Chris Mohler DDS

Today's Date: _____

First Name: _____ **MI:** _____ **Last Name:** _____

Date of Birth: _____ **Sex:** __Male __Female **Family Status:** __Single __Married __Child __Other

Social Security Number: _____ **Driver's License Number:** _____

Email: _____

HOME ADDRESS

Address: _____ City, State, and Zip: _____

PHONE NUMBERS (*Please check preferred contact number)* Best Time to Call: _____

____Home: _____ ____Work: _____ ____Cell: _____

EMPLOYER INFORMATION

Employer's Name: _____ Phone: _____

Address: _____ City, State, and Zip: _____

PARENT/GUARDIAN INFORMATION (*Parent/Guardian accompanying child is responsible for account.*)

Parent/Guardian Name: _____ Phone: _____

Address of Parent/Guardian: _____

Whom should we contact in case of an emergency? (*Please provide phone number and relation to child.*)

_____

Whom are we allowed to speak to about your dental health? (*Besides you, parent/guardian or insurance.*)

_____

Whom may we thank for referring you? _____

PREFERENCES ___No phone calls ____No correspondence

RESPONSIBLE PARTY INFORMATION

Person responsible for the account: _____ Phone: _____

Relationship to patient: _____ SSN: _____ Date of Birth: _____

Address: _____ City, State, and Zip: _____

Employment Information

Employer's Name: _____ Phone: _____

Address: _____ City, State, and Zip: _____

Whom should we contact in case of an emergency? (*Please provide phone number and relation to child.*)

_____

Whom are we allowed to speak to about your dental health? (*Besides you, parent/guardian or insurance.*)

_____

DENTAL INSURANCE *(Please input the policy holder's information.)*

Is the insurance policy holder a patient at this office? ____Yes ____No

If yes, what is the policy holder's relationship to the patient? _____

Policy holder's full name: _____

Phone: _____ Date of Birth: _____ SSN: _____

Address: _____ City, State, and Zip: _____

Policy Holder's Employment Information (*if different from above.)*

Employer's Name: _____ Phone: _____

Address: _____ City, State, and Zip: _____

Insurance Company Information

Insurance Company Name: _____ Phone: _____

Address: _____ City, State, and Zip: _____

Insurance Plan Name: _____ Union or Local Name: _____

ID Number: _____ Group ID Number: _____

MEDICAL HISTORY

If you are completing this form for another person, please tell us your relationship: _____

If you are completing this for the patient, are you the legal guardian? ____Yes ____No

Your name *(if you are not the patient):* _____

Physician's Name: _____ Phone Number: _____

Other Physicians: _____

Approximate date of last physical examination: _____ Height: _____ Weight: _____

Please list any conditions or illnesses for which you are currently being treated: _____

_____

Have you been hospitalized or under the care of a medical doctor during the last 2 years? ____Yes ____No

If yes, for what? _____

Hospital/Physician's Name: _____ Phone: _____

Hospital/Physician's City, State, Zip: _____

PLEASE CHECK EACH BOX FOR ANY HEALTH CONDITIONS YOU HAVE

□ Alzheimer's	□ Anemic	□ Arthritis	□ Artificial/prosthetic joint
□ Asthma	□ Cancer	□ Diabetes	□ Epilepsy
□ Gall bladder disorder	□ Glaucoma	□ Hay fever/sinus problems	□ Heart disease
□ Heart murmur	□ Hepatitis	□ High blood pressure	□ HIV/AIDS
□ Kidney disease	□ Liver disease	□ Low blood pressure	□ Mental health problems
□ Multiple Sclerosis	□ Pacemaker	□ Pregnancy	□ Pre-Medicate
□ Radiation treatment	□ Respiratory problems	□ Rheumatic fever	□ Sickle cell trait
□ Smoker	□ Sleep apnea	□ Snoring	□ Stomach problems
□ Stroke	□ Thyroid problems	□ Tuberculosis	□ Ulcers

Are there any other medical conditions we should be aware of? ____Yes ____No

If yes, please describe: _____

ALLERGY HISTORY *(please select if applicable.)*

____Allergies like hay fever ____Allergies which cause a stopped up nose ____Seasonal allergies

____Multiple environmental allergies ____Dental Restorative Materials (fillings)

I have no medication allergies: ____

OR

Please select if you are allergic to any of these medications:

____Penicillin ____Iodine Dye ____Codeine ____Latex ____Sulfa ____Aspirin

Please list any other allergies: _____

Please list any previous surgeries you have had with approximate dates *(i.e. back surgery, gall bladder, tonsillectomy, prosthetic joint replacement, etc.):* _____

