Waukee Dental
Kaisha Brown, DDS

350 East Hickman Road
Waukee, Iowa 50263

Patient Information Forms

Last Name: _____ First Name: _____

Preferred Name: _____ Sex: ☐ Male ☐ Female

Date of Birth: _____ Social Security Number: _____ Marital Status: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Cell Phone: _____ Home Phone: _____

Email Address: _____

How do you prefer your appointment reminders?

☐ Phone Call ☐ Text Message ☐ Email

How did you hear about us? _____

If referral, whom may we thank for referring you? _____

Emergency Contact

In case of an emergency who should be notified? _____

Relationship: _____ Phone Number: _____

Preferred Pharmacy

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____

Responsible Party

☐ Please check if you are the responsible party

Name: _____ Relationship: _____

Social Security Number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Cell Phone: _____ Home Phone: _____

Email Address: _____

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Dental Insurance Information

Primary Dental Insurance

Subscriber (Policy holder) Name: _____ Relationship: _____

Policy holder's Employer: _____

Date of birth: _____ Social Security Number: _____

Primary insurance carrier name: _____

Group plan name: _____ Group number: _____

Member ID number: _____

Secondary Dental Insurance

Subscriber (Policy holder) Name: _____ Relationship: _____

Policy holder's Employer: _____

Date of birth: _____ Social Security Number: _____

Primary insurance carrier name: _____

Group plan name: _____ Group number: _____

Member ID number: _____

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage as stated above and assign directly to Dr. Kaisha J. Brown D.D.S., doing business as Waukee Dental P.C., all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Waukee Dental may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Signature: _____ Date: _____

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Health History Information

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Patient Name: _____ Date of Birth: _____ Today's Date: _____

Dental History

Reason for today's visit: _____

Do you have regular dental checkups? ☐ Yes ☐ No

Date of last examination: _____ Date of last dental x-rays? _____

Former Dental Office: _____

Have you had any trouble associated with previous dental treatment? Yes No

If so, please explain: _____

Have you noticed any lumps or sores in your mouth? ☐ Yes ☐ No

Do your gums bleed when you brush your teeth? ☐ Yes ☐ No

Have you ever injured your face, jaws, or teeth? ☐ Yes ☐ No

If so, please explain: _____

Do you suffer from pain in the mouth, face, eyes, neck or throat? ☐ Yes ☐ No

Are you happy with the appearance of your teeth? ☐ Yes ☐ No

If not, please explain: _____

Has fear ever prevented you from seeking dental treatment? ☐ Yes ☐ No

Please mark (x) the types of dental treatment you have received?

☐ Orthodontics (braces) ☐ Dentures ☐ Root canal treatments ☐ Fillings
☐ Implants ☐ Oral Surgery ☐ Periodontal (gum) treatments

Physician List

Please list your family physician and any medical specialist you see at least once per year:

_____

_____

_____

_____

Medical History

Are you under a physician's care now?	☐ Yes ☐ No	If yes, _____
Have you ever been hospitalized or had a major operation?	☐ Yes ☐ No	If yes, _____
Have you ever had a serious head or neck injury?	☐ Yes ☐ No	If yes, _____
Are you taking any medications, pills or drugs?	☐ Yes ☐ No	If yes, _____
Do you take or have you taken, Phen-Fen or Redux?	☐ Yes ☐ No	If yes, _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	☐ Yes ☐ No	If yes, _____
Do you use tobacco products?	☐ Yes ☐ No	
If so, are you interested in stopping your tobacco use?	☐ Yes ☐ No	
Do you use controlled substances?	☐ Yes ☐ No	If yes, _____
Do you bleed excessively upon injury?	☐ Yes ☐ No	If yes, _____
Has a doctor ever told you that you have a heart problem?	☐ Yes ☐ No	If yes, _____
Do you ever have difficulty breathing?	☐ Yes ☐ No	If yes, _____

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Medical History Continued

- ☐ AIDS/HIV Positive
- ☐ Alzheimer's Disease
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Angina/Chest Pains
- ☐ Arthritis/Gout
- ☐ Artificial Heart Valve
- ☐ Artificial Joint
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Cold Sores/Fever Blisters
- ☐ Congenital Heart Disorder
- ☐ Convulsions
- ☐ Cortisone Medicine
- ☐ Diabetes
- ☐ Epilepsy/Seizures
- ☐ Excessive Bleeding
- ☐ Excessive Thirst
- ☐ Fainting Spells/Dizziness
- ☐ Frequent Headaches
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Heart Attack/Failure
- ☐ Heart Murmur
- ☐ Heart Pacemaker
- ☐ Hemophilia
- ☐ Hepatitis A
- ☐ Hepatitis B or C
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hives or Rash
- ☐ Hypoglycemia
- ☐ Irregular Heart Beat
- ☐ Kidney Problems
- ☐ Leukemia
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Osteoporosis
- ☐ Pain in Joints
- ☐ Parathyroid Disease
- ☐ Psychiatric Disease
- ☐ Rheumatic Fever
- ☐ Sickle Cell Disease
- ☐ Sinus Trouble
- ☐ Stomach/Intestinal Disease
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumors or Growths
- ☐ Radiation Therapy
- ☐ Ulcers

Have you ever had any serious illness not listed above? If so, please explain: _____
_____
_____

Allergies

Please mark (x) all that apply:

☐ Acrylic ☐ Aspirin ☐ Codeine ☐ Latex ☐ Local Anesthetics ☐ Metal ☐ Penicillin ☐ Sulfa Drugs
☐ Other _____

Medications

Please list all prescription and over-the-counter medications you are currently taking:

_____
_____
_____
_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian: _____

Date_____

Phone: (515) 777 – 7568
Fax: (515) 777 – 7569

waukeedental@securepracticemail.com
www.waukee.dental

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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 required to give you this Notice about our policy 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. This Notice takes effect September 15, 2017 and remains 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 such changes are permitted applicable law. 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 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 operations. For example:

Treatment: We may use or 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.

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 qualification of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

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 disclosure permitted by your authorization while it is in effect. Unless you give us a written authorization, we cannot use or disclose your information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose 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.

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 incapacity or emergency circumstances, we will disclose health information based on determination using our professional judgement disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgement 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.

Abuse or Neglect: We may disclose your 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 or the health or 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 institution or law enforcement official having lawful custody of protected health information of 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, or letters).

Please flip over.

Phone: (515) 777 – 7568
Fax: (515) 777 – 7569

waukeedental@securepracticemail.com
www.waukee.dental

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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 practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form requesting access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expense 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 prefer, we will prepare a summary or 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 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. 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 Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

Questions and Complaints – If you want more information about our privacy practices or have 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 use communicate with your by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice 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: Kaisha Brown DDS
Telephone: 515-777-7568 Fax: 515-777-7569
E-mail: waukeedental@securepracticemail.com
Address: 350 East Hickman Road
Waukee, Iowa 50263

I received notice of and acknowledge these privacy practices as they relate to my protected healthcare information and treatment.

Signature

Date

☐ Self
☐ Parent/guardian
☐ Power of attorney

_____
Printed Name