Welcome to Mercy Dental, ***Feel free to ask questions about your care and treatment options.***

Patients Name:_____Date of Birth :___/___/____ Age: ____

Gender:_____ Driver's License: _____ State: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home: (____) _____ Cell: (____) _____

☐ It is ok to leave a voice mail. ☐ It is ok to leave a voice mail.

E-mail: _____

Mailing Address (if different) : _____

City: _____ State: _____ Zip: _____

Employer / Occupation: _____ Bus. Phone: (____)_____

Spouse's name & phone # _____, (____)_____

☐ It is ok to leave detailed messages with my spouse.

Emergency contact other than spouse: _____, (____)_____

Name of your medical doctor: _____ Date of last visit: _____

Name of prior dentist: _____ Date of last dental visit: _____

Who told you about us?: _____

DENTAL HEALTH HISTORY

	YES	NO
Are you apprehensive about dental treatment?	[ ]	[ ]
Have you had problems with previous dental treatment?	[ ]	[ ]
Do you gag easily?	[ ]	[ ]
Does food catch between your teeth?	[ ]	[ ]
Do you have difficulty in chewing your food?	[ ]	[ ]
Do you chew on only one side of your mouth due to pain?	[ ]	[ ]
Do your gums bleed easily?	[ ]	[ ]
Do your gums bleed when you floss?	[ ]	[ ]
Do your gums feel swollen or tender?	[ ]	[ ]
Have you ever noticed slow-healing sores in or about your mouth?	[ ]	[ ]
Do you take fluoride supplements?	[ ]	[ ]
Are you dissatisfied with the appearance of your teeth?	[ ]	[ ]

	YES	NO
Do you prefer to save your teeth?	[ ]	[ ]
Do you want complete dental care?	[ ]	[ ]
How often do you brush?		
How often do you floss?		
Are your teeth sensitive?	[ ]	[ ]
Do you feel twinges of pain when your teeth come in contact with:		
Hot foods or liquids?	[ ]	[ ]
Cold foods or liquids?	[ ]	[ ]
Sours?	[ ]	[ ]
Sweets?	[ ]	[ ]
Do you have any jaw joint problems? Explain	[ ]	[ ]

MEDICAL HISTORY

	YES	NO
Diabetes	[ ]	[ ]
Tuberculosis or other respiratory disease (COPD,	[ ]	[ ]
Hepatitis, jaundice, or liver trouble	[ ]	[ ]
Herpes or other STD	[ ]	[ ]
HIV-positive/AIDS	[ ]	[ ]
Glaucoma	[ ]	[ ]
Allergy Problems? Explain:	[ ]	[ ]
Intestinal Problems: Explain:	[ ]	[ ]
Bone or Joint Problems: Explain	[ ]	[ ]
Joint replacement (for example: total hip, pins, or implants)	[ ]	[ ]
Premedication required by physician	[ ]	[ ]
Cancer/Tumor	[ ]	[ ]

Are you allergic, or have you reacted adversely, to any of the following?	YES	NO
Local anesthetics ("Novocain")	[ ]	[ ]
Penicillin or other antibiotics	[ ]	[ ]
Barbiturates, sedatives, or sleeping pills	[ ]	[ ]
Aspirin, acetaminophen, or Ibuprofen	[ ]	[ ]
Codeine, Demerol, or other narcotics	[ ]	[ ]
Reaction to metals	[ ]	[ ]
Latex or rubber	[ ]	[ ]

Other:

Notes:

