WELCOME

We are pleased to welcome you to our practice. Please take a few minutes to fill this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Patient's Name: _____
Last Name First Name Middle Initial

Soc. Sec. # _____ Patient's Birthdate:_____/_____/_____ Sex: M____ F____

Email: _____

Cell: _____ Home Phone #_____

Residence Address: _____

City:_____ State:_____ Zip: _____

How would you like to be contacted? Please choose one:

Home Phone: ☐ Email: ☐ Text: ☐ Cell: ☐ Cell Phone Company: _____

Patient Employed By: _____ Business Phone: _____

Spouse's Name:_____ SS #_____ Birthdate:____/____/____
Last Name First Name Initial

Spouse Employed By: _____ Business Phone: _____

In case of emergency who should be notified? _____
Name Phone #

Referred By (*Check All That Apply*): ☐ PRINT (*Mailer or Flyer*) ☐ ONLINE (*Facebook, Google , Website request*)
☐ TV (*TV ad or YouTube video*) ☐ FRIEND (*Pt of record, employee, or friend*)_____

Insurance

Person Responsible for Account:_____
Last Name First Name

Primary Dental Insurance Company:_____
Insured Name:_____

Secondary Dental Insurance Company: _____
Insured Name:_____

Authorization

- **I authorize the dentist to perform an examination, diagnostic procedures and prophylaxis as may be necessary for proper dental evaluation.**
- **I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dentist.**
- **I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered.**
- **I authorize the use of this signature on all insurance submissions.**
- **I authorize the dentist to release all information necessary to secure the payment of benefits.**
- **I understand that I am financially responsible for all charges whether or not paid by insurance.**

Signature:_____ Date: _____

Payment is due in full at time of treatment unless prior arrangements have been approved.

Minor

IF YOU ARE UNDER THE AGE OF EIGHTEEN YEARS:

Name of Father:_____ SS # _____ Birthdate:____/____/_____

Father Employed By:_____ Business Phone: _____

Name of Mother:_____ SS # _____ Birthdate:____/____/_____

Mother Employed By:_____ Business Phone:_____

It is important to tell all dental personnel involved in your treatment about the general state of your health. This information is confidential.

Name _____ Date of Birth _____

1. Former Dentist _____ Address _____
2. When did you last visit a dentist? _____ X-rays taken? Yes ____ No ____
   What was done at that time? _____
   Why did you leave that practice? _____
3. Have you lost or have had any teeth removed, including wisdom teeth? Yes ____ No ____
   Why? _____
4. Do you have any bridge work or dentures? _____
5. Are you unhappy with the replacement? Yes ____ No ____ Why _____
6. Do you feel your breath is offensive at times? Yes ____ No ____
7. Have you ever been told you have gum disease? Yes ____ No ____
8. Have you ever had gum treatment or Surgery? Yes ____ No ____
9. Does food chronically collect between your teeth? Yes ____ No ____
10. Are your teeth acutely sensitive to: Sweet ❑ Cold ❑ Heat ❑ Pressure ❑ No ❑
11. How often do you brush your teeth? _____
12. How often do you floss your teeth? _____
13. Do you clench or grind your teeth? Yes ____ No ____
14. Does your jaw click or pop? Yes ____ No ____
15. Do you have frequent headaches? Yes ____ No ____
16. Have you had any orthodontic work? Yes ____ No ____
17. Has any dental treatment been recommended to you that you have not had done? _____
    _____
18. Are you happy with the appearance of your smile? Yes ____ No ____ Explain _____
    _____
19. Anything else that would be valuable for me to know? Yes ____ No ____ Explain _____
    _____

I certify that the above information is complete and accurate.

Patient's/Guardian's Signature _____ Date _____

DENTAL HISTORY REPORT

HEALTH HISTORY

Patients Name: _____

It is important to tell all dental personnel involved in your treatment about the general state of your **health. This information is confidential.**

Patients Home/Cell Phone Number: _____

DATE OF BIRTH _____

Emergency Contact Name/Relationship _____ Phone # _____

Physician Name _____ Phone # _____

Physician Address _____

Mark your response if you have had any of the following diseases or problems. Y=Yes, N=No, DK=Don't Know

Y	N	DK	
☐	☐	☐	Have you ever been told you should be taking an antibiotic (premedication) prior to dental visits?
☐	☐	☐	Are you taking a blood thinner?
☐	☐	☐	Are you presently taking an osteoporosis medication?
☐	☐	☐	(Women) Are you pregnant/nursing?
☐	☐	☐	Do you have tuberculosis?

