUSTIN IMPLANTS &PERIODONTICS

P 512·912·9750
F 512·693·0774
E info@austinimplants.com

ACKNOWLEDGEMENT OF RECEIPT of NOTICE of PRIVACY PRACTICES

You may refuse to sign this acknowledgement

I acknowledge that I have received a copy of, read, and understood this office's Notice of Privacy Practices.

_____

Printed name of patient, parent, or legal guardian

_____

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 ☐ Communication barrier prohibited obtaining the acknowledgement ☐ An emergency situation prevented us from obtaining acknowledgement ☐ Other (please specify): _____ _____

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. The Health Insurance Portability and Accountability Act of 1996 was signed into law on August 21, 1996. This Notice took effect on 12/01/2015 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 that 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 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 operation. For example:

Treatment: We may use or disclose your health information to a physician or 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, only where applicable. Your health information will not be disclosed unless mandatory.

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 the 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 and provide written consent for such disclosure.

Person Involved in Care: We may use or disclose health information to notify or assist in notification of (including identifying or location) 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 judgement to disclose only health information that is directly relevant to the person's involvement in your healthcare. We will use our professional judgement and our experience with common practice to make reasonable inference of your best interest in allowing a person to pick up prescriptions, medical supplies, x-rays, digital photographs, or similar forms of health information.

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

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 and the 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 inmates or patients under certain circumstances.

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

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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 in order to obtain 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 $0.50 for each page, $25.00 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 a right to receive a list of instances in which we or our business associated disclosed your health information for purposes other than treatment, payment, healthcare operations and certain other activities, for the last 6 years. 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 website or by e-mail, you are entitled to receive this notice in written form.

NOTICE OF ELECTRONIC DISCLOSURE OF PROTECTED HEALTH INFORMATION

Please be advised that this office maintains our patients' protected health information (PHI) in electronic form ("Electronic Health Records"). All electronic health records maintained by this office, including your PHI, are subject to electronic disclosure.

This office cares about the privacy of your Protected Health Information (PHI). If we obtain or create information about your health, we are required by law to protect the privacy of your information. PHI may include information that relates to:

- Your past, present, or future physical or mental health or condition
- Healthcare provided to you
- Past, present, or future payment for your healthcare.

Under applicable federal and Texas state law, we are required under certain circumstances to obtain a separate authorization from you for each electronic disclosure of your protected health information. This authorization may be made in written or electronic form or orally if documented in writing by our office. The authorization for electronic disclosure of protected health information is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. (Tex. Health & Safety Code §§ 181.154(b),(c), § 241.153; 45 C.F.R. §§ 164.502(a)(1); 164.506, and 164.5080).

For a complete list of reasons that this office is allowed by law to share your PHI, please refer to our Notice of Privacy Practices for electronic disclosures of protected health information that do and do not require your authorization.

QUESTIONS AND COMPLAINTS:

If you want more information about our privacy practices or have any 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 alternative means or alternative locations, you may complain to us using the contact information listed at the end of this notice. You may also 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: Cuong Ha, D.D.S., M.S.

Telephone (512) 912-9750

Address: 2500 W. William Cannon, Suite 103, Austin, Tx 78745