	YES	NO
Heart Problems	[ ]	[ ]
Chest pain	[ ]	[ ]
Shortness of breath	[ ]	[ ]
Blood pressure problem	[ ]	[ ]
Heart murmur	[ ]	[ ]
Heart valve problem	[ ]	[ ]
Taking heart medication	[ ]	[ ]
Rheumatic fever	[ ]	[ ]
Pacemaker	[ ]	[ ]
Artificial heart valve	[ ]	[ ]
Blood Problems	[ ]	[ ]
Easy bruising	[ ]	[ ]
Frequent nosebleeds	[ ]	[ ]
Abnormal bleeding	[ ]	[ ]
Blood disease (anemia)	[ ]	[ ]
Ever require a blood transfusion?	[ ]	[ ]
Fainting Spells, Seizures, or Epilepsy	[ ]	[ ]
Stroke(s)	[ ]	[ ]
Frequent or severe headaches	[ ]	[ ]
Thyroid problems	[ ]	[ ]
Persistent cough or swollen glands	[ ]	[ ]
History of head injury	[ ]	[ ]
Epilepsy or other neurological disease	[ ]	[ ]
History of alcohol or drug abuse	[ ]	[ ]

Do you have any disease, condition, or problem not listed previously that you feel we should know about? [ ] [ ]

Write down all prescribed medications you currently are taking or provide a list.

Women

Are you taking a contraceptive or other hormones? [ ] [ ]

Are you pregnant? [ ] [ ]

If so, what is your expected delivery date? _____

Notes:

Patient/Parent Signature Date:

Dentist Initial: Date:

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Neighbors helping neighbors...

CROOKED RIVER RANCH
MERCY DENTAL

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.

WHO WILL FOLLOW THIS NOTICE

This notice describes the information privacy practices followed by our employees, staff and other office personnel.

YOUR HEALTH INFORMATION

This notice applies to the information and record we have about your health, health status, and the health care and services you receive at this office. We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

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, nurses, technicians, office staff or other personnel who are involved in taking care of you and your health. For example, your doctor may be treating you for a joint replacement and may need to know if you have other health problems that could complicate your treatment. The doctor may use your medical history to decide what treatment is best for you. The doctor may also tell another doctor about your condition so that doctor can help determine the most appropriate care for you.

Different personnel in our office may share information about you and disclose information to people who do not work in our office in order to coordinate your care, such as phoning in prescriptions to your pharmacy. Family members and other health care providers may be a part of your dental care outside this office and may require information about you that we have. We work in open treatment areas. We will attempt to keep your personal health information (PHI) to the minimum.

FOR PAYMENT: We may use and disclose health information about you if contacted by your insurance provider. For example, we may need to give your insurance provider information about a service you received here so your health plan will reimburse you for the service.

APPONTMENT REMINDERS: We may contact you as a reminder that you have and appointment for treatment or cleaning at the office. We may send notices to alert you that it is time for a regular exam and cleaning. We may also contact you with cards for a holiday or to say thank you.

FOR HEALTH CARE OPERATIONS: We may use and disclose health information about you in order to run the office and make sure that you and our other patients receive quality care. For example, we may use your health information to evaluate the performance of our staff in caring for you. We may also use health information about all or many of our patients to help us decide what additional service we should offer, how we can become more efficient or whether certain new treatments are effective.

SPECAIL SITUATIONS

We may use or disclose health information about you without your permission for the following purposes, subject to all applicable legal requirements and limitations:

TO AVERT SERIOUS THREAT TO HEALTH OR SAFETY: We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

REQUIRED BY LAW: We will disclose health information about you when required to do so by federal, state or local law. We may release health information if asked to do so by a law enforcement official in response to court order, subpoena, warrants summons or similar process, subject to all applicable legal requirements. This includes Coroners, Medical Examiners and Funeral Directions. We may release health information about you in a way that does not personally identify you or reveal who you are.

FAMILY AND FRIENDS: We may disclose health information about you to your family members or friends if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgment that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse when you bring our spouse with you into the exam room during treatment or while treatment is discussed. In situations where you are not capable of giving consent (because you are not present due to your incapacity or medical emergency), we may, using our professional judgment, determine that a disclosure to your family member or friend is in your best interest. In that situation, we will disclose only health information relevant to the person's involvement in your care. For example, we may inform the person who accompanied you to the office for an extraction of the prescriptions and follow up care regarding the extraction.

