THOMAS FRANK, DDS
Dentistry for Total Body Wellness

Patient Acquaintance Form

The benefits of a healthy, beautiful smile are immeasurable. The information on these forms is confidential and will enable us to provide you with the best care possible.

Name_____ Birth Date _____
First M Last

*How do you prefer to be addressed?*_____SS# _____

Address_____City _____ Zip _____

Email: _____

Home#: _____ Cell#: _____ Work#: _____

How do you prefer to be contacted? ❑ All listed ❑ Home ❑ Cell ❑ Text ❑ Email

Your Occupation_____Employer _____

Business Address_____City _____ Zip _____

Spouse Name _____ Occupation_____ Phone _____

Other than your spouse, a person to contact in case of emergency _____

Relation to patient_____Phone#: _____ Alt#: _____

How did you hear about our practice?

❑ Our website ❑ Social Media ❑ Print Media ❑ Personal Referral

Personal Referral: If so, who can we thank for inviting you to our practice? _____

FOR OUR PATIENTS WITH DENTAL INSURANCE

Name of subscriber_____ Birth Date _____SS# _____

Insurance Co._____Group# _____

Name of employer_____Relationship to Patient _____

Are you covered by another insurance plan?

Name of subscriber_____ Birth Date _____SS# _____

Insurance Co._____Group# _____

Name of employer_____Relationship to Patient _____

I hereby authorize the Dental Office to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for the proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payers and/or other health professionals by any method, including electronic transfer. I understand I am financially responsible for all treatment rendered, regardless of insurance involvement.

_____

Signature of patient or responsible party Date State / Drivers Lic #

THOMAS FRANK, DDS

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Dental History

Patient Name: _____ Age today: _____

Previous Dentist: _____ How long had you been a patient _____

Date of most recent dental exam: _____ Date of most recent treatment (other than a cleaning): _____

I routinely see my dentist every: O 3mo O 4mo O 6 mo O 12mo O Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES or NO TO THE FOLLOWING: **YES** **NO**

PERSONAL HISTORY | O | O | O |

1. Are you fearful of dental treatment? How fearful on a scale of 1 (least) to 10 (most)? ( ) _____ O O
2. Have you had an unfavorable dental experience? _____ O O
3. Have you ever had complications from past dental treatment? _____ O O
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? _____ O O
5. Did you have braces, orthodontic treatment or had your bite adjusted? _____ O O
6. Have you had any teeth removed? _____ O O

GUM & BONE | O | O | O |

7. Do your gums bleed or is it painful when brushing or flossing? _____ O O
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____ O O
9. Have you ever noticed an unpleasant taste or odor in your mouth? _____ O O
10. Is there anyone with a history of periodontal disease in your family? _____ O O
11. Have you ever experienced gum recession? _____ O O
12. Have you ever had any teeth become loose on their own (without injury) or do you have difficulty eating an apple? __ O O
13. Have you experienced a burning sensation in your mouth? _____ O O

TOOTH STRUCTURE | O | O | O |

14. Have you had any cavities within the past 3 years? _____ O O
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing food? _____ O O
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? _____ O O
17. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? _____ O O
18. Do you have grooves or notches on your teeth near the gum line? _____ O O
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? _____ O O
20. Do you frequently get food caught between any teeth? _____ O O

BITE & JAW JOINT | O | O | O |

21. Do you have problems with your jaw joint (pain, sounds, limited opening, locking, popping)? _____ O O
22. Do you feel like your lower jaw is being pushed back when you bite your teeth together? _____ O O
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels or any other hard, dry foods? _____ O O
24. Have your teeth changed in the last 5 years, become shorter, thinner or worn? _____ O O
25. Are your teeth crowding or developing spaces? _____ O O
26. Do you have more than one bite and squeeze to make your teeth fit together? _____ O O
27. Do you chew ice, bite your nails, use your teeth to hold objects or have any other oral habits? _____ O O
28 Do you clench your teeth in the daytime or make them sore? _____ O O
29. Do you have problems with sleep or wake up with an awareness of your teeth? _____ O O
30. Do you wear or have you ever worn a bite appliance? _____ O O

SMILE CHARACTERISTICS | O | O | O |

31. Is there anything about the appearance of your teeth that you would like to change? _____ O O
32. Have you ever whitened (bleached) your teeth? _____ O O
33. Have you ever felt uncomfortable or self-conscious about the appearance of your teeth? _____ O O
34. Have you been disappointed with the appearance of previous dental work? _____ O O
35. ***Please indicate on a scale of 1 (least) to 10 (most) your highest answer?*** How important is your dental health to you? ( )
    How would you rate your current dental health? ( ) What would you like your dental health to be? ( )
    How clearly has the connection between your dental health and overall health been explained ( )
    What, if anything, has kept you from reaching optimal dental health? ( )Fear ( )Finances ( )Time ( )Value ( )Insurance Driven
    Is there anything else you would like us to know about your dental history? If yes. please explain: _____

_____

Patient's Signature _____ Date: _____

Doctor's Signature _____ Date: _____

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Medical History

Patient Name: _____ Age today: _____
Name of physician and their specialty: _____
Most recent physical exam: _____ Purpose: _____
What is your estimate of your general health? O Excellent O Good O Fair O Poor

