

PATIENT INFORMATION

Patient's Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_ City State ZipCode

Home Telephone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Marital Status: S M D W

Social Security Number: \_\_\_\_\_

Employer: \_\_\_\_\_

Address: \_\_\_\_\_

Work Telephone: \_\_\_\_\_ Occupation: \_\_\_\_\_

Who is financially responsible for your account? \_\_\_\_\_

What is their relationship to you? \_\_\_\_\_

Address if different from yours: \_\_\_\_\_

Telephone: \_\_\_\_\_ Is

the patient currently a full time student? YES NO

If yes, what school? \_\_\_\_\_

Your physician: \_\_\_\_\_ Tel: \_\_\_\_\_

Your dentist: \_\_\_\_\_ Tel: \_\_\_\_\_

Dental Insurance Information

Name of plan: \_\_\_\_\_ ID# \_\_\_\_\_ Group# \_\_\_\_\_

Subscriber: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Relationship to you: \_\_\_\_\_

Employer: \_\_\_\_\_ Medical Insurance Information

Name of plan: \_\_\_\_\_ ID# \_\_\_\_\_ Group# \_\_\_\_\_

Subscriber: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Relationship to you: \_\_\_\_\_

Employer: \_\_\_\_\_

Please hand your insurance cards to the receptionist so that we may photocopy them for your record.

# HEALTH HISTORY

Patient's Name \_\_\_\_\_

**All responses are kept confidential**

**Answer all questions by circling Yes (Y) or No (N)**

1. Are you in good health? ..... Y N
2. Has there been any change in your general health in the past year? ..... Y N
3. Date of last physical exam \_\_\_\_\_
4. Are you now under a physician's care for a particular problem? ..... Y N
5. Have you ever had any serious illnesses, operations or hospitalizations? If so, describe: ..... Y N  
\_\_\_\_\_

- D. High Blood Pressure medications? ..... Y N
- E. Steroids (Cortisone, etc.)? ..... Y N
- F. Tranquillizers? ..... Y N
- G. Insulin or Oral Anti-Diabetic drugs? ..... Y N
- H. Inderal, Nitroglycerin or other heart drug? ..... Y N
- I. Medication for osteoporosis (Fosamax)? ..... Y N
- J. Any regular medicine, pills or drugs — either over-the-counter or prescription ..... Y N  
Please List: \_\_\_\_\_

6. Height \_\_\_\_\_ Weight \_\_\_\_\_

**7. DO YOU HAVE OR HAVE YOU EVER HAD:**

- A. Rheumatic Fever or Rheumatic Heart Disease? ..... Y N
- B. Congenital Heart Disease? ..... Y N
- C. Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker?) ..... Y N
- D. Lung Disease (Asthma, Emphysema, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing)? ..... Y N
- E. Seizures, Convulsions, Epilepsy, Fainting, Dizziness, Psychiatric Treatment, or other Nervous Disorder? ..... Y N
- F. Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion? Do you bruise easily? ..... Y N
- G. Liver Disease (Jaundice, Hepatitis)? ..... Y N
- H. Kidney Disease? ..... Y N
- I. Diabetes? ..... Y N
- J. Thyroid Disease (Goiter)? ..... Y N
- K. Arthritis? ..... Y N
- L. Stomach Ulcers or Colitis? ..... Y N
- M. Glaucoma? ..... Y N
- N. Implants placed anywhere in your body (Heart Valve, Pacemaker, Hip, Knee)? ..... Y N
- O. Radiation (X-ray) treatment for Cancer? ..... Y N
- P. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth? ..... Y N
- Q. Sinus or Nasal problems? ..... Y N
- R. Any disease, drug or transplant operation that has depressed your immune system? ..... Y N
- S. HIV, AIDS or ARC? ..... Y N

**9. ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:**

- A. Local Anesthesia (Novocain, etc.)? ..... Y N
- B. Penicillin or other antibiotics? ..... Y N
- C. Sedatives, Barbiturates? ..... Y N
- D. Aspirin or Ibuprofen? ..... Y N
- E. Codeine or other pain killers? ..... Y N
- F. Latex or Rubber Products? ..... Y N
- G. Other allergies or reactions? Please, list ..... Y N  
\_\_\_\_\_

10. Do you smoke or chew Tobacco? ..... Y N  
How much per day? \_\_\_\_\_

11. Is there any past history of Alcohol or Chemical Dependency or Emotional Disorder that may affect the care we provide you? ..... Y N
12. Have you had any serious problems associated with any previous dental treatment? ..... Y N
13. Have you or an immediate family member had any problem associated with intravenous anesthesia? ..... Y N
14. Do you have any other disease, condition or problem not listed above that you think the doctor should know about? ..... Y N
15. Do you wish to talk to the doctor privately about anything? ..... Y N

**16. FOR WOMEN ONLY**

- A. Are you Pregnant, or is there any chance you might be Pregnant? ..... Y N
- B. Are you using oral contraceptives? ..... Y N
- C. If **you are using Oral Contraceptives**, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed. Talk to your MD.

