Carl D. Werts, DDS, FAGD

Patient Information and Medical History

Welcome to our practice! Dental care is more than repair. It is maintaining your best dental health. This is done by restoring your teeth and tissues to health so they are comfortable, functional, and attractive. The goal is to have your dentition for a lifetime. Your answers to the following questions are the first step in determining your immediate and long term care. Please add any comments you might have - the more we know about your needs and concerns, the better we can serve you. Thank you!

Patient's Name: _____

Today's Date: _____/_____/_____ Last Dental Visit _____/_____/_____

Street Address:_____ Birthdate: _____/_____/_____

City, State, Zip:_____ Driver's Lic No: _____

PHONES: Home:_____ Work:_____ Mobile:_____ Rec'v Text? Yes ☐ No ☐

Email Address:_____

Social Security No:_____-_____-_____ Marital Status:_____

Whom may we thank for referring you to our office?

Employer:_____Occupation:_____

Employer's Address:_____City:_____Zip:_____

If minor, parent or guardian:_____If student, school name:_____

Primary Insured Dental Insurance Information (Please complete all pertinent information so we may serve you better.)

Name:_____Birthdate:_____/_____/_____ Social Security No:_____-_____-_____

Insurance Company:_____ Group Number:_____

Street Address:_____ Telephone:_____

City:_____State:_____ Zip:_____

Insured's Employer:_____

Employer's Street Address:_____ Telephone:_____

City:_____State:_____Zip:_____

Secondary Insured Dental Insurance Information N/A (no secondary insurance coverage)

Name:_____Birthdate:_____/_____/_____ Social Security No:_____-_____-_____

Insurance Company:_____ Group Number:_____

Street Address:_____ Telephone:_____

City:_____State:_____Zip:_____

Insured's Employer:_____

Employer's Street Address:_____ Telephone:_____

City:_____State:_____ Zip:_____

Insurance Authorization: Signature on file *Please initial as appropriate:*

_____ I understand that I am responsible for my bill, and any finance charges that may accumulate after 90 days.

_____ I authorize payment directly to my doctor.

_____ I authorize release of information to all my insurance companies to assist in payment.

Please continue on the reverse side.

Medical / Dental History

General Health Condition:

_____Excellent_____Good_____Fair_____Poor

Physician's Name:_____
Address:_____
Telephone No:_____

Y	N	CONDITIONS
□	□	PRE-MED ANTIBIOTICS BEFORE APPTS
□	□	HEART PROBLEMS
□	□	HEART ATTACK
□	□	HEART SURGERY
□	□	HEART MURMUR
□	□	BACTERIAL ENDOCARDITIS
□	□	CONGENITAL DEFECT
□	□	MITTRAL VALVE PROLAPSE
□	□	ARTIFICIAL HEART VALVE
□	□	ABNORMAL RHYTHM
□	□	HEART PACEMAKER
□	□	HIGH BLOOD PRESSURE
□	□	DIABETES
□	□	ARTIFICIAL JOINT
□	□	SURGICAL IMPLANTS
□	□	ORGAN TRANSPLANT
□	□	SURGERY
□	□	ARTHRITIS / RHEUMATISM
□	□	KIDNEY PROBLEMS
□	□	PROLONGED BLEEDING
□	□	BISPHOSPHONATES (EX - FOSAMAX)
□	□	CORTISONE MEDICATION

Y	N	CONDITIONS
□	□	LIVER DISEASE
□	□	HEPATITIS - A, B, OR C ? OTHER?
□	□	THYROID PROBLEMS
□	□	EMPHYSEMA
□	□	TUBERCULOSIS
□	□	ULCERS
□	□	ASTHMA, HAY FEVER
□	□	SINUS PROBLEMS
□	□	CANCER
□	□	RADIATION / CHEMOTHERAPY
□	□	STROKE / NEUROLOGICAL
□	□	SEIZURES
□	□	FAINTING SPELLS
□	□	ALCOHOL / DRUG ABUSE
□	□	BLOOD DISORDERS
□	□	ANEMIA
□	□	HEMOPHILIA
□	□	AUTOIMMUNE DISORDER
□	□	HIV + / AIDS
□	□	VENEREAL DISEASE
□	□	HERPES
□	□	PSYCHOLOGICAL CARE

