

Confidential Patient Information

Date: ____/____/____

A. Patient Name _____ Birth Date _____ Age _____
 Address _____ Cell # _____ Phone# _____
 City _____ Zip _____
 Soc Sec. No _____ Driver's License No. _____
 Employed By _____ Occupation _____ How Long _____
 Business Address _____ Phone () _____

B. Responsible Party or Spouse _____ DOB: _____ Phone () _____
 Address _____
 Soc Sec. No _____ Driver's License No. _____
 Employed By _____ Occupation _____ How Long _____
 Business Address _____ Phone () _____
 Relationship to patient _____ Bill to address A _____ B _____
 In Full-Time Student - School: _____ City : _____ # of Units: _____
 Insurance Name _____ Group No. / Name of Plan _____
 Whom may we thank for referring you? _____
 Whom may we contact in case of Emergency? Name: _____ Tel. # () _____

Please answer each of the following questions by Placing an "X" under either "Yes" or "NO."

	Yes	No
1. Are you in good health? Date of last medical exam ____/____/____.	1. _____	_____
2. Reason for Today's Visit: _____ Date of last Dental Visit _____ Date of last x-rays taken: _____		
3. Are you currently under a physicians care? If yes, Physicians Name _____ Phone No. () _____	3. _____	_____
4. Have you ever had any major surgery, illness, or been hospitalized?	4. _____	_____
5. (For women only) Are you pregnant?	5. _____	_____
6. Are you taking any medications or drugs of any kind?	6. _____	_____
7. Are you sensitive or allergic to: Penicillin ____; Tetracycline ____; Sulfa Drugs ____; Aspirin ____; Codeine ____; Latex ____; Other ____? (explain) _____	7. _____	_____
8. Have you ever had any complications with previous dental or oral surgery treatment?	8. _____	_____
9. Do you have high () or low () blood pressure?	9. _____	_____
10. Do you bleed easily or have anemia or hemophilia?	10. _____	_____
11. Have you ever had an artificial joint, heart pacemaker, or rheumatic fever, mitral valve prolapse?	11. _____	_____
12. Do you have a heart murmur or heart problems or valvular replacements?	12. _____	_____
13. Have you tested positive for AIDS?	13. _____	_____
14. Have you had, or are you now being treated for venereal disease? e.g. syphilis or gonorrhea?	14. _____	_____
15. Have you ever had sinus trouble, asthma, bronchitis, TB, emphysema, or other lung disease?	15. _____	_____
16. Have you ever had hepatitis, jaundice or other liver disease?	16. _____	_____
17. Have you ever had thyroid, kidney or diabetic problems?	17. _____	_____
18. Are you currently taking or have you ever taken any type of weight loss medication like Pondimin, Redux, or Phen-Fen?	18. _____	_____
19. Have you even been treated for mental or nervous disorders? e.g. epilepsy, psychiatric treatment?	19. _____	_____
20. Please explain any "Yes" responses and list any conditions not covered above that your Dentist should know about: _____ _____ _____		

Patient Signature (or Parent, if a minor): _____ **Date:** ____/____/____

Doctor's Signature: _____ **Date:** ____/____/____

Year 2: ____/____/____ **Changes in Health? Yes** ____ **No** ____ **Year 3:** ____/____/____ **Changes in Health? Yes** ____ **No** ____

Pat. Sig.: _____ **Pat. Sig.:** _____

Dr. Sig.: _____, ____/____/____ **Dr. Sig.:** _____, ____/____/____

Dr. Gregory Robins Notice of Privacy Practices

This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully.

At Dr. Robins' office we have always kept your health information secure and confidential. A new law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice.

The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by a specialist doctor whom we may involve in your care.

We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company.

We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer.

We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy.

We may use your information to contact you. For example, we may send newsletters or other information. We may also want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone.

In an emergency, we may disclose your health information to a family member or another person responsible for your care.

We may release some or all of your health information when required by law. If this practice is sold, your information will become the property of the new owner. Except as described above, this practice will not use or disclose your health information without your prior written authorization.

You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.

You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.

As we will need to contact you from time to time, we will use whatever address or telephone number you prefer.

You have the right to transfer copies of your health information to another practice. We will mail your files for you.

You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you also want a copy of your records, we may charge you a reasonable fee for the copies.

You have the right to request an amendment or change to your health information. Give us your request to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but we will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add new information.

You have the right to receive a copy of this notice.

If we change any of the details of this notice, we will notify you of the changes in writing.

You may file a complaint with the Department of Health and Human Services, 200 Independence Avenue, S.W. Room 509F, Washington, DC 20201. You will not be retaliated against for filing a complaint.

However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our Privacy Officer, Diane Ward, at (626) 919-7707

This notice goes into effect as of April 14, 2003.

Acknowledgement

I have received a copy of the Dr. Robins' Notice of Privacy Practices.

Date _____

Signed _____

Print Name _____

If signing as a parent or guardian, please note the name of the patient