**8. ARE YOU USING ANY OF THE FOLLOWING:**

- A. Antibiotics? ..... N
- B. Anticoagulants (Blood Thinners)? ..... N
- C. Aspirin or drugs such as Motrin, Aleve, Ibuprofen? Y  
N Date \_\_\_\_\_

I understand the importance of a truthful Health History to assist the doctor in providing the best care possible. I have had the opportunity to discuss my Health History with my doctor.

Date \_\_\_\_\_

Signature of Person Completing Health History \_\_\_\_\_

Doctor's Initials \_\_\_\_\_

Medical Update: I have ready my Health History dated \_\_\_\_\_ and confirm that it adequately states past and present conditions.

Date \_\_\_\_\_

Exceptions or changes \_\_\_\_\_

Patient's Signature \_\_\_\_\_

Doctor's Initials \_\_\_\_\_

Date \_\_\_\_\_

Exceptions or \_\_\_\_\_

Patient's Signature \_\_\_\_\_

Doctor's Initials \_\_\_\_\_

# *Keith Sherwood DDS, LLC*

{NAME OF PRACTICE}

## 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.  
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.**

### **OUR LEGAL DUTY**

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 6/15/06, 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. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available 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.

### **USES AND DISCLOSURES OF HEALTH INFORMATION**

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

**Treatment:** We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

**Payment:** We may use and disclose your health information to obtain payment for services we provide to you.

**Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

**Your Authorization:** In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

**To Your Family and Friends:** We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

**Persons Involved In Care:** We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of Our best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

**Marketing Health-Related Services:** We will not use your health information for marketing communications without your written authorization.

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

**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.

**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 of protected health information of inmate or patient under certain circumstances.

**Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

---

## PATIENT RIGHTS

**Access:** You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you \$0. .50 for each page, \$ \$20 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

**Disclosure Accounting:** You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

**Restriction:** You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

**Alternative Communication:** You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

**Amendment:** You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why The information should be amended.) We may deny your request under certain circumstances.

**Electronic Notice:** If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

---

## QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact [Kathy Silva](#)

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

E-mail: \_\_\_\_\_ Address: \_\_\_\_\_

---

# CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

---

---

## SECTION A: PATIENT GIVING CONSENT

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

Patient#1: \_\_\_\_\_

---

## SECTION B: TO THE PATIENT — PLEASE READ THE FOLLOWING STATEMENTS 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.

**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. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices 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:

Contact Person:

Telephone: \_\_\_\_\_ Fax \_\_\_\_\_

Atoms: \_\_\_\_\_

**Right to Revoke:** You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. 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.

## SIGNATURE

\_\_\_\_\_, have had full opportunity to read and consider the contents 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 to carry out treatment, payment activities and health care operations.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

**YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.  
Include completed Consent in the patient's chart.**

INSURANCE AUTHORIZATION

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

\_\_\_\_\_ I AUTHORIZE RELEASE OF ANY INFORMATION RELATED TO MY DENTAL TREATMENT BY DR. KEITH SHERWOOD. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL COSTS OF TREATMENT.

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO DR. KEITH SHERWOOD OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.

\*IF YOU ARE COVERED BY AN H.M.O. AND HAVE NOT REQUESTED A REFERRAL FROM YOUR PRIMARY CARE PROVIDER PRIOR TO THIS VISIT THE FOLLOWING MUST BE SIGNED:

\_\_\_\_\_ I AM BEING SEEN TODAY BY DR. KEITH SHERWOOD WITHOUT A \_\_\_\_\_ REFERRAL. I UNDERSTAND THAT I AM RESPONSIBLE FOR THE CHARGES FOR ANY SERVICES PROVIDED TO ME IF PAYMENT IS DENIED BECAUSE NO VALID REFERRAL WAS GENERATED AND AGREE TO PAY FOR SERVICES IN THAT EVENT.

FINANCIAL ARRANGEMENTS DISCLAIMER:

INSURANCE COVERAGE IS ESTIMATED. YOUR ACTUAL INDEMNITY MAY BE MORE OR LESS. YOU, THE PATIENT, ARE RESPONSIBLE FOR ALL AMOUNTS NOT COVERED BY YOUR INSURANCE CARRIER. ULTIMATELY, YOU ARE RESPONSIBLE FOR ALL FINANCIAL OBLIGATIONS FOR YOUR HEALTHCARE SERVICES. IF FOR SOME REASON THE ACCOUNT SHOULD BECOME DELINQUENT, YOU AGREE TO PAY FOR ALL REBILLING CHARGES, INTEREST CHARGED, COLLECTION COSTS AND ATTORNEY FEES.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date