_____

Do you consume alcohol? ____None ____Social use ____More than social use

Do you use street drugs? ____None ____Marijuana ____Cocaine ____Methamphetamine ____Heroine ____Other

Do you use tobacco products? ____None ____Cigarettes ____Cigar ____Smokeless ____Pipe

For children – are immunizations up to date? ____Yes ____No ____Uncertain

Preferred pharmacy name and phone number: _____

Do you take prescribed or over-the-counter medications on a regular basis? ____Yes ____No

If yes, please list: _____

Please list any herbals or other remedies you take regularly: _____

Please list any vitamins you take regularly: _____

Do you take the blood thinning medication Coumadin? ____Yes ____No

Do you take Aspirin or Plavix? ____Aspirin ____Plavix ____Neither

Do you take steroid medication? ____Yes ____No

Have you ever taken Bisphosphonates for osteoporosis or chemotherapy for multiple myeloma? ____Yes ____No

DENTAL HISTORY

How can we help you today? _____

_____

Do you have any tooth or oral pain? ____Yes ____No

If yes, where is the pain? _____

Are you taking pain medication for oral pain? ____Yes ____No ____Uncertain

If yes, what pain medication: _____

Are you currently taking any antibiotics for oral infection? ____Yes ____No

If yes, which antibiotic: _____

Please check any which may apply:

□ Broken fillings	□ Chewing problems	□ Cavity problems	□ Missing teeth
□ Broken teeth	□ Teeth cosmetic issues	□ Gum problems	□ Old filling to evaluate
□ Bite problems	□ Bad breath	□ Grinding	□ Jaw problems

ORAL CARE HABITS

How often do you see a dentist for routine care? ____Annually ____Twice a year ____Only for pain
____Seldom ____Never

When was your last dental treatment? _____

What was done at that visit?
____Cleaning ____Denture/Partial ____Root Canal ____Evaluation
____Filling/crown/bridge ____Extraction ____Gum treatment ____Uncertain

Are you aware of any infection in your mouth? ____Yes ____No

When were your last dental X-Rays taken? _____

Have you lost any teeth besides your baby teeth? ____Yes ____No
Please select below the reason for loss if applicable:
____Wisdom teeth extracted ____Extracted due to a gum problem ____Extracted due to decay
____For braces care ____From an accident ____Other_____

Are you interested in replacing lost teeth? ____Yes ____No

How is your family's dental health? ____Most have good teeth ____Most have bad teeth ____Uncertain

What are your brushing habits?
____Once per day ____Twice per day ____Three times per day ____Seldom ____Never ____Not applicable

What type of brush do you use? ____Hard ____Medium ____Soft ____Uncertain ____Not applicable

How many times per day do you eat or drink sugar containing items?
____Less than 3 times ____More than 3 times ____None

Is the water at your home fluoridated? ____Yes ____No ____Uncertain

Do you floss your teeth? ____Daily ____Weekly ____Occasionally ____Seldom ____Never

Do you use other oral cleaning products?
____WaterPik ____Sonicare toothbrush ____Toothpick ____Mouth rinse ____Rotary toothbrush
____Electric toothbrush ____Not applicable

PERIODONTAL (GUM) HEALTH

Does food get stuck between your teeth? ____Yes, a few places ____Yes, in many places ____No
Do your gums ever bleed when brushing your teeth? ____Yes ____No ____Occasionally
Are any of your teeth loose? ____Yes ____No

Does your mouth feel dry most of the time? ____Yes ____No
Are you concerned about receding gums? ____Yes ____No

CHEWING ABILITY

Can you chew your food well? ____Yes ____Not very well ____No
Do you have partials or dentures? ____Yes ____No
If yes, do they work well? ____Yes ____No
Are your teeth sensitive to hold or cold? ____Yes ____No ____Sometimes
Do you have any aches or pains in your jaws or ears? ____Yes ____No
Do you have any jaw clicking or popping? ____Yes ____No
Are you aware of any habit of grinding or clenching? ____Yes ____No

SMILE

Do you like your smile? ____Yes ____No
Would you like whiter teeth? ____Yes ____No ____I would like to talk about it

What are your goals?
□ Health & Prevention
□ Function
□ Cosmetics
Please describe: _____
_____

PAST DENTAL CARE

Have you ever had trouble with a previous dental treatment? ____Yes ____No
If yes, please describe: _____
Dentist: _____ City, State, and Zip: _____ Phone: _____
Why are you changing dentists? _____

