# TRADE WINDS DENTAL

Derek M. Winegar, D.D.S.

www.TradeWindsDental.com

We know you have many choices for dentists in our area. We are honored that you have selected our office.
To help us meet all your healthcare goals, please fill out this form completely.
If there is anything on this form which is unclear, feel free to ask us about it. We will be happy to assist you.

## PATIENT INFORMATION

**NAME** (FIRST, MIDDLE, LAST): ______________________ TODAY'S DATE: ______________
**I PREFER TO BE ADDRESSED AS:** ______________________ BIRTHDATE: ______________

EMAIL ADDRESS: ______________________ CELL PHONE: ______________

MAILING ADDRESS: ______________________ HOME PHONE: ______________
CITY: ______________ STATE: __________ ZIP: __________

SS#: ______________ STATE DRIVER'S LICENSE/ID #: ______________

EMPLOYER: ______________________ WORK PHONE: ______________
BUSINESS ADDRESS: ______________________
CITY: ______________ STATE: __________ ZIP: __________

**WHAT IS THE BEST WAY TO CONTACT YOU?** ☐ HOME ☐ CELL ☐ WORK ☐ E-MAIL

PLEASE CHECK IF YOU ARE: ☐ MINOR ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

IF STUDENT, NAME OF SCHOOL/COLLEGE: ______________________ STATUS: ☐ FULL-TIME ☐ PART-TIME

**PERSON TO CONTACT IN CASE OF EMERGENCY:** ______________________ PHONE: ______________
RELATIONSHIP TO PATIENT: ______________________

**WHOM MAY WE THANK FOR REFERRING YOU?**
☐ INTERNET SEARCH ☐ ONLINE DIRECTORY ☐ PHONE BOOK
☐ WEBSITE ☐ SUN CITY DIRECTORY ☐ MAILER
☐ FRIEND/FAMILY ______________________ ☐ YELP
☐ OTHER: ______________________ ☐ HEALTHGRADES

**PLEASE TELL US WHAT'S IMPORTANT TO YOU IN FINDING A DENTIST:** ______________________
______________________________________________
______________________________________________
______________________________________________

☐ ***CHECK HERE IF RESPONSIBLE PARTY IS SELF/PATIENT AND PROCEED TO MEDICAL HISTORY SECTION ON BACK***

***RESPONSIBLE PARTY*** (FIRST, MIDDLE, LAST): ______________________ CELL PHONE: ______________
RELATIONSHIP TO PATIENT: ______________ BIRTHDATE: ______________
ADDRESS: ______________________ HOME PHONE: ______________
CITY: ______________ STATE: __________ ZIP: __________
EMAIL ADDRESS: ______________
______________
______________
______________

PLEASE CHECK IF: ☐ MINOR ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

SS#: ______________ STATE DRIVER'S LICENSE/ID #: ______________

**RESPONSIBLE PARTY'S EMPLOYER:** ______________________ WORK PHONE: ______________
BUSINESS ADDRESS: ______________________
CITY: ______________ STATE: __________ ZIP: __________

**IS THE RESPONISBLE PARTY CURRENTLY A PATIENT IN OUR OFFICE?** ☐ YES ☐NO

OVER PLEASE FOR PATIENT MEDICAL HISTORY

PATIENT'S PREFERRED PHARMACY: ________________________________ PHARMACY PHONE: ________________________

1. Are you undergoing medical treatment now, or under a physician's care? ☐ YES ☐NO
If yes, please explain:
______________________________________________
______________________________________________

PHYSICIAN:______________________________________
PHYSICIAN's PHONE: ______________________________

2. Have you been hospitalized for a surgical operation or illness within the last 5 years? ☐ YES ☐NO
If yes, please explain:
______________________________________________
______________________________________________
______________________________________________

3. Have you had a serious head or neck injury? ☐ YES ☐NO

4. Are you taking any medication(s), including non-prescription medicine? ☐ YES ☐NO
If yes, please list the medications:
______________________________________________
______________________________________________
______________________________________________
______________________________________________

5. Do you take, or have you taken, Phen-fen or Redux? ☐ YES ☐NO

6. Have you ever taken Fosamax, Boniva, Actonel or any other medications containing biphosphonates? ☐ YES ☐NO

7. Are you on a special diet? ☐ YES ☐NO
If yes, please explain:
______________________________________________
______________________________________________