Y	N	DK	
☐	☐	☐	Any changes in your health within the past year?

Date of last physical examination: _____

Y	N	DK	Cardiovascular
☐	☐	☐	High Blood Pressure
☐	☐	☐	Angina (Chest Pain)
☐	☐	☐	Heart Attack
☐	☐	☐	Irregular Heart Beat
☐	☐	☐	Heart Surgery
☐	☐	☐	Heart Failure
☐	☐	☐	Damaged Heart Valve
☐	☐	☐	High Cholesterol
☐	☐	☐	Heart Infection
☐	☐	☐	Stroke

Y	N	DK	Hematologic
☐	☐	☐	Anemia
☐	☐	☐	Sickle Cell Anemia
☐	☐	☐	Excessive or Prolonged Bleeding

Y	N	DK	Respiratory
☐	☐	☐	Asthma
☐	☐	☐	Emphysema/Bronchitis
☐	☐	☐	Sleep Apnea
☐	☐	☐	Sinus Trouble

Y	N	DK	Endocrine
☐	☐	☐	Diabetes
☐	☐	☐	Thyroid Problem

Y	N	DK	Renal
☐	☐	☐	Kidney Disorder
☐	☐	☐	Dialysis

Y	N	DK	Immune
☐	☐	☐	Past use of Steroids
☐	☐	☐	Delayed Healing

Y	N	DK	Musculoskeletal
☐	☐	☐	Arthritis
☐	☐	☐	Artificial Joint (Date: _____)
☐	☐	☐	Fibromyalgia
☐	☐	☐	Lupus
☐	☐	☐	Sjogren's Syndrome
☐	☐	☐	Osteoporosis

Y	N	DK	Hepatic
☐	☐	☐	Liver Disease
☐	☐	☐	Jaundice
☐	☐	☐	Hepatitis

Y	N	DK	Gastrointestinal
☐	☐	☐	Acid Reflux/GERD
☐	☐	☐	Irritable Bowel Syndrome
☐	☐	☐	Stomach Ulcer

Y	N	DK	Neurologic
☐	☐	☐	Epilepsy/Seizures
☐	☐	☐	Parkinson's Disease
☐	☐	☐	Multiple Sclerosis
☐	☐	☐	Headaches

Y	N	DK	Skin
☐	☐	☐	Hives or Skin Rash
☐	☐	☐	Other Skin Lesions

Y	N	DK	Eyes/Ears
☐	☐	☐	Glaucoma
☐	☐	☐	Impaired Vision
☐	☐	☐	Detached Retina
☐	☐	☐	Impaired Hearing

Y	N	DK	Infections
☐	☐	☐	HIV Positive/AIDS
☐	☐	☐	Sexually Transmitted Disease

Are You Allergic to:

Y	N	DK	
☐	☐	☐	Local anesthetic
☐	☐	☐	Antibiotics
			List: _____
☐	☐	☐	Aspirin/Ibuprofen
☐	☐	☐	Acetaminophen/Tylenol
☐	☐	☐	Codeine/Narcotics
☐	☐	☐	Metals
☐	☐	☐	Latex
☐	☐	☐	Other
			List: _____

Y	N	DK	Mental Health
☐	☐	☐	Bipolar Disorder
☐	☐	☐	Depression
☐	☐	☐	Anxiety
☐	☐	☐	Eating Disorder
☐	☐	☐	Sleep Disorder
☐	☐	☐	Dementia
☐	☐	☐	Learning Disorders

Y	N	DK	Other
☐	☐	☐	Cancer
☐	☐	☐	Cancer Treatment
☐	☐	☐	Nursing Infant
☐	☐	☐	Tobacco Use
☐	☐	☐	Alcohol Use
☐	☐	☐	Chemical Dependency
☐	☐	☐	Street/Recreational Drugs

Have you had any other serious illness, hospitalization or accident?