DO YOU HAVE OR HAVE YOU EVER HAD:	YES	NO
1. Hospitalization for illness or injury _____	O	O
2. An allergic reaction to		
O aspirin, ibuprofen, acetaminophen, codeine		
O penicillin		
O erythromycin		
O tetracycline		
O sulfa		
O local anesthetic		
O fluoride		
O metals (nickel, gold, silver,_____)		
O latex		
O other		
3. Heart problems or cardiac stent within the last 6 months _____	O	O
4. Artificial heart valve or repaired heart defect (PFO) _	O	O
5. Pacemaker if implantable defibrillator _____	O	O
6. Artificial Joints _____	O	O
7. High or low blood pressure _____	O	O
8. A stroke (taking blood thinners) _____	O	O
9. Anemia or other blood disorder _____	O	O
10. Prolonged bleeding due to slight cut (INR> 3.5)	O	O
11. Emphysema, shortness of breath (COPD) ____	O	O
12. Tuberculosis, measles, chicken pox _____	O	O
13. Asthma _____	O	O
14. Breathing or sleep problems (i.e. sleep apnea, snoring, sinus) _____	O	O
15. Kidney disease _____	O	O
16. Liver disease _____	O	O
17. Jaundice _____	O	O
18. Thyroid, parathyroid disease or calcium deficiency	O	O
19. Hormone deficiency _____	O	O
20. High cholesterol or taking statin drugs _____	O	O
21. Diabetes (HbA1c= __). _____	O	O
22. Stomach or duodenal ulcer _____	O	O

	YES	NO
23. Digestive disorders (i.e. celiac disease, gastric reflux)	O	O
24. Osteoporosis/osteopenia (i.e. taking bisphosphonates)	O	O
25. Arthritis, rheumatoid arthritis, Lupus _____	O	O
26. Glaucoma _____	O	O
27. Contact lenses _____	O	O
28. Head or neck injuries _____	O	O
29. Epilepsy, convulsions (seizures) _____	O	O
30. Neurologic disorders (ASS/ ADHD, prion disease)	O	O
31. Viral infections or cold sores _____	O	O
32. Any lumps or swelling in mouth _____	O	O
33. Hives, skin rash, hay fever _____	O	O
34. Hepatitis (type _____) _____	O	O
35. HIV/AIDS _____	O	O
36. Tumor, abnormal growth _____	O	O
37. Radiation therapy _____	O	O
38. Chemotherapy, immunosuppressive _____	O	O
39. Emotional problems _____	O	O
40. Psychiatric treatment _____	O	O
41. Antidepressant medication _____	O	O
42. Alcohol/street drug use _____	O	O
ARE YOU:		
43. Presently being treated for any other illness ___	O	O
44. Aware of a change in your health in the last 24 hours (i.e. fever, chills, new cough or diarrhea) _____	O	O
45. Taking medication for weight management (i.e. fen-phen)	O	O
46. Taking dietary supplements _____	O	O
47. Often exhausted or fatigued _____	O	O
48. Experiencing frequent headaches _____	O	O
49. A smoker, smoked previously or use smokeless tobacco	O	O
50. Considered an anxious person _____	O	O
51. Often unhappy or depressed _____	O	O
52. **FEMALE:** Taking birth control pills _____	O	O
53. **FEMALE:** Pregnant _____	O	O

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment _____

List all current medications and/or supplements you are taking and for what purpose. Having this list is critical to assist us in proper diagnosis and treatment. *Please advise us, in the future, if there are any changes in your medical history or medications*

Drug	Purpose	Drug	Purpose

Patient's Signature _____ Date: _____
Doctor's Signature _____ Date: _____

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Notice of Privacy Practices Acknowledgement

I understand that, under Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received the *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a copy of the *Notice of Privacy Practices.*

_____ I authorize that I give my permission to Dr. Frank and his representatives to speak with
Initials
_____ regarding treatment, medical and account information.

I understand that I may request in writing that you restrict how my information is used or disclosed to carry out treatment, payment and health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: ❑ Self ❑ Other: _____
(Please specify relationship to patient)

Signature: _____ Date: _____

For Office Use Only

I attempted to obtain the patient's signature in acknowledgement to the *Notice of Privacy Practices acknowledgement*, but was unable to do so as documented below :

_____

Initials Date Reason

_____

THOMAS FRANK, DDS
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Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you haveregarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; examining your teeth; prescribing medications and faxing them to be filled; referring you to another doctor or clinic for other health care or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we usually will not ask you for special written permission.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires use to use or disclose your health information without your permision.Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- When a state or federal law mandates that certain health information be reported for a specific purpose;
- For public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
- Disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence; investigation of possible violations of health care laws;
- Disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- Disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
- Disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- Uses or disclosures for health related research;
- Uses and disclosures to prevent a serious threat to health or safety;
- Uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health or members of the foreign service;
- Disclosures of de-identified information;
- Disclosures relating to worker's compensation programs;
- Disclosures of a "limited data set" for research, public health, or health care operations;
- Incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- Disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information;

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your dental care.

APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post care, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of you health information unless you sing a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this Notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

- Ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address, fax or email shown at the beginning of this Notice.
- Ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using email to your personal email address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax, or email shown at the beginning of this Notice.
- Ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30 day extension of the time for us to give you access or photocopies of your health information, send a written request to the office contact person at the address, fax, or email shown at the beginning of this Notice.
- Ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or rebuttal is included in your health information, we will send it along
whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax, or email shown at the beginning of this Notice.
- Get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include disclosures for purposes of treatment, payment or health care operations; disclosures with your authorizations; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address, fax, or email shown at the beginning of this Notice.
- Get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies send a written request to the office contact person at the address, fax, or email shown at the beginning of this Notice.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our Web site.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax, or email shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office at the address of phone number shown at the beginning of this Notice.