Masters *of* Dentistry

Tad Hodgert, DMD
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Bend, Oregon 97701
(541) 389-2300 Fax (541) 389-2301
www.mastersofdentistry.net

Name: _____ Birth Date: _____
Address:_____
_____
E-Mail:_____
Phone: _____ Work: _____ Cell:_____
Emergency Contact: _____
Who may we thank for referring you? _____
Allergies: _____
Sensitivities: _____
Concerns about materials: _____
Date of last physical: _____
Physician name and phone number: _____
What should we know about you medically? _____
_____
What special needs do you have? _____
_____
Date of last dental exam: _____
Previous dentist: _____
Was all treatment completed: _____
May we request your dental history and films? _____

Do you have or have you had any of the following?

- ❑ Heart trouble, attack, etc.
- ❑ High or low blood pressure
- ❑ Sleep Apnea
- ❑ Rheumatic fever
- ❑ Asthma
- ❑ Sinusitis
- ❑ Hay fever
- ❑ Bleeding disorders
- ❑ Blood transfusions
- ❑ Other _____
- ❑ Glaucoma
- ❑ Ulcers/Stomach problems/GERD
- ❑ Kidney/Bladder/ Urinary problems
- ❑ Epilepsy/ Convulsions
- ❑ Dizziness
- ❑ Tuberculosis
- ❑ Hepatitis/Jaundice/ Liver problems
- ❑ AIDS/HIV/ARC
- ❑ Contact lenses
- ❑ Headaches
- ❑ Neckaches/ Backaches
- ❑ TMJ/TMD/MFD/ Jaw joint pain/noise
- ❑ Pyorrhea/Gingivitis/ Periodontitis/Gum disease
- ❑ Bleeding gums

Do you smoke or chew tobacco? ☐ Yes ☐ No How much? _____
Weekly alcohol consumption? ☐ Yes ☐ No How much? _____
Do you premedicate for dental treatment? ☐ Yes ☐ No
Are you pregnant? ☐ Yes ☐ No Due Date:_____
Do you take birth control pills ☐ Yes ☐ No

Other conditions now being treated and by whom: _____
_____
List all drugs you currently or frequently take: _____
_____

Release: I accept responsibility for asking questions about anything I don't understand. Because each patient is unique, and due to new technologies, etc some treatment choices will vary from usual and customary for Deschutes County. I hereby grant authority to Masters of Dentistry to perform all phases of dentistry deemed appropriate in diagnosis and treatment. I acknowledge I have been informed of true risks and possible consequences of procedures, and that I may request further information. I authorize Masters of Dentistry to proceed.

I will be responsible for ALL fees. I hereby authorize the release of any information to my insurance company.

Patient or Guardian's Signature: _____Date: _____

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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. THESE PRACTICES ARE FOLLOWED BY OUR EMPLOYEES, STAFF, AND OTHER OFFICE PERSONNEL. PLEASE REVIEW IT CAREFULLY.

YOUR HEALTH INFORMATION

Your health information includes information created and received by this office. It may be in written or spoken words, and may include information about your health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions and related billing activity.

We are required by law to give you this notice. It will tell you about your rights and our obligations regarding the use and disclosure of that information.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose health information for the following purposes:

• FOR TREATMENT We may use health information about you to provide you with dental treatment or services. We may disclose health information about you to doctors, technicians, opticians, office staff or other personnel who are involved in taking care of you. Different personnel in our office may share information about you and disclose information to people who do not work our office in order to coordinate your care

.• FOR PAYMENT We may use and disclose health information about you so that the treatment and services you receive at this office may be billed and payment may be collected from you, an insurance company or third party.

• APPOINTMENT REMINDERS We may contact you as a reminder that you have an appointment scheduled at our office or are due to set up an appointment. This may be done either by telephone, mail or email. If we reach a voice message machine we may opt to leave a message reminding you of your appointment, unless otherwise requested not to in advance.

• SPECIAL SITUATIONS We will disclose health information about you when required to do so by federal, state, or local law. We may release information about you for work compensation claims, in response to a court or administrative order, or to health oversight agency for adults, investigations, inspections, or licensing purposes. We may also disclose health information about you to your family members or friends if we receive your verbal agreement to do so.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the following rights regarding health information we maintain about you:

• RIGHT TO INSPECT AND COPY You have the right to inspect and copy your health information, such as medical and billing records, that we keep and use to make decisions about your care.

• RIGHT TO AMEND If you believe health information we have about you is incorrect or incomplete; you may ask us to amend the information.

• RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS AND RESTRICTIONS You have the right to request that we communicate with you about dental matters in a certain way or at a certain location. For example, you can ask that we only contact you at a certain location. For example, you can ask that we only contact you at work or by mail. You also have the right to request a restriction of limitation on the health information we use or disclose about you for treatment, payment or health care operations.

CHANGE TO THIS NOTICE We reserve the right to change this notice, and to make the revised or changed notice apply to medical information we already have about you as well as any information we receive in the future. We will post the current notice in our office and you are entitled to copy of the notice currently in effect.

Signature: _____ Date: _____