



# Medical History

Name \_\_\_\_\_

Physician's Name \_\_\_\_\_ Phone \_\_\_\_\_ Date of Last Visit \_\_\_\_\_

Circle Yes or No (Y or N) if you have ever had any of the following:

- |                             |                                 |   |
|-----------------------------|---------------------------------|---|
| Y--N AIDS or HIV positive   | Y--N Glaucoma                   | Heart Problems                          |
| Y--N Acid Reflux/ G.E.R.D   | Y--N Hepatitis, Type: _____     | Y--N Low blood pressure                 |
| Y--N Arthritis, Type: _____ | Y--N Kidney problems            | Y--N High blood pressure                |
| Y--N Artificial joints      | Y--N Liver problems or Jaundice | Y--N Pacemaker                          |
| Y--N Asthma                 | Y--N Lung or breathing problems | Y--N Artificial valves                  |
| Y--N Cancer                 | Y--N Sinus trouble              | Y--N Infective (Bacterial) Endocarditis |
| Y--N Chemical Dependency    | Y--N Smoking/chewing tobacco    | Y--N Congenital heart defects           |
| Y--N Diabetes, Type: _____  | Y--N Stroke                     | Y--N Heart Surgeries                    |
| Y--N Eating disorder        | Y--N Swollen neck glands        | Y--N Other _____                        |
| Y--N Epilepsy               | Y--N Thyroid problems           | Y--N Serious illnesses/hospitalizations |
| Y--N Excessive bleeding     | Y--N Tuberculosis               | Y--N Currently under a physician's care |
|                             |                                 | Y--N Antibiotics for dental treatment   |

Give details of the above 'Yes' items \_\_\_\_\_

Women:  
Are you pregnant? \_\_\_\_\_ Due when? \_\_\_\_\_  
Are you nursing? \_\_\_\_\_

**ALLERGIES** Circle if you are allergic to:  
Aspirin – Codeine – Latex – Local anesthetic – Penicillin – Sulfa  
Other allergies: \_\_\_\_\_

**MEDICATIONS:** Please list medications you are currently taking and why:  
\_\_\_\_\_  
\_\_\_\_\_

## Dental History (New Patients Only)

Circle if you have ever had any of the following:

- |                                  |                            |                                  |                      |
|----------------------------------|----------------------------|----------------------------------|----------------------|
| Bad breath problem               | Canker sores in mouth      | Orthodontics (braces)            | Oral surgery         |
| Frequent headaches, neck aches   | Cold sores on outer lips   | Full dentures / Partial dentures | Excessive gag reflex |
| TMJ, jaw joint pain or treatment | Dental anesthetic problems | Biteguard / Nightguard           | Fear of dental care  |
| Gum disease treatment            |                            |                                  |                      |

Circle if you currently have any of the following:

- |            |                         |                            |                                  |
|------------|-------------------------|----------------------------|----------------------------------|
| Pain       | Sensitivity to:         | Dry mouth                  | Clicking or popping jaw          |
| Toothache  | heat – cold – biting    | Mouth breathing            | Clenching or grinding of teeth   |
| Vague ache | sweets – pressure       | Sores or growths in mouth  | Tired, sore or painful jaw joint |
| Swelling   | Broken tooth or filling | Bleeding gums              | Pain around ear                  |
|            | Loose tooth             | Food packing between teeth | Other: _____                     |

Give details and location of the above circled items \_\_\_\_\_

How often do you brush? \_\_\_\_\_ floss? \_\_\_\_\_ What type toothbrush do you use? Ultrasoft – Soft – Medium – Hard – Electric

Would you like improve the appearance of your smile? \_\_\_\_\_ How? \_\_\_\_\_

Reason for today's visit \_\_\_\_\_

Former Dentist \_\_\_\_\_ City/State \_\_\_\_\_ Phone \_\_\_\_\_

Date and reason of last dental visit \_\_\_\_\_ Date of last dental X-rays \_\_\_\_\_

What have you liked about any dental office you've been to? \_\_\_\_\_ Least? \_\_\_\_\_

## TREATMENT AUTHORIZATION

I have reviewed the information on both sided of this form and it is accurate to the best of my knowledge. I authorize and give consent for the dentist and/or team of this office to perform dental services as agreed between doctor and patient and/or guardian, including the use of local anesthetic and other medication as indicated.

Signature (Parent/Guardian if under age 18)

Relationship (if patient is under age 18)

Date

# *WILLITS & WOLTKAMP FAMILY DENTISTRY*

## **Notice of Privacy Practices**

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

The Health Insurance Portability & Accountability Act (HIPAA) requires all health care records be kept confidential. This federal law gives you rights to control how your health information is used. We have prepared this explanation of how we maintain the privacy of your health information and how it may be used and disclosed.

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Without specific written authorization, we are only permitted to use and disclose your health care records for the purposes of treatment, payment and health care operations.

**Treatment** means providing, coordinating or managing health care and related services by one or more health care providers.

**Payment** refers to obtaining reimbursement for services, confirming eligibility, billing and collection activities.

**Health Care Operations** include the business aspect of running our practice, such as quality assessment or training. Unless you request otherwise, we may use or disclose your personal health information to a family member, friend, personal representative or other individual only to the extent necessary to help with your health care or with payment for your health care. In the event of an emergency or your incapacity, we will use our professional judgment in disclosing only the protected health information necessary to facilitate needed care. Any other uses and disclosures will be made only with your written authorization, unless requested by public health, judicial, police or military organizations. You may revoke such authorization in writing at any time.

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You have certain rights in regard to your protected health information, which you can exercise by presenting a written request to our Privacy Officer at the practice address listed at the bottom of this notice. You have the following rights:

- To request restrictions on certain uses and disclosures of your protected health information. We are, however, not required to agree to a requested restriction.
- To request confidential communications from us, by alternate means, of your protected health information.
- To obtain a copy of your protected health information, with limited exceptions. A fee will be charged for duplication. By federal law, all original records are property of this practice.
- To request an amendment to your protected health information. We may, however, deny your request in certain situations.
- To receive an accounting of disclosures of protected health information made outside of treatment, payment or health care operations or based on your previous authorization.
- To obtain a paper copy of this Notice from us upon request, even if you have agreed to receive the Notice electronically.

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We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This Notice is effective as of April 14, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office.

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You have the right to file a formal written complaint with us at the address below, or with the Department of Health and Human Services, Office of Civil Rights, in the event that you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about our Privacy Practices, contact:

Richard H. Willits, D.D.S.  
Willits and Woltkamp Family Dentistry  
5600 W. 95<sup>th</sup> St., Suite 201  
Overland Park, KS 66207

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services  
Office of Civil Rights  
200 Independence Ave. S.W.  
Washington, DC 20201

*WILLITS & WOLTKAMP FAMILY DENTISTRY*

**Acknowledgment of Receipt of Privacy Practices**

**\*\* You may refuse to sign this acknowledgement\*\***

I have received a copy of this office's Notice of Privacy Practices.

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Please Print Patient Name(s)

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Signature (please note relationship to patient if not same)

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Date

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FOR OFFICE USE ONLY

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We attempted to obtain written acknowledgement of this Receipt of Privacy Practices, but acknowledgement could not be obtain because:

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

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