Welcome

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please complete this form. The better we communicate, the better we can care for you.

About You

Today's Date: _____

Email Address: _____

Name: _____ I prefer to be called:_____
Last First MI Mr. Mrs. Ms. Dr.

Mailing Address:_____
Street /PO Box City State Zip

___Male ___Female Date of Birth ____/_____/_____ Age: _____ SS#_____

___Single ___Married ___Divorced ___Widowed___Separated DL#_____

Home#(____)_____ Work#(_____)_____ext_____ Cell#(_____)_____

How were you referred to our office? _____

Other family members seen by us:_____

Employer:_____ Occupation_____ How long there?____

Employer's Address:_____
Street/PO Box City State Zip

Emergency contact other than spouse:

Name _____ Relation:_____ Contact #_____

Address: _____
Street/PO Box City State Zip

Spouse Information:

His / Her Name: _____

Address (If Different): _____
Street/PO Box City State Zip

Birthdate: ___/___/___ Social Security#:_____ Drivers License#:_____

Employer:_____ Occupation_____

Home#(___)_____ Work#(____)_____Cell#(_____)_____

Email Address:_____

If Under 18 Years Of Age, Parent/Guardian Responsible For Account:

Mother's Name _____Email Address:_____

Billing Address: _____
Street/PO Box City State Zip

Birthdate: ___/___/___ Social Security#_____Driver's License #_____

Home#(____)_____ Work#(____)_____Cell#(____)_____

Father's Name: _____Email Address:_____

Billing Address: _____
Street/PO Box City State Zip

Birthdate: ___/___/___ Social Security#_____Driver's License #_____

Employer:_____ Occupation: _____

Home#(____)_____ Work#(____)_____Cell#(____)_____

Dental Insurance Information

Primary Insurance

Dental Coverage: ____Yes ___No

Insurance Company Name: _____

Insurance Company Address: _____
Street/PO Box City State Zip

Insurance Company Phone #: _____

Group Name: _____ Group # _____

Insured's Name:_____ Relation: _____

Insured's Birthdate: ___/___/___ Insured's ID# _____

Insured's Employer:_____

Employer's Address: _____

Secondary Insurance

Dental Coverage: ____Yes ___No

Insurance Company Name: _____

Insurance Company Address: _____
Street/PO Box City State Zip

Insurance Company Phone #: _____

Group Name: _____ Group # _____

Insured's Name:_____ Relation: _____

Insured's Birthdate: ___/___/___ Insured's ID# _____

Insured's Employer:_____

Employer's Address: _____

Dental History

What is the primary purpose for your visit today? _____

_____

Y N Are you currently in pain?
Y N Have you experienced problems associated with any previous dental work?
Y N Do you have fears about going to the dentist?
Y N Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)?
Y N Do your gums ever bleed?
Y N Have you ever had periodontal disease?
Y N Have you ever had gum treatment?
Y N Do you have any loose teeth?

Your current dental health is _____Good _____Fair _____ Poor

Do you have sensitivity to heat, cold, or pressure? Y / N
If so, where? _____
_____

Medical History

Do you have a primary physician? __yes __no

Physician's Name:_____ Phone #(___)_____Date of last visit:_____

Address: _____
Street/PO Box City State Zip

Your Current Physical Health is: ___Good ___Fair ___Poor

Are you currently under the care of a physician for specialized treatment ? __ yes __no

If yes, please describe: _____

_____

Please list all Prescription Medications are you currently taking?

Please list all Over-The-Counter Medications or Herbal Supplements are you taking?

Have you ever been told by a physician that you require medication (antibiotics) prior to dental treatment? Y / N Reason for medication: _____
If yes, please list physician's name, phone number and medication required:

_____

Y N Do you smoke ?
Y N Do you use smokeless tobacco?
Y N Do you have any metal rods, pins or implants?
Y N Have you ever taken Fosamax, or any other Bisphosphonate?

Women only complete the next four questions.

Y N Are you pregnant? Week# _____
Y N Is there any possibility you could be pregnant?
Y N Are you nursing?

