SCOTT HERRE
DENTISTRY

INTEGRITY ♦ CARE ♦ EXCELLENCE

Our Philosophy

Integrity

We are committed to treating each patient with honesty and respect. Every decision made and every action taken is done so with the patient's well-being in mind.

Care

We are committed to recognizing the individuality of each patient. Building a communicative and long lasting relationship with each member of our dental family is out top priority. We strive to provide personalized care with specific consideration to the physical, emotional, and financial needs of each patient.

Excellence

We are committed to providing the best care that modern dentistry has to offer. We combine cutting edge technology with state-of-the-art equipment to ensure the long-term dental health of each patient.

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that it is my responsibility to inform this office of any changes in my medical status. I authorize the staff of Scott Herre Dentistry to perform any necessary dental services, such as radiographs, study models, the taking of photographs or any other services deemed appropriate by the dentist. I also authorize the dentist and staff to perform any and all dental treatment as necessary. It is my understanding that I am responsible for all fees, and that payment is due at the time of service unless previous arrangements have been made.

Patient Signature: _____ Date: _____

Witness: _____

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Privacy Practices

Notice of Privacy Practices Acknowledgement

Scott B. Herre Dentistry
11237 Nall Avenue, Suite 140
Leawood, KS 66211

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I acknowledge that I have received your *Notice of Privacy Practices* containing more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change it's *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____ Date: _____

Office Use Only

I attempted to obtain the patient's signature in acknowledgement of this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date _____ Initials _____ Reason _____

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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 (HIPPA) 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 new rights to understand and control how your health information is used. HIPPA provides penalties for covered entities that misuse personal health information.
As required by HIPPA, 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 healthcare operations.

- Treatment means providing, coordinating, or managing healthcare and related services by one or more health care providers. An example of this would include teeth cleaning services.
- 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.
- Healthcare Operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis, and consumer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified 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.
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 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 accounting 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 or by mail before your service date.
- The right to provide and we are obligated to receive a written aknowledgement that you have received a copy of our Notice of Privacy Practices.

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 December 1, 2002 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 violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us
for more information:
Privacy Officer
Scott Herre Dentistry
11237 Nall Ave.,Ste 140
Leawood, KS 66211
913 912-7341

For more information about
HIPAA or to file a complaint:
The U.S Department of
Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, DC 20201
202.619.0257
Toll Free: 1.877.696.6775

SCOTT HERRE
DENTISTRY

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Patient Information

Date
Patient Name
Address
City State Zip
Best way to contact you: H W C Phone E-mail Text message
Home Phone No.
Work Phone No.
Cellular Phone No.
E-mail Address
Birth date Age Male ❑ Female ❑
Social Security Number
Married ❑ Single ❑ Divorced ❑ Widowed ❑
Employer Position
School

The best time for your appointments are at:

_____ AM _____ PM

The best day of the week is: (circle one or more)

M T W T R

Emergency Contact Information:
Name
Relationship
Phone Number
Address
City State Zip

Who may we thank for referring you:
❑ Friend's Name
❑ Website/Internet Search
❑ Other

Responsible Party
Address
City State Zip
Responsible Party Social Security Number

Notes

DENTAL INSURANCE INFORMATION

PRIMARY INSURANCE Group#		Policyholder ID#
Insurance Company		Insurance Company Address(P.O.Box/Street)
Insurance Company Phone	Policy Holder	City State Zip
Policy Holder's Birthdate	Policy Holder's Social Security No.	Persons covered under this policy
Employer Name		
Employer Address		Employer Phone

SECONDARY INSURANCE Group#		Policyholder ID#
Insurance Company	Insurance Company Phone	Insurance Company Address (P.O. Box/Street)
Policy Holder	Persons Covered Under This Policy	City State Zip

AUTHORIZATION/RELEASE OF INFORMATION. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

SIGNATURE OF RESPONSIBLE PARTY _____

❑ Adult Patient ❑ Father (or husband) ❑ Mother (or wife) ❑ Guardian

DOCTOR SIGNATURE _____ Date _____ State Driver's License Number _____

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Health History

Correct answers to the following questions will allow Dr. Herre to treat you on a more individual basis, providing the care appropriate for your particular needs. Your answers are for our records only and will be kept confidential.

Name_____ Birthdate_____ Age_____

Why are you now seeking dental treatment?_____

Please answer each question. Circle Yes or No. If in doubt, leave blank.

1. Are you in good health now? ..... Yes No

2. Are you under the care of a physician? ..... Yes No

If so, what is the condition being treated?_____

Your Physician's name_____ Phone Number._____

3. Have you ever been hospitalized or had a serious illness? ..... Yes No

If yes, explain._____

4. Have you ever had excessive bleeding following an extraction, or do cuts take longer to heal now than previously? ..... Yes No

5. (Women) are you pregnant? If so, give due date._____ Yes No

6. Are you taking birth control pills? ..... Yes No

7. Do you use tobacco in any form? If yes, how much ..... Yes No

8. Do you use alcoholic beverages (more than 2 drinks a day) ..... Yes No

9. Do you have, or have you ever had any of the following?

GENERAL		
Tire easily, weakness	Yes	No
Marked weight change	Yes	No
Persistent fever	Yes	No
SKIN		
Eruptions (rash) hives	Yes	No
Change in skin color	Yes	No
EYES		
Visual change	Yes	No
Glaucoma	Yes	No
EARS		
Loss of hearing	Yes	No
Ringing in ears	Yes	No
NOSE		
Frequent nosebleeds	Yes	No
Sinus problems	Yes	No
THROAT		
Soreness/hoarsness	Yes	No
NERVOUS SYSTEM		
Stroke	Yes	No
Headaches	Yes	No
Convulsions/epilepsy	Yes	No
Numbness/tingling	Yes	No
Dizziness/fainting/vertigo	Yes	No
Psychiatric treatment	Yes	No
RESPIRATORY		
Tuberculosis	Yes	No
Emphysema	Yes	No
Asthma/hay fever	Yes	No
Persistent cough	Yes	No
ENDOCRINE		
Diabetes	Yes	No
Family history of diabetes	Yes	No
Thyroid condition/goiter	Yes	No
Other_____		