Y	N	ALLERGIES TO:
□	□	PENICILLIN
□	□	TETRACYCLINE
□	□	ERYTHROMYCIN
□	□	CODEINE
□	□	ASPIRIN
□	□	DENTAL ANESTHETICS
□	□	LATEX
□	□	METALS
□	□	JEWELRY
□	□	OTHER, PLEASE LIST:_____

_____
_____
_____

Y	N	WOMEN ONLY:
□	□	ARE YOU PREGNANT? NO WKS_____
□	□	ARE YOU NURSING?
□	□	TAKING BIRTH CONTROL PILLS?

Y □ N □ Is there any other disease, condition, or problem that you think this office should be aware of? Please describe: _____
_____

Please list current medications:_____
_____

Dental information

Are any of your teeth sensitive to □ Hot □ Cold □Sweets □ Pressure

Y □ N □ Do you know of any inflamed areas, growths, sore spots, unhealed Injuries in or around your mouth?

Y □ N □ Have you noticed any loosening of your teeth?

Y □ N □ Do you suffer from pain / swelling of your gums?

Y □ N □ Do your gums bleed when you brush your teeth?

Y □ N □ Are you missing teeth? Have they been replaced?

Y □ N □ Have you ever had a local anesthetic ("Novacaine")?
Y □ N □ Have you ever had an unfavorable reaction from local anesthetic? Please describe:_____
_____

Have you experienced:
Y □ N □ Pain in Temporal Mandibular Joint (TMJ), ear, side of face?

Y □ N □ Difficulty in opening or closing of the jaw?
Difficulty in chewing?

Have you ever had:
Y □ N □ Periodontal therapy (gum treatment)?
Y □ N □ Oral surgery?
Y □ N □ Orthodontic treatment (braces)?

The information in this questionnaire is accurate to the best of my knowledge. This will be used by the Dentist and staff to determine appropriate dental treatment. If there is any change in my medical status, I will inform the Dentist and staff.

Patient's Signature:_____ Today's date:_____
(If under 18, Parent or Guardian Signature Required)

In case of an emergency, whom should we notify?

Name:_____**Relationship**_____**Telephone**_____

Address:_____**City:**_____**State**_____**Zip:**_____

CARL D. WERTS, DDS, FAGD • (818) 241-1824

Protecting Your Confidential Health Information is Important to Us

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.

Our Promise!

Dear Patient:
This is not meant to alarm you! Quite the opposite! It is our desire to communicate to you that we are taking the new Federal (HIPAA - Health Insurance Portability and Accountability Act) laws written to protect the confidentiality of your health information seriously. We do not ever want you to delay treatment because you are afraid your personal health history might be unnecessarily made available to others outside of our office.

So what has changed? Why a privacy policy now? Very good questions!

The most significant variable that has motivated the Federal government to legally enforce the importance of the privacy of health information is the rapid evolution of computer technology and its use in healthcare. The government has appropriately sought to standardize and protect the privacy of the electronic exchange of your health information. This has challenged us to review not only how your health information is used within our computers but also with the Internet, phone, faxes, copy machines, and charts. We believe this has been an important exercise for us because it has disciplined us to put in writing the policies and procedures we use to ensure the protection of your health information everywhere it is used.

We want you to know about these policies and procedures which we developed to make sure your health information will not be shared with anyone who does not require it. Our office is subject to State and Federal law regarding the confidentiality of your health information and in keeping with these laws, we want you to understand our procedures and your rights as our valuable patient.

We will use and communicate your HEALTH INFORMATION only for the purposes of providing your treatment, obtaining payment and conducting health care operations. Your health information will not be used for other purposes unless we have asked for and been voluntarily given your written permission.

How your HEALTH INFORMATION may be used

To Provide Treatment

We will use your HEALTH INFORMATION within our office to provide you with the best dental care possible. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care between hygienist, dental assistant, dentist, and business office staff. In addition, we may share your health information with physicians, referring dentists, clinical and dental laboratories, pharmacies or other health care personnel providing you treatment.

