PATIENT INFORMATION

Name: ____ Preferred Name: ____________________
First Middle Last

Address: ____
Street City State Zip code

Home Phone: ___________________ Work: ___________________ Cell/Other: ____________________

Employer: ________________________________ Occupation: __________________________________

Employment Status: Full-Time ☐ Part-Time ☐ Student ☐ Retired ☐ Male ☐ Female ☐

Marital Status: Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐

DOB: _____ /_____ /_____ Social Security Number: ______________ Email: ______________________

Preferred Pharmacy: ______________________ How were you referred to our office? __________________

In case of emergency, notify: ____
Name Relationship Phone

FAMILY INFORMATION

Spouse's Name: ___________________ Employer: __________________ Occupation: ________________

Number of Children: _______ Children's names: ____

Is anyone in your family a patient of ours? ____

RESPONSIBLE PARTY (Spouses, Parents, or Legal Guardians)

Name: ______________________________ Relationship to Patient: Parent/Guardian ☐ Spouse ☐ Other ☐

Address: ____
Street City State Zip code

Home Phone: ___________________ Work: ___________________ Cell/Other: ____________________

Employer: ___________________________ DOB: _____/_____/_____ Social Security No: _____________

DENTAL INSURANCE

Carrier: __________________________________ Subscriber's Name: _____________________________

Subscriber's DOB: _____/_____/_____ Subscriber's Employer: _____________________________________

Subscriber's ID Number or Social Security No: __________________ Group Number: _________________

____ ___________________________

Signature of Patient, Parent or Guardian Date

*As a courtesy to our patients with insurance: We will gladly file your insurance claim on your behalf. However, assignment of benefits is not an option with certain insurance companies. If your insurance company is one of these companies, we kindly ask that you pay for the cost of our services rendered at the time of your appointment and your insurance company will reimburse you directly. Our staff will let you know if your insurance is one of these companies. If you would like an exception, we would be happy to discuss it with you.

RANDOLPH L. LAIS, DDS, PA

MEDICAL HISTORY

Name ______________________ Age ________ Date ______________

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Question	Yes	No	If yes, please explain:
Are you under a physician's care now?	○ Yes	○ No	If yes, please explain: ______
Have you ever been hospitalized or had a major operation?	○ Yes	○ No	If yes, please explain: ______
Have you ever had a serious head or neck injury?	○ Yes	○ No	If yes, please explain: ______
Are you taking any medication, pills, or drugs?	○ Yes	○ No	If yes, please explain: ______
Do you take, or have you taken, Phen-Fen or Redux?	○ Yes	○ No	If yes, please explain: ______
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	○ Yes	○ No	If yes, please explain: ______
Are you on a special diet?	○ Yes	○ No	If yes, please explain: ______
Do you use tobacco?	○ Yes	○ No	If yes, please explain: ______
Do you use controlled substances?	○ Yes	○ No	If yes, please explain: ______

Women: Are you

Pregnant/Trying to get pregnant? ○ Yes ○ No — Taking oral contraceptives? ○ Yes ○ No — Nursing? ○ Yes ○ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex

☐ Sulfa Drugs ☐ Other ☐ None If yes or other, please explain: ______________

Do you have, or have you had, any of the following?