8. ARE YOU ALLERGIC TO, OR HAVE YOU HAD ANY REACTION TO, THE FOLLOWING:

| | | |
|---|---|---|
| ASPIRIN | ☐ YES | ☐NO |
| CODEINE | ☐ YES | ☐NO |
| LOCAL ANESTHETICS | ☐ YES | ☐NO |
| PENICILLIN | ☐ YES | ☐NO |
| SULFA DRUGS | ☐ YES | ☐NO |
| SEDATIVES | ☐ YES | ☐NO |
| IODINE | ☐ YES | ☐NO |
| ANY METALS (i.e. NICKEL, MERCURY, ETC.) | ☐ YES | ☐NO |
| LATEX RUBBER | ☐ YES | ☐NO |
| ACRYLIC | ☐ YES | ☐NO |
| OTHER ANTIBIOTICS ____________ | ☐ YES | ☐NO |
| OTHER ____________ | ☐ YES | ☐NO |

9. Do you use tobacco? ☐ YES ☐NO

10. Do you use controlled substances? ☐ YES ☐NO

11. WOMEN ONLY:

| | | |
|---|---|---|
| Are you pregnant? | ☐ YES | ☐NO |
| Are you trying to get pregnant? | ☐ YES | ☐NO |
| Are you taking oral contraceptives? | ☐ YES | ☐NO |
| Are you nursing? | ☐ YES | ☐NO |

12. Do you have or have you had any of the following?

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| AIDS/HIV POSITIVE | ☐ YES | ☐NO | EXCESSIVE BLEEDING | ☐ YES | ☐NO | LUNG DISEASE | ☐ YES | ☐NO |
| ALZHEIMER'S DISEASE | ☐ YES | ☐NO | EXCESSIVE THIRST | ☐ YES | ☐NO | MITRAL VALVE PROLAPSE | ☐ YES | ☐NO |
| ANAPHYLAXIS | ☐ YES | ☐NO | FAINTING SPELLS/DIZZINESS | ☐ YES | ☐NO | OSTEOPOROSIS | ☐ YES | ☐NO |
| ANEMIA | ☐ YES | ☐NO | FREQUENT COUGH | ☐ YES | ☐NO | PAIN IN JAW JOINTS | ☐ YES | ☐NO |
| ANGINA | ☐ YES | ☐NO | FREQUENT DIARRHEA | ☐ YES | ☐NO | PARATHYROID DISEASE | ☐ YES | ☐NO |
| ARTHRITIS/GOUT | ☐ YES | ☐NO | FREQUENT HEADACHES | ☐ YES | ☐NO | PSYCHIATRIC CARE | ☐ YES | ☐NO |
| ARTIFICIAL HEART VALVE | ☐ YES | ☐NO | GENITAL HERPES | ☐ YES | ☐NO | RADIATION TREATMENTS | ☐ YES | ☐NO |
| ARTIFICAL JOINT ________ | ☐ YES | ☐NO | GLAUCOMA | ☐ YES | ☐NO | RECENT WEIGHT LOSS/GAIN | ☐ YES | ☐NO |
| ASTHMA | ☐ YES | ☐NO | HAY FEVER | ☐ YES | ☐NO | RENAL DIALYSIS | ☐ YES | ☐NO |
| BLOOD DISEASE | ☐ YES | ☐NO | HEART ATTACK/FAILURE | ☐ YES | ☐NO | RHEUMATIC FEVER | ☐ YES | ☐NO |
| BLOOD TRANSFUSION | ☐ YES | ☐NO | HEART MURMUR | ☐ YES | ☐NO | RHEUMATISM | ☐ YES | ☐NO |
| BREATHING PROBLEM | ☐ YES | ☐NO | HEART PACEMAKER | ☐ YES | ☐NO | SCARLET FEVER | ☐ YES | ☐NO |
| BRUISE EASILY | ☐ YES | ☐NO | HEART TROUBLE/DISEASE | ☐ YES | ☐NO | SHINGLES | ☐ YES | ☐NO |
| CANCER ____________ | ☐ YES | ☐NO | HEMOPHILIA | ☐ YES | ☐NO | SICKLE CELL DISEASE | ☐ YES | ☐NO |
| CHEMOTHERAPY | ☐ YES | ☐NO | HEPATITIS A | ☐ YES | ☐NO | SINUS TROUBLE | ☐ YES | ☐NO |
| CHEST PAINS | ☐ YES | ☐NO | HEPATITIS B OR C | ☐ YES | ☐NO | SPINA BIFIDA | ☐ YES | ☐NO |
| COLD SORES/FEVER BLISTERS | ☐ YES | ☐NO | HERPES | ☐ YES | ☐NO | STOMACH/INTESTINE DISEASE | ☐ YES | ☐NO |
| CONGENTIAL HEART DISEASE | ☐ YES | ☐NO | HIGH BLOOD PRESSURE | ☐ YES | ☐NO | STROKE | ☐ YES | ☐NO |
| CONVULSIONS | ☐ YES | ☐NO | HIGH CHOLESTEROL | ☐ YES | ☐NO | SWELLING OF LIMBS | ☐ YES | ☐NO |
| CORTISONE MEDICINE | ☐ YES | ☐NO | HIVES OR RASH | ☐ YES | ☐NO | THYROID DISEASE | ☐ YES | ☐NO |
| DIABETES | ☐ YES | ☐NO | HYPOGLYCEMIA | ☐ YES | ☐NO | TONSILITIS | ☐ YES | ☐NO |
| DRUG ADDICTION | ☐ YES | ☐NO | IRREGULAR HEARTBEAT | ☐ YES | ☐NO | TUBERCULOSIS | ☐ YES | ☐NO |
| EASILY WINDED | ☐ YES | ☐NO | KIDNEY PROBLEMS | ☐ YES | ☐NO | TUMORS OR GROWTHS | ☐ YES | ☐NO |
| EMPHYSEMA | ☐ YES | ☐NO | LEUKEMIA | ☐ YES | ☐NO | ULCERS | ☐ YES | ☐NO |
| EPILEPSY OR SEIZURES | ☐ YES | ☐NO | LIVER DISEASE | ☐ YES | ☐NO | VENEREAL DISEASE | ☐ YES | ☐NO |
| OTHER ________________ | | | LOW BLODD PRESSURE | ☐ YES | ☐NO | YELLOW JAUNDICE | ☐ YES | ☐NO |