To Obtain Payment

We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically. We will be sure to only work with companies with a similar commitment to the security of your health information.

To Conduct Health Care Operations

Your health information may be used during performance evaluations of our staff. Some of our best teaching opportunities use clinical situations experienced by patients receiving care at our office. As a result, health information may be included in training programs for students, interns, associates, and business and clinical employees. It is also possible that health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine processes of certification, licensing or credentialing activities.

In Patient Reminders

Because we believe regular care is very important to your oral and general health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you or your family.

These communications are an important part of our philosophy of partnering with our patients to be sure they receive the best preventive and restorative care modern dentistry can provide. They may include postcards, folding postcards, letters, telephone reminders or electronic reminders such as email (unless you tell us that you do not want to receive these reminders).

Abuse or Neglect

We will notify government authorities if we believe a patient is the victim of abuse, neglect or domestic violence. We will make this disclosure only when we are compelled by our ethical judgment, when we believe we are specifically required or authorized by law or with the patient's agreement.

Public Health and National Security

We may be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public health or national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic or the understanding of new side effects of a drug treatment or medical device.

For Law Enforcement

As permitted or required by State or Federal law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstances, if you are a victim of a crime or in order to report a crime.

Family, Friends and Caregivers

We may share your health information with those you tell us will be helping you with your home hygiene, treatment, medications, or payment. We will be sure to ask your permission first. In the case of an emergency, where you are unable to tell us what you want we will use our very best judgment when sharing your health information only when it will be important to those participating in providing your care.

Authorization to Use or Disclose Health Information

Other than is stated above or where Federal, State or Local law requires us, we will not disclose your health information other than with your written authorization. You may revoke that authorization in writing at any time.

Patient Acknowledgment

Patient Name(s):_____

_____

_____

Thank you very much for taking time to review how we are carefully using your health information. If you have any questions we want to hear from you. If not, we would appreciate very much your acknowledging your receipt of our policy by signing and returning this card. We look forward to seeing you again soon!

_____

Patient Signature

Date_____/_____/_____

Patient Rights

This new law is careful to describe that you have the following rights related to your health information.

Restrictions

You have the right to request restrictions on certain uses and disclosures of your health information. Our office will make every effort to honor reasonable restriction preferences from our patients.

Confidential Communications

You have the right to request that we communicate with you in a certain way. You may request that we only communicate your health information privately with no other family members present or through mailed communications that are sealed. We will make every effort to honor your reasonable requests for confidential communications.

Inspect and Copy Your Health Information

You have the right to read, review, and copy your health information, including your complete chart, x-rays and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable fee to duplicate and assemble your copy.

Amend Your Health Information

You have the right to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe your reason for the change.

Your request may be denied if the health information record in question was not created by our office, is not part of our records or if the records containing your health information are determined to be accurate and complete.

Documentation of Health Information

You have the right to ask us for a description of how and where your health information was used by our office for any reason other than for treatment, payment or health operations. Our documentation procedures will enable us to provide information on health information usage from April 14, 2003 and forward. Please let us know in writing the time period for which you are interested. Thank you for limiting your request to no more than six years at a time. We may need to charge you a reasonable fee for your request.

Request a Paper Copy of this Notice

You have the right to obtain a copy of this Notice of Privacy Practices directly from our office at any time. Stop by or give us a call and we will mail or email a copy to you.

We are required by law to maintain the privacy of your health information and to provide to you and your representative this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our Notice. If we change our privacy practices we will be sure all of our patients receive a copy of the revised Notice.

You have the right to express complaints to us or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information. Please let us know of your concerns or complaints in writing.

#FM-0304 • Printed in U.S.A.

Carl D. Werts DDS, FAGD

ACKNOWLEDGEMENT OF RECEIPT OF

NOTICE OF PRIVACY POLICIES

****You May Refuse to Sign This Acknowledgement****

I have received a copy of this office's Notice of Privacy Policy.

_____
(Please Print Name)

_____
(Signature)

_____
(Date)

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Policy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify) _____