Name Dr. Mr. Ms. Mrs. Miss _____ **Date:** _____
last *first* *middle*

Address _____ **Date of Birth:** _____
street *city* *state* *zip*

Home Phone ( ) _____ **Cell Phone ( )** _____ **SS #** _____

Employer _____ **Work Phone ( )** _____

Your Chief Complaint _____

Who Referred You? _____

Your Dentist's Name _____

MEDICAL HEALTH

General Health: *(please check)*

☐ Excellent ☐ Fair
☐ Good ☐ Poor

Name and address of physician _____

Date of last complete medical examination _____

Have you ever had or been treated for: *(check yes or no)*

Heart disease	Yes ☐ No ☐	Liver disease, Jaundice	Yes ☐ No ☐	AIDS	Yes ☐ No ☐
Hemophilia	Yes ☐ No ☐	Fainting spells	Yes ☐ No ☐	Chemotherapy	Yes ☐ No ☐
Lung trouble	Yes ☐ No ☐	Stroke	Yes ☐ No ☐	Heart valve replacement	Yes ☐ No ☐
Heart murmur	Yes ☐ No ☐	Have you ever had		Blood trouble	Yes ☐ No ☐
Venereal disease	Yes ☐ No ☐	radiation treatment?	Yes ☐ No ☐	Hepatitis	Yes ☐ No ☐
Diabetes	Yes ☐ No ☐	Cancer	Yes ☐ No ☐	Mental & Nervous disorders	Yes ☐ No ☐
Artificial joint replacement	Yes ☐ No ☐	Rheumatic fever	Yes ☐ No ☐	Convulsions, Epilepsy	Yes ☐ No ☐
Excessive bleeding	Yes ☐ No ☐	High blood pressure	Yes ☐ No ☐	Asthma, hay fever	Yes ☐ No ☐
Anemia, Leukemia	Yes ☐ No ☐	Arthritis, sore joints	Yes ☐ No ☐	Substance abuse	Yes ☐ No ☐

Have you been told you require antibiotic coverage for all dental procedures because of: Yes ☐ No ☐

☐ mitral valve prolapse ☐ prosthetic joint replacement
☐ heart murmur

Have you had any operations within the last 10 years: Yes ☐ No ☐

If yes, please explain _____

Have you become sick for, shown an allergy to, or been told not to take: *(please check)*

☐ Antibiotics (Penicillin) ☐ Codeine ☐ Novacaine ☐ Other _____

Are you now taking medications for:

Diabetes	Yes ☐ No ☐	Headaches	Yes ☐ No ☐
Sleeping	Yes ☐ No ☐	Arthritis, Rheumatism	Yes ☐ No ☐
Cancer	Yes ☐ No ☐	Taking hormones	
Stomach Trouble	Yes ☐ No ☐	(birth control)	Yes ☐ No ☐
Allergy	Yes ☐ No ☐	Taking Dilantin	Yes ☐ No ☐
Nerves	Yes ☐ No ☐	Taking Anticoagulents	Yes ☐ No ☐
Heart or blood pressure	Yes ☐ No ☐	Taking Thyroid meds	Yes ☐ No ☐
Blood (liver or iron pills)	Yes ☐ No ☐	Taking Antidepressants	Yes ☐ No ☐

Do you smoke? Yes ☐ No ☐

Women: Are you pregnant? Yes ☐ No ☐

If you are taking any medications, please list:

_____

_____

_____

_____

Do you have a disease or problem not listed? Yes ☐ No ☐

If yes, explain _____

Please complete and sign other side

Troy Periodontics
Mahogany Miles, DMD, MSD, PLLC
2119 Burdett Avenue, Troy, NY 12180
(518) 274-5015 fax (518) 274-5426

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

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

Print name: _____

Signature: _____

Date: _____

FOR OFFICE USE ONLY

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

Individual refused to sign

Communications barriers prohibited obtaining acknowledgement

An emergency situation prevented us from obtaining acknowledgement

Other

_____

Mahogany Miles, DMD, MSD, PLLC D/B/A Troy Periodontics
(NAME OF PRACTICE)

Sample 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.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 8/1/16, and will remain 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 by applicable law, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice 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.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.

Required by Law. We may use or disclose your health information when we are required to do so by law.

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

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 the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

Opt Out