Are you Allergic to any of the following?

Y N Aspirin	Y N Dental Anesthetics	Y N Latex	Y N Sulfa Drugs
Y N Benzodiazepines	Y N Erythromycin	Y N Penicillin	Y N Tetracycline
Y N Codeine	Y N Jewelry	Y N Other	

Please list any other medications/materials that you are allergic to: _____
_____

Do you or have you ever experienced the following?

Y N Abnormal Bleeding	Y N Fever Blisters	Y N Pacemaker
Y N Alcohol Abuse	Y N Glaucoma	Y N Persistent Cough
Y N Anemia	Y N Hay Fever	Y N Psychiatric Problems
Y N Arthritis	Y N Headaches	Y N Radiation Treatment
Y N Artificial Bone/Joints	Y N Heart Attack	Y N Rheumatic Fever
Y N Asthma	Y N Heart Murmur	Y N Scarlet Fever
Y N Blood Transfusion	Y N Heart Surgery	Y N Seizures
Y N Cancer	Y N Hemophilia	Y N Shingles
Y N Chemotherapy	Y N Hepatitis A	Y N Sickle Cell Disease
Y N Chicken Pox	Y N Hepatitis B	Y N Stroke
Y N Colitis	Y N Hepatitis C	Y N Thyroid Problems
Y N Congenital Heart Defect	Y N HIV+/Aids	Y N Tonsillitis
Y N Diabetes	Y N Hospitalized for Any Reason	Y N Tuberculosis (TB)
Y N Difficulty Breathing	Y N Kidney Problems	Y N Ulcers
Y N Drug Abuse	Y N Liver Disease	Y N Venereal Disease
Y N Emphysema	Y N Low Blood Pressure	Y N Vertigo
Y N Epilepsy	Y N Lupus	Y N Hypoglycemia
Y N Fainting Spells	Y N Mitral Valve Prolapse	Y N Herpes
Y N High Blood Pressure		

Consultation Application

Please answer the following questions completely.

1) What motivated you to schedule an appointment with Dr. Oppenheim?

2) What frustrates you most about your dental situation?

3) What would you like to see accomplished when your dental care is complete?

4) Why do you feel now is the time to address your dental concerns? When would you like to begin your care?

5) Do you have partials or dentures? How long? Do you wear them every day?

6) Have you ever had any unpleasant dental experiences? If so, please describe.

PLEASE CHECK ANY OF THE FOLLOWING THAT MAY APPLY TO YOU:

- ☐ Avoid eating in public
- ☐ Ashamed to smile
- ☐ Bad breath that won't go away
- ☐ Unattractive smile
- ☐ Teeth do not look real
- ☐ Loss of confidence
- ☐ Increased wrinkles
- ☐ Feel older than you are
- ☐ Inconvenience
- ☐ Difficulty in sleeping
- ☐ Difficulty chewing
- ☐ Difficulty swallowing
- ☐ Food limitations
- ☐ Decreased taste of food
- ☐ Pain on chewing
- ☐ Teeth are uncomfortable
- ☐ Difficulty speaking
- ☐ Headaches
- ☐ Dizziness or ringing in the ears
- ☐ Previous traumatic dental experiences
- ☐ Loss of self esteem
- ☐ Denture/partial looks phony/fake
- ☐ Withdrawal from social interactions
- ☐ Depressed/insecure about loss of teeth
- ☐ Burning sensations
- ☐ Loss of support for the face
- ☐ Shrinking gums
- ☐ Teeth/jaw grinding
- ☐ Nutritional/Digestive disorders
- ☐ Jaw is sore
- ☐ A need to feel whole again
- ☐ Chew better without your partial/dentures
- ☐ Dentures/partials are painful
- ☐ Food trapped between/under teeth

PLEASE RANK EACH OF THE FOLLOWING TO THE LEVEL OF INFLUENCE EACH MAY HAVE REGARDING THE COMPLETION OF YOUR DENTAL TREATMENT.

