**Masters of Dentistry**
**628 NW York Drive**
**Suite 101**
**Bend, OR 97701**
**541-389-2300**

**Patient Information** **Date: _____**

Name: _____ Birth Date: _____
Address: _____ Zip Code: _____
E-Mail:_____
Home Phone: _____ Work Phone: _____
Cell Phone: _____ Emergency Contact: _____

Who may we thank for referring you? _____

How can we help you? _____
Your main dental concerns and goals? _____
_____

List any serious operations and illnesses: _____
_____
List any 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? _____
_____
Please review dental history: _____
_____
What have you been told about your mouth? _____
_____
Date of last dental exam: _____
Was all treatment completed: _____
May we request your dental history and films? _____
Previous dentist: _____
Are your teeth always comfortable? _____
Do your teeth chew and function as well as you like? _____
Do your teeth look like you'd like? _____
How would you like them different? _____
_____

| **Have you had or have been tested for:** | **No:** | **Yes:** | **Date:** | **Comments:** |
|---|---|---|---|---|
| Heart trouble, attack, etc. | ___ | | | |
| High or low blood pressure | ___ | | | |
| Sleep Apnea | ___ | | | |
| Rheumatic fever | ___ | | | |
| Do you pre-medicate for dental treatment? | ___ | | | |
| Asthma, Sinusitis, Hay fever | ___ | | | |
| Birth control pills | ___ | | | |
| Bleeding disorders | ___ | | | |
| Blood transfusions | ___ | | | |
| Glaucoma | ___ | | | |
| Ulcers/Stomach problems/GERD | | | | |
| Kidney/Bladder/Urinary problems | ___ | | | |
| Epilepsy/Dizziness/Convulsions | ___ | | | |
| Tuberculosis | ___ | | | |
| Hepatitis/Jaundice/Liver problems | ___ | | | |
| AIDS/HIV/ARC | ___ | | | |
| Contact lenses | ___ | | | |
| Headaches/Neck aches/Backaches | ___ | | | |
| TMJ/TMD/MFD/Jaw joint pain/noise | ___ | | | |
| Pyorrhea/Gingivitis/Periodontitis/Gum disease | ___ | | | |
| Bleeding gums | ___ | | | |
| Pregnant? Due Date: | ___ | | | |
| Smoke or chew tobacco? How much? | ___ | | | |
| Weekly alcohol consumption | ___ | | | |

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 PRACTICS

**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 OUT EMPLOYEES, STAFF, AND OTHER OFFICE PERSONAL.**

**PLEASE REVIEW IT CAREFULLY**

## YOUR HEALTH INFORMATIION

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, diagnosis, 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 personal 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 veral agreement to do so.

YOUR RIGHTS REGARING 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 RETRICTIONS 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: _____