Shadow Mountain Dental
Meghan McMenemy, D.D.S
3901 Louisiana Blvd Suite F
Albuquerque,NM 87110

Date _____

Name _____ **Date of Birth** _____

Address _____ ZIP: _____ **Telephone** _____

Business Address _____ **Business Phone** _____

SS # _____

Patient Medical History

Physician _____ *Office Phone* _____ *Date of Last Exam* _____

	Yes	No
1. *Are you under medical treatment now?*	☐	☐
2. *Have you ever been hospitalized for any surgical operation or serious illness?*	☐	☐
3. *Are you taking any medication(s) including non-prescription medicine?* *If yes, what medication(s) are you taking?* _____	☐	☐
4. *Do you use tobacco?*	☐	☐
5. *Do you use alcohol, cocaine or other drugs?*	☐	☐
6. *Are you wearing contact lenses?*	☐	☐

7. *Are you allergic to or have you had any reactions to the following?*	Yes	No
Local Anesthetics (eg. novocaine)	☐	☐
Penicillin or other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Other	☐	☐

8. *Women Only:*	Yes	No
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking birth control pills?	☐	☐

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

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	*Heart Disease*	☐	☐	*Chest Pains*	☐	☐
Heart Attack	☐	☐	*Cardiac Pacemaker*	☐	☐	*Easily Winded*	☐	☐
Rheumatic Fever	☐	☐	*Heart Murmur*	☐	☐	*Stroke*	☐	☐
Swollen Ankles	☐	☐	*Angina*	☐	☐	*Hay Fever / Allergies*	☐	☐
Fainting / Seizures	☐	☐	*Frequently Tired*	☐	☐	*Tuberculosis*	☐	☐
Asthma	☐	☐	*Anemia*	☐	☐	*Radiation Therapy*	☐	☐
Low Blood Pressure	☐	☐	*Emphysema*	☐	☐	*Glaucoma*	☐	☐
Epilepsy / Convulsions	☐	☐	*Cancer*	☐	☐	*Recent Weight Loss*	☐	☐
Leukemia	☐	☐	*Arthritis*	☐	☐	*Liver Disease*	☐	☐
Diabetes	☐	☐	*Joint Replacement or Implant*	☐	☐	*Heart Trouble*	☐	☐
Kidney Diseases	☐	☐	*Hepatitis / Jaundice*	☐	☐	*Respiratory Problems*	☐	☐
AIDS or HIV Infection	☐	☐	*Sexually Transmitted Disease*	☐	☐	*Other*	☐	☐
Thyroid Problem	☐	☐	*Stomach Troubles / Ulcers*	☐	☐			

Patient Dental History

	Yes	No
1. *Do your gums bleed while brushing or flossing?*	☐	☐
2. *Are your teeth sensitive to hot or cold liquids/foods?*	☐	☐
3. *Are your teeth sensitive to sweet or sour liquids/foods?*	☐	☐
4. *Do you feel pain to any of your teeth?*	☐	☐
5. *Do you have any sores or lumps in or near your mouth?*	☐	☐
6. *Have you had any head, neck or jaw injuries?*	☐	☐
7. *Have you ever experienced any of the following problems in your jaw?*		
a) Clicking?	☐	☐
b) Pain (joint, ear, side of face)?	☐	☐
c) Difficulty in opening or closing?	☐	☐
d) Difficulty in chewing?	☐	☐

	Yes	No
8. *Do you have frequent headaches?*	☐	☐
9. *Do you clench or grind your teeth?*	☐	☐
10. *Do you bite your lips or cheeks frequently?*	☐	☐
11. *Have you ever had any difficult extractions in the past?*	☐	☐
12. *Have you had any orthodontic work?*	☐	☐
13. *Have you ever had any prolonged bleeding following extractions?*	☐	☐
14. *Have you ever had instruction on the correct method of brushing your teeth?*	☐	☐
15. *Have you ever had instructions on the care of your gums?*	☐	☐

Signature _____

86757-F

PATIENT MEDICATION INFORMATION

NAME: _____ **DATE:** _____

NAME OF DRUG /	PURPOSE /	STRENGTH /	TIMES A DAY /	PRESCRIBING DR.

Any changes in these medications will need to be updated with our office as soon as possible. We appreciate your cooperation in this matter.

Meghan McMenemy, D.D.S.
3901-F Louisiana, NE
Albuquerque, NM 87110
Telephone (505) 881-8441

NOTICE OF PRIVACY PRACTICE CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Policies
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition treatment upon the execution of this Consent.

May we call your home and/or work to confirm future appointments? YES____ NO____

Is there anyone with you now or at home that you DO NOT want your case discussed with? NO____ YES____ if so, please name_____

This Consent was signed by: _____ Date _____
Signature - Patient or Representative

_____
Printed Name

Relationship to Patient (if other than patient):_____

In front of _____
Printed name – Practice representative

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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 protected health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 3/15/2013, 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 provide the new Notice at our practice location, and we will distribute it 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.

Your Authorization: In addition to our use of your health information for the following purposes, 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.

Security: You will be notified as soon as possible if the security of your personal health information is breached.

Uses and Disclosures of Health Information

We use and disclose health information about you without authorization for the following purposes.

Treatment: We may use or disclose your health information for your treatment. For example, we may disclose your health information to a physician, pharmacist, 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. 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, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

To You Or Your Personal Representative: 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 your personal representative, 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 absence or incapacity or in 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 your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

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

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization. We will not use your information for fundraising purposes without authorization. We will disclose any financial conflicts of interests that may be involved with your treatment.

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

Public Health and Public Benefit: We may use or disclose your health information to report abuse, neglect, or domestic violence; to report disease, injury, and vital statistics; to report certain information to the Food and Drug Administration (FDA); to alert someone who may be at risk of

contracting or spreading a disease; for health oversight activities; for certain judicial and administrative proceedings; for certain law enforcement purposes; to avert a serious threat to health or safety; and to comply with workers' compensation or similar programs.

Decedents: We may disclose health information about a decedent as authorized or required by law.

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 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).

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. You may also request access by sending us a letter to the address at the end of this Notice. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying. If you request copies, we will charge you $0.25 for each page to 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. In most cases we are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in certain circumstances where disclosure is required or permitted, such as an emergency, for public health activities, or when disclosure is required by law). We must comply with a request to restrict the disclosure of protected health information to a health plan for purposes of carrying out payment or health care operations (as defined by HIPAA) if the protected health information pertains solely to a health care item or service for which we have been paid out of pocket in full.

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

Non-disclosure to insurance company: If you pay out of pocket, in full, for a service or a procedure or service; we will not submit the claim for that service to your insurance company upon your request.

Electronic Notice: You may receive a paper copy of this notice upon request.

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.