HEART/BLOOD VESSELS		
Rheumatic Fever	Yes	No
Heart Murmur	Yes	No
Chest pain/discomfort	Yes	No
Heart attack/trouble	Yes	No
Shortness of breath	Yes	No
High blood pressure	Yes	No
Congenital heart disease	Yes	No
Artificial heart valve	Yes	No
Pacemaker	Yes	No
Heart surgery	Yes	No
Other_____		
BONE/MUSCLES		
Arthritis/rheumatism	Yes	No
Artificial joints	Yes	No
DIGESTIVE SYSTEM		
Hepatitis (any form)	Yes	No
Jaundice	Yes	No
Ulcers	Yes	No
Change in appetite	Yes	No
URINARY		
Kidney disease	Yes	No
Increase in frequency of urination (night)	Yes	No
Sexually transmitted disease	Yes	No
BLOOD		
Bruise easily	Yes	No
Anemia	Yes	No
Blood transfusion	Yes	No
OTHER		
Radiation therapy	Yes	No
Tumors or growths	Yes	No
Cancer	Yes	No
AIDS/HIV Positive	Yes	No
Sore/enlarged Lymph Nodes	Yes	No

10. Are you required to premedicate prior to dental treatment? Yes No

Please complete the second page

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Health History pg 2

11. Are you ALLERGIC or have you ever experienced any reaction to the following?

Local anesthetics (e.g. Novocain)	Yes	No	Aspirin or codeine	Yes	No
Barbiturates/sedatives/sleeping pills	Yes	No	Sulfa drugs	Yes	No
Penicillin/other antibiotics	Yes	No	Other allergies_____		

12. Are you taking any of the following?

Antibiotics/sulfa drugs	Yes	No	Anti-depressants/Anti-anxiety drugs	Yes	No
Blood thinners	Yes	No	Insulin/other diabetes drugs	Yes	No
Blood pressure medication	Yes	No	Recreational drugs	Yes	No
Thyroid medication	Yes	No	Digitalis/other heart medications	Yes	No
Cortisone/steroids	Yes	No	Nitroglycerin	Yes	No
Antihistamines/allergy drugs/cold remedies	Yes	No	Aspirin	Yes	No
			Other medication_____		

If yes to any of the above, list name of medication and dosage below:

1._____ 3._____

2._____ 4._____

13. Is there any disease, condition or problem not listed above that you think we should know about, or is there any activity your doctor says you cannot do? If so, explain_____

14. Do you have a specific dental problem at this time? If so, explain_____

15. Have you ever had any serious trouble associated with previous dental treatment? Yes No
If so, explain_____

16. Does dental treatment make you nervous? No Slightly Moderately Extremely

17. Date of last dental visit_____ Dentist's Name_____

18. Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? Yes No
If so, when?_____

19. Do you have or have you ever had any of the following?

MOUTH

Bleeding, sore gums	Yes	No
Unpleasant taste/bad breath	Yes	No
Burning tongue/lips	Yes	No
Fever blister, lips/mouth	Yes	No
Swelling/lumps in mouth	Yes	No
Orthodontic treatments (braces)	Yes	No
Biting cheeks/lips	Yes	No
Clicking/popping jaw	Yes	No
Difficulty opening or closing jaw	Yes	No

JAW

Have you ever been diagnosed with a "TMJ" problem?

Does your jaw pop or click when you open your mouth?	Yes	No
Are you aware of any clenching or grinding of your teeth?	Yes	No
Do you have pain or difficulty opening your mouth wide?	Yes	No
Do you have a history of headaches or neck aches?	Yes	No

TEETH

Loose teeth	Yes	No
Sensitive to hot	Yes	No
Sensitive to cold	Yes	No
Sensitive to sweets	Yes	No
Sensitive to biting	Yes	No
Food impaction between teeth	Yes	No
Clenching/grinding	Yes	No
Shifting of teeth	Yes	No
Change in bite	Yes	No

How often do you brush?_____
Brush is: soft medium hard
How often do you floss?
_____

20. Circle one:

A. My mouth is:
(a) very comfortable
(b) moderately comfortable
(c) uncomfortable

B. (a) think the appearance of my mouth is excellent
(b) am satisfied with the appearance of my mouth
(c) am dissatisfied with the appearance of my mouth

C. (a) will do anything to keep my natural teeth.
(b) want to keep my teeth, but have a certain budget of time and money

D. (a) have set goals for my dental health
(b) want to set goals concerning my dental health

E. (a) have always done the best that was recommended for my dental health
(b) have not done what dentists have recommended
(c) rarely go, and don't care much about having dental work completed

F. (a) have put dentistry for myself and family high on my priority list
(b) have put dentistry for myself and family low on my priority list
(c) dentistry is on my list but it is hard to find

G. I think my present state of dental health is
(a) Excellent (b) Good (c) Poor

21. What are some questions about dentistry and your dental health that you have never adequately had answered?_____
_____

PATIENT SIGNATURE _____

DOCTOR SIGNATURE _____

DATE _____

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