OTHER USES AND DISCLOSURES OF HEALTH INFORMATION: We will not use or disclose health information for any purpose other than those identified in the previous sections without your specific written authorization. If you give us authorization to use or disclose health information about you, you may revoke the authorization, but we cannot take back any uses or disclosures already made with your permission. If we have HIV or substance abuse information about you, we cannot release that information without a special signed, written authorization (different than the authorization and consent mentioned above) from you. In order to disclose those types of records for purpose of treatment, payment or health care operation, we will have to have both your signed consent and a special written authorization that complies with the law governing HIV or substance abuse records.

YOUR RIGHTS REGARDING HEATH INFORMATIN ABOUT YOU

RIGHT TO INSPECT AND COPY: You have the right to inspect and copy your health information, such as dental and billing records, that we use to make decisions about your care. You must submit a written request to our office in order to inspect and/or copy your health information. If you request a copy of the information, we may charge a fee for the cost of copying, mailing or other associated supplies. We may deny your request to inspect and /or copy in certain limited circumstances. If you are denied access to your health information you may ask that the denial be reviewed. If such a review is required by the law, we will select a licensed health care professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

RIGHT TO AMEND: If you believe health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by this office. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that: a) We did not create. b) Is not part of the health information that we keep. c) You would not be permitted to inspect and copy. d) Is accurate and complete.

RIGHT TO AN ACCOUNTING OF DISCLOSURES: You have the right to request and "accounting of disclosures." This is a list of the disclosures other than treatment, payment and health care operations. To obtain this list, you must submit your request in writing to our office. It must state a time period and state if you want the list emailed or on paper. We may charge you for the cost of providing the list.

RIGHT TO REQUEST RESTRICTIONS AND CONFIDENTIAL COMMUNICATIONS: You have the right to request restrictions or limitations on the health information we use or disclose about you for the treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for it, Like a family member or friend. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. Requests must be specific. For example, you can ask that we only contact you at work or by mail. Request for restrictions should be made in writing. We will accommodate all reasonable requests.

WE ARE NOT REQUIRED TO AGREE TO YOUR REQUEST: If we do agree, we will comply with your request unless the information is needed to provide your emergency treatment.

RIGHT TO A PAPER COPY OF THIS NOTICE: You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive it electronically, you are still entitled to a paper copy. To obtain such a copy, contact our office.

CRR MERCY DENTAL

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT OF

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have been offered a copy of this office's Notice of Privacy Practices.
(Please Print Name)

_____ _____/_____/_____
(Street Address) (City) (Zip Code) (Date of Birth)

_____ _____
(Signature) (Date)

***To the Patient*: PLEASE READ THE FOLLOWING CAREFULLY**

Purpose of Consent: By signing this form you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations as detailed in the Notice.
Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations; of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information, and of other important matters about your protected health information. A copy of our Notice is available to you – we encourage you to read it carefully and completely before signing this consent.
We reserve the right to change our privacy policies as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices which will contain the changes. Those changes may apply to any of your protected health information that we maintain.
You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice at any time by contacting our receptionist at: 541-241-4621.
Right to revoke: You have the right to revoke this consent at any time by giving us written notice of your revocation submitted to our receptionist. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.
I,_____, have had full opportunity to read and consider the contents
(Please Print Name)
of this consent form and your Notice of Privacy Practices. I understand that by signing this Consent form I am giving my consent to your use and disclosure of my protected health information in the limited was described in the notice, to carry out treatment, payment activities and other health care operations.

_____
(Date)

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice to Privacy Practices, but acknowledgement could not be obtained because:

- **Individual refused to sign**
- **Communication barriers prohibited obtaining the acknowledgement**
- **An emergency situation prevented us from obtaining acknowledgement**
- **Other, (please, specify) _____**
  _____

Employee Signature: _____Date:_____