Condition		Condition		Condition		Condition	
Acid Reflux	○ Yes ○ No	Cortisone Medicine	○ Yes ○ No	Hemophilia	○ Yes ○ No	Radiation Treatments	○ Yes ○ No
AIDS/HIV Positive	○ Yes ○ No	Diabetes	○ Yes ○ No	Hepatitis A	○ Yes ○ No	Recent Weight Loss	○ Yes ○ No
Alzheimer's Disease	○ Yes ○ No	Drug Addiction	○ Yes ○ No	Hepatitis B or C	○ Yes ○ No	Renal Dialysis	○ Yes ○ No
Anaphylaxis	○ Yes ○ No	Easily Winded	○ Yes ○ No	Herpes	○ Yes ○ No	Rheumatic Fever	○ Yes ○ No
Anemia	○ Yes ○ No	Emphysema	○ Yes ○ No	High Blood Pressure	○ Yes ○ No	Rheumatism	○ Yes ○ No
Angina	○ Yes ○ No	Epilepsy or Seizures	○ Yes ○ No	High Cholesterol	○ Yes ○ No	Scarlet Fever	○ Yes ○ No
Arthritis/Gout	○ Yes ○ No	Excessive Bleeding	○ Yes ○ No	Hives or Rash	○ Yes ○ No	Shingles	○ Yes ○ No
Artificial Heart Valve	○ Yes ○ No	Excessive Thirst	○ Yes ○ No	Hypoglycemia	○ Yes ○ No	Sickle Cell Diseases	○ Yes ○ No
Artificial Joint	○ Yes ○ No	Fainting Spells/Dizziness	○ Yes ○ No	Irregular Heartbeat	○ Yes ○ No	Sinus Trouble	○ Yes ○ No
Asthma	○ Yes ○ No	Frequent Cough	○ Yes ○ No	Kidney Problem	○ Yes ○ No	Spina Bifida	○ Yes ○ No
Blood Disease	○ Yes ○ No	Frequent Diarrhea	○ Yes ○ No	Leukemia	○ Yes ○ No	Stomach/Intestinal Disease	○ Yes ○ No
Blood Transfusion	○ Yes ○ No	Frequent Headaches	○ Yes ○ No	Liver Disease	○ Yes ○ No	Stroke	○ Yes ○ No
Breathing Problem	○ Yes ○ No	Genital Herpes	○ Yes ○ No	Low Blood Pressure	○ Yes ○ No	Swelling of Limbs	○ Yes ○ No
Bruise Easily	○ Yes ○ No	Glaucoma	○ Yes ○ No	Lung Disease	○ Yes ○ No	Thyroid Disease	○ Yes ○ No
Cancer	○ Yes ○ No	Hay Fever	○ Yes ○ No	Mitral Valve Prolapse	○ Yes ○ No	Tonsillitis	○ Yes ○ No
Chemotherapy	○ Yes ○ No	Heart Attack/Failure	○ Yes ○ No	Osteoporosis	○ Yes ○ No	Tuberculosis	○ Yes ○ No
Chest pains	○ Yes ○ No	Heart Murmur	○ Yes ○ No	Pain in Jaw Joints	○ Yes ○ No	Tumors or Growths	○ Yes ○ No
Cold Sores/Fever Blisters	○ Yes ○ No	Heart Pace Maker	○ Yes ○ No	Parathyroid Disease	○ Yes ○ No	Ulcers	○ Yes ○ No
Congenital Heart Disorder	○ Yes ○ No	Heart Trouble/Disease	○ Yes ○ No	Psychiatric Care	○ Yes ○ No	Venereal Disease	○ Yes ○ No
Convulsions	○ Yes ○ No					Yellow Jaundice	○ Yes ○ No

Have you ever had any serious illness not listed above? ○ Yes ○ No If yes, please explain: ______________

Comments: ____

____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN ______________________ DATE ____________

DENTAL HEALTH, APPEARANCE & HISTORY

Name ____ Date ______________________________

What are the reasons for today's visit? ____

What primary concern would you like addressed first? ____

Are there any special dates/events you want to have your treatment completed before? Yes□ No□
If yes, please explain: ____

Previous Dental Care

Have you had regular preventative dental care? Yes□ No□

Approximate date of last dental visit: ____

What did you have done at last visit? ____

Previous dentist's name, address and phone number: ____

Have you had past orthodontic treatment? Yes□ No□

Have you had any serious problems with previous dental treatment? Yes□ No□
If yes, please explain: ____

What, if anything, happened in previous experiences at the dentist that was a reason for you not to return? ____

Current Dental Condition

How often do you brush? _________________________ Floss? (Routinely) _________________________

What type of brush do you use? Soft □ Med □ Hard □ Electric □

Do your gums bleed when brushing/flossing? Yes□ No□

Do your gums ever feel tender or swollen? Yes□ No□

Do you feel, or have you been told, you don't have fresh breath? Yes□ No□

Are your teeth sensitive to: Hot □ Cold □ Sweet □ Sour □ Chewing □ No sensitivity □

Do you usually have many cavities? Yes□ No□

Do you chew on only one side of your mouth? Yes□ No□
If yes, please explain ____

Are you aware of significant wear on your teeth? Yes□ No□

Do you clench or grind your teeth? Yes□ No□

Do your jaws ever "pop", feel tired, or ache? Yes□ No□

Do you have frequent headaches or earaches? Yes□ No□

Do you have any missing teeth? Yes□ No□

If yes, have you had the teeth replaced? Yes□ No□

If yes, are you pleased with the results? Yes□ No□

If no, are you interested in learning about your options to replace them? Yes□ No□

DENTAL HEALTH, APPEARANCE & HISTORY (continued)

Getting to know you and your goals

How important to you is the appearance of your smile? Extremely □ Moderately □ Not at all □