## *AUTHORIZATION, RELEASE AND ACKNOWLEDGMENT*

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits, as needed, otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for these services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

I have been informed of the Notice of Privacy Practice for Trade Winds Dental, PLLC. explaining my rights as a patient, and have been given an opportunity to review it. I understand the Notice of Privacy Practice is available online for viewing and printing at www.TradeWindsDental.com. I also understand I may request a copy of the Notice of Privacy Practice at any time. I understand electronic communications between Trade Winds Dental and me are not encrypted and the information may be vulnerable to interception.

☐ YES, you may... ☐ NO, you may not... use my testimonial, photos and name to let other patients know about my great experience with your office.

X______________________________________ ______________________
Patient Signature (or parent/guardian if minor) 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.

We, at TRADE WINDS DENTAL, P.A., recognize that protecting your privacy and confidentiality is very important. We strive to ensure information integrity and security in everything we do. The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health 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.

Without specific written authorization, we are 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. Personal health information may be used and shared with, but not limited to, other healthcare providers and their teams, such as doctors and specialists, and medical and/or dental labs when determining and executing the best treatment options for you. Examples of treatment would include crowns, fillings, oral hygiene services, etc.

- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. For the purposes of timely payment and collection for services rendered, we may bill your dental plan for your dental services, or submit information on delinquent accounts to collection agencies.

- **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. Examples include a periodic assessment of our documentation protocols, the use of a consultant, computer upgrades, etc.

In addition, your confidential information may be used to remind you of an appointment by phone, mail (postcard), and/or email, or provide you with information about treatment alternatives or other health-related services via phone, fax, mail, or email. Any electronic communication allows the possibility of interception of electronic protected health information. 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.

Access to our patients' information is limited to our business associates and healthcare team who need it to adequately perform their job functions. We implement and use as many security methods possible to ensure your privacy. Examples of such measures are the use of a paper shredder to discard documents containing personal information, computer user identification codes, passwords, locks, etc. Our business philosophy and practice helps ensure that the personal health information of our patients are properly gathered, processed, and stored. We continually educate ourselves on technological advances, striving to incorporate the electronic means currently available that promote confidentiality and business efficiency for our patients. Team members who misuse such information are subject to disciplinary actions.

You have certain rights in regards to your protected health information, which you can exercise by presenting a written request to our Privacy Officer at the practice address listed below:

- 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 request to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to access, inspect and copy your protected health information.
- The right to request an amendment to your protected health information.
- The right to receive an accounting of disclosures of protected health information outside of treatment, payment and health care operations.
- The right to obtain a paper copy of this notice from us upon request.
- The right to obtain information in electronic form not later than 15 business days after receiving a written request, unless there is an allowable exception.

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 August 29, 2012. 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.

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, in the event 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,
Please contact:

TRADE WINDS DENTAL, P.A.
Privacy Official • Alanna Gail
3613 Williams Drive, Suite 1001
Georgetown, TX 78628-3201
512.863.6888
info@TradeWindsDental.com

For more information about HIPAA, or to file a complaint,
Please contact:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
877.696.6775 (toll-free)

# NOTICE OF HEALTH INFORMATION PRACTICES ACKNOWLDEGEMENT FORM

*The attached notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please sign this cover sheet acknowledging receipt of the policy and return it to the office administrator. Review the policy carefully and let us know if you have any questions or requests.*

By my signature below, I acknowledge that I have received the Notice of Health information Practices of Trade Winds, Dental, P.A. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to request restrictions as to how my health information may be used or disclosed and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

________________________________________
Name of Patient

________________________________________
Signature of Patient

________________________________________
Date