Have you ever had root canal treatment? ____Yes ____No ____Uncertain
Have you ever had Periodontal (gum) treatment? ____Yes ____No ____Uncertain
Have you ever had braces? ____Yes ____No
Have you ever had your teeth ground or your bite adjusted? ____Yes ____No ____Uncertain

BREATH ODOR

Do you have a problem with bad breath odor? ____Yes ____No

DENTAL CARE ANXIETY *(Please check any of the following that describe you.)*

____Dental care does not frighten me
____I am frightened of dental care
____I require IV sedation or general anesthesia
____Nitrous Oxide (laughing gas) helps me tolerate dental care
____A relaxation pill helps me with dental care
____Local anesthesia works well for me
____I have extreme dental phobia

OTHER MATTERS YOU WOULD LIKE TO TELL US ABOUT

Do you have other problems you would like to tell us about which have not been identified? _____
_____

If you are completing this form for a child, please answer the following questions:

Is this your child's first visit to the dentist? ____Yes ____No

If not, date and location of last dental care: _____

Has your child ever had a space maintainer, retainer, braces or any other dental tooth movement? _____

_____

Was your child breast fed or bottle fed? ____Breast ____Bottle ____Uncertain

Age discontinued: _____

Does your child have a past or current history of: ____Thumb sucking ____Finger sucking ____Pacifier

Do you want oral hygiene instructions given to your child? ____Yes ____No

OFFICE POLICIES

I understand that responsibility for payment of dental service provided by this office for myself or my dependents is solely mine, with full payment due and payable at the time services are rendered. In some cases, a non-refundable deposit will be requested to schedule dental services. In the event of a default in my payment, I promise to pay the legal interest rate on such indebtedness until fully paid together with all collection cost(s) including non-sufficient fund fees, court costs and reasonable attorney fees. _____Initials

I hereby authorize Dr. Chris Mohler and/or his staff to take photographs, slides and/or videos of my face, jaws and teeth. I understand that the photographs, slides and videos will be used as a record of my care and treatment and hereby authorize their use for educational purposes in the future lectures and demonstrations by Dr. Mohler. _____Initials

I hereby give my permission to have my testimonials and/or photos, slides and videos utilized by Dr. Mohler for professional marketing to help other patients understand the benefits of the services rendered by this office. I further understand that I will receive no financial compensation for the use at any time in the future of my testimonials, photos, slides or videos of Dr. Mohler. _____Initials

Pursuant to South Carolina Law – Any patient who exposes a healthcare provider or their employees to body fluids which may transmit human immunodeficiency virus (HIV), Hepatitis B or Hepatitis C virus is deemed to have consented to HIV, Hepatitis B or Hepatitis C testing and disclosure of the result to the person exposed. This deemed consent also applies to a healthcare provider who exposes a patient to body fluids. _____Initials

I understand that I must provide 2 business days advanced notice of any cancellations of any of my (or my dependents) missed appointment whenever possible. Failure to do so may result in the imposition of cancellation fees, which are determined by the length and type of service being rendered at the scheduled visit, up to the full amount of the scheduled treatment. Such cancellation fees are non-refundable. _____Initials

I have read and understood this entire agreement before signing below, and I have initialed this agreement endorsing my compliance voluntarily, without duress, and of my own free will and choice.

Printed Name of Patient: _____

Signature: _____ Date: _____

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. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant rights to control how your health information is used. HIPAA provides penalties for covered entities that misuse personal information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes:

- Treatment, payment and health care operations.
- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include treatment for pain or injury to your teeth.

- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identifiable health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.
We may also use or disclose your personally-identifiable health information:

- To your family and friends: We must disclose your information to you. We may also disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment of your healthcare, but only if you agree that we may do so, or if we are presented a valid legal document showing authority of another person to act on your behalf, as, for example, a medical power of attorney or declaration of guardianship.
- To persons involved in your care: We may use or disclose health information to notify, assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care of your general condition. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to use uses or disclosure.
- As required by law: We may use or disclose your health information when we are required to do so by law.
- In case or suspected abuse or neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety, or the health or safety of others.
- For other governmental purposes: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to correctional institution or law enforcement official having custody of protected health information of inmate or patient under certain circumstances.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an account of disclosures of protected health information.
- The right to obtain and we have the obligation to provide to you a paper copy of this notice from us at your first service delivery date.
- The right to request a written acknowledgement that you have received a copy of our Notice of Privacy Practices, and an obligation to document our good faith efforts why an acknowledgement was not obtained.

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 OR the date office opened if later than 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. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.
You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, about violation of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

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, D.C. 20201
202-619-0257

You May Refuse To Sign This Acknowledgement

I, _____, have received a copy of this office's notice of privacy practices.

Signature: _____ Date: _____