Please rate your smile from 1 (hate it) to 10 (awesome): 1□ 2□ 3□ 4□ 5□ 6□ 7□ 8□ 9□ 10□
Explain what made you choose that number: ____

If you could safely and easily whiten your teeth, would you be interested? Yes□ No□

Do you believe a great smile can benefit you both personally and professionally? Yes□ No□

What, if anything, would you like to change about your smile? ___________________________________

**There are several benefits to quality dental care. What benefits are most important to you at this time? Please rate the following from 1 (most important) to 7 (least important) using each number only once.*

____ **Comfort**—I don't want my teeth and jaws to hurt.

____ **Function**—I want to be able to chew my food well.

____ **Health**—A healthy mouth is necessary for a healthy body.

____ **Appearance**—A great smile is very important to me.

____ **Longevity**—I want treatment done correctly so it will last.

____ **Peace of Mind**—I want to know I am doing everything I can to prevent future problems.

____ **Other** ____

**Please help us understand your concerns regarding your dental care. Please rate the following from 1 (biggest concern) to 6 (least concern) using each number only once.*

____ **Time**—dental emergencies or treatment don't work into my schedule, I'm too busy.

____ **Fear/Anxiety**—coming to the dentist makes me nervous.

____ **Money**—Dental treatment is not something I can afford to spend extra money on.

____ **Trust**—I've had bad experiences with dentists in the past and am afraid to pursue treatment again.

____ **Physical Discomfort**—I have extreme sensitivity, and find dental treatment very painful and unpleasant.

____ **Other** ____

In some cases, great smiles and youthful faces cannot be achieved by treating only the teeth. If you would benefit from an interdisciplinary treatment involving a team approach, would you be interested in knowing about it? Yes□ No□ Maybe□

_______________________________________ _______________________

Patient Signature Date

NOTICE OF PRIVACY PRACTICES

This notice is to inform you that your personal health information will only be used for purposes of treatment in our facility and will not be misused or disclosed by anyone outside of our practice. You may gain access to this information if you desire.

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 on April 14, 2003 and will remain 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 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 who is currently providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you (i.e. insurance companies).

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 qualification of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

- **YOUR AUTHORIZATION**: You may give us written authorization to use your health information or to disclose it to anyone for any purpose (e.g. a family member picking up records, referral to a dental specialist, etc.). If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you hive a written authorization, we cannot use or disclose your health information for any reason except this 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 (included identifying or location) 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 or your health information, we will provide you with an opportunity to object to such use of 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 that 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.

- **MARKETING HEALTH-RELATION SERVICES**: Our dental office does not use patient information for any marketing purposes. We will not use your health information for marketing communication without your written authorization.

- **REQUIRED BY LAW**: We may use or disclose your health information when it is required by law to do so (i.e. missing person, etc.).

- **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 heath 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 lawfully authorize federal officials health information required by lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials 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 may request access by sending us a letter to the address a t the end of this notice. We may charge you a reasonable cost-based fee for expenses such as copies and staff time. You may request access by sending us a letter to the address at the end of this notice. 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 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 any purpose, 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 t these additional requests.

Restrictions: You have the right to request that we place additional restriction 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 Communications: You have the right to request that we communicate with you about your health information by alternative means for to alternative locations. You must make your request in writing. Your request must specify the alternative means or locations, 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. It must explain why the information should be amended. We may deny your request under certain circumstances.

Questions and Complaints: If you desire further information about our privacy practices or if you have questions, please contact us. If you are concerned that 1) we may have violated your privacy right) you disagree with a decision we made about access to your health information, 3) in response to a request you made to amend or restrict the use or disclosure of your health information or 4) 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 Officer: Dr. Randolph Lais, Privacy Officer, Owner

Telephone: (479) 845-1225

Address: 5508 Pinnacle Point Drive, Suite A
Rogers, AR 72758

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of Dr. Lais' **Notice of Privacy Practices**.

____

Patient Name (Please Print)

____

Signature of Patient or Guardian

____

Date

Please note: It is your right to refuse to sign this acknowledgement.

____

Office Use Only

We tried to obtain written acknowledgement, by the individual noted above, of receipt of the **Notice of Privacy Practices** for this office**,** but it could not be obtained because:

_____An emergency prevented us from obtaining acknowledgement.

_____A communication barrier prevented us from obtaining acknowledgement.

_____The individual was unwilling to sign the acknowledgement.

Other:
____
____
____

5508 Pinnacle Point Drive, Suite A, Rogers, Arkansas 72758
p) 479.845.1225 f) 479.845.1227 www.laisdentistry.com