If yes, please explain: _____

Patient's / Guardian's Signature _____ Date _____

Patients Name: ____________________

Patients Home/Cell Phone Number: ____________________

DATE OF BIRTH ____________________

Medication List

For use by dentist

Patient to fill out

Medication & Dose	Condition prescribed for	. MM/YYYY started	Update section (enter date of change & the new dose of medication. If discontinued, enter D/C)		
			Date/Change	Date/Change	Date/Change

OFFICE USE ONLY

DATE ____________

1. Any changes in medical history? Y or N
2. Are you under a doctor's care? Y or N
3. Any changes in medications or dosages? Y or N
4. Any new allergies? Y or N
5. Are you pregnant or nursing? Y or N

Notes: ____________________

Signature: ____________________

DATE ____________

1. Any changes in medical history? Y or N
2. Are you under a doctor's care? Y or N
3. Any changes in medications or dosages? Y or N
4. Any new allergies? Y or N
5. Are you pregnant or nursing? Y or N

Notes: ____________________

Signature: ____________________

DATE ____________

1. Any changes in medical history? Y or N
2. Are you under a doctor's care? Y or N
3. Any changes in medications or dosages? Y or N
4. Any new allergies? Y or N
5. Are you pregnant or nursing? Y or N

Notes: ____________________

Signature: ____________________

DATE ____________

1. Any changes in medical history? Y or N
2. Are you under a doctor's care? Y or N
3. Any changes in medications or dosages? Y or N
4. Any new allergies? Y or N
5. Are you pregnant or nursing? Y or N

Notes: ____________________

Signature: ____________________

Main Street Dental Clinics

comfortable dentistry

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign this Acknowledgement

I have received a copy of Main Street Dental Clinic's Notice of Privacy Practices.

Print Name: _____

Signature: _____

Date: _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____Individual refused to sign

_____Communications barriers prohibited obtaining the acknowledgement

_____An Emergency situation prevented us from obtaining acknowledgement

_____Other (please specify)

2016

405 East Main Street
Blooming Prairie, MN 55917
Blooming Prairie
(507) 583-2141
bloomingprairie@mainstreetdentalclinics.com

1170 E. Frontage Road
Owatonna, MN 55060
Owatonna
(507) 455-1000
owatonna@mainstreetdentalclinics.com

3110 Wellner Drive NE
Rochester, MN 55906
Rochester
(507) 536-7700
rochester@mainstreetdentalclinics.com

132 North Broadway
New Richland, MN 56072
New Richland
(507) 463-0502
newrichland@mainstreetdentalclinics.com

287 St. Andrews Drive, Suite #100
Mankato, MN 56001
Mankato
(507) 720-0250
mankato@mainstreetdentalclinics.com

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Main Street Dental Clinics

comfortable dentistry

UPDATED NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY. THE PRIVACY OF YOUR HEALTH 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.

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 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 written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

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 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 describe 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. By signing this Notice, you are NOT giving us authorization to use your health information for marketing purposes.

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 worker's compensation or similar programs.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorize 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 information of an inmate or patient under certain circumstances.

Secretary of HHS: We will disclose your health information to the Secretary of the US Dept of Health & Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation: We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement: We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Judicial and Administrative Proceedings: If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research: We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.
Coroners, Medical Examiners, and Funeral Directors: We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.
Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voice mail messages, postcards or letters.)

YOUR HEALTH INFORMATION 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 practically do so. You must make a request in writing to obtain access to your health information such as electronically. 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. If there is a cost to copying your personal health information we may charge you a reasonable, cost-based fee.

If you are denied a request, you have the right to have the denial reviewed in accordance with applicable law.

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 the additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both and (3) to whom you want the limits to apply. 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 concerns, 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 request this 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. We will accommodate all reasonable requests. However, if we are unable to contact you using the alternative, we will use what information we have.

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. If we agree to your request, we will amend your record and notify you of such. If we deny, we will provide you with a written explanation as to why it was denied.

Right to Notification of a Breach: You will receive notifications of breaches of your unsecured PHI as required by law.

Electronic Notice: You may receive a paper copy of this notice upon request, even if you have agreed to receive this notice electronically on our website or by e-mail.

QUESTIONS AND COMPLAINTS: If you want more information about our privacy practices or have questions, 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 you may notify us by using the contact information listed at the end of this Notice. You may also submit a written complaint to the US Department of Health and Human Services. We will provide you with the address to file your complaint 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 US Department of Health and Human Services.

CONTACT:	HIPAA COMPLIANCE COMMITTEE
TELEPHONE:	507-583-2141 Fax: 507-583-7574
E-MAIL:	oa@mainstreetdentalclinics.com
ADDRESS:	405 E. Main Street, Blooming Prairie, MN 55917