1= will not keep me from getting my dental treatment
5 = will very likely keep me from getting my dental treatment

The **COST** of dental treatment	1	2	3	4	5
My **FEAR** of the dentist	1	2	3	4	5
My lack of **TIME**	1	2	3	4	5
My **EXPECTATIONS** are unrealistic	1	2	3	4	5

FINANCIAL POLICY

PAYMENT OPTIONS

I understand that payment is due in full at the time of treatment and that I am responsible for all cost of dental treatment.

We desire to make dental treatment affordable to all of our patients and make every effort to fit your care within your budget and schedule. Therefore we offer the following financial options for treatment over $1,000:

1. **5% Cash Discount** – offered for payment IN FULL with check or cash at the start of treatment.

2. **Other** – for patients requiring extensive treatment, payment options including exterior financing (dental line of credit) is available through CareCredit or Lending Club. Please refer to CareCredit or Lending Club brochure for further information.

FOR OUR PATIENTS WITH DENTAL INSURANCE:

Because we understand that dental insurance plays a role in helping defray some of the costs of dental care, we would like to share with you the following facts about dental insurance.

Dental insurance is not meant to be a pay-all*…it is meant only to assist in paying for your dental care. Dental insurance plans have no correlation to actual patient needs. As such, many routine and necessary dental services are not covered, even though you may need those services. Our responsibility is to provide you with the best treatment to meet your needs, not to try to match your care to insurance plan limitation.*

The benefits your plan pays are largely determined by how much your employer or union pays in premiums for the plan. We are happy to submit your claims and help you to receive the maximum benefits due you, but please understand that **we cannot accept responsibility for collecting an insurance claim, or for negotiating disputed claims.**

I hereby assign to the dentist all payment for dental services rendered. I have read and understand the above financial policy. Insurance will be filed as a courtesy; therefore I am responsible for payment of any restorative dental fees for myself and/or my dependents at the time of service and reimbursement of any dental benefits will be mailed to the subscriber. There is no guarantee of refund based on treatment outcome.

I authorize Dr. Thomas E. Oppenheim to furnish information to insurance carriers concerning treatment for myself or my dependents.

Signature_____ **Date**_____

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 protected health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 01/01/09, 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 applicable law permits such changes. 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, provide the new Notice at our practice location, distribute to all patients by direct mail, and distribute it 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.

Your Authorization: In addition to our use of your health information for the following purposes, 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.

Uses and Disclosures of Health Information

We use and disclose health information about you without authorization for the following purposes.

Treatment: We may use or disclose your health information for your treatment. For example, we may 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. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. For example, 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.

To You Or Your Personal Representative: 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 your personal representative, 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 absence or incapacity or in 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.

Public Health and Public Benefit: We may use or disclose your health information to report abuse, neglect, or domestic violence; to report disease, injury, and vital statistics; to report certain information to the Food and Drug Administration (FDA); to alert someone who may be at risk of contracting or spreading a disease; for health oversight activities; for certain judicial and administrative proceedings; for certain law enforcement purposes; to avert a serious threat to health or safety; and to comply with workers' compensation or similar programs.

Decedents: We may disclose health information about a decedent as authorized or required by law.

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 the 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, letters, e-mail or text message).

Access: You may obtain a copy of radiographs taken with-in the last year with a signed written request provided by this practice.
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. In most cases we are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in certain circumstances where disclosure is required or permitted, such as an emergency, for public health activities, or when disclosure is required by law). We must comply with a request to restrict the disclosure of protected health information to a health plan for purposes of carrying out payment or health care operations (as defined by HIPAA) if the protected health information pertains solely to a health care item or service for which we have been paid out of pocket in full.
Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request.

Electronic Notice: You may receive a paper copy of this notice upon request, even if you have agreed to receive this notice electronically on our Web site or by electronic mail (e-mail).

Questions and Complaints If you want more information about our privacy practices or have questions or concerns, please contact us.

Acknowledgement of Receipt of Notice of Privacy Practices

* You May Refuse to Sign This Acknowledgment*

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

Print

Name_____

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
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)