



325 2nd Street, Monument, Colorado, 80132
 Telephone: 719.481.4949 Fax: 719.481.4989
 E-mail: info@monumentfamilydentistry.com
 Web Site: www.monumentfamilydentistry.com

Patient: _____ M: F: _____ / /
Last Name First Name Middle Initial Social Security Number Gender Age Date of Birth

Address: _____
Street Address, Building, Apartment # City State Zip Code

Phone: () _____ () _____ () _____
Home Phone Cell Phone Work Phone Extension

Email Address: _____ Referred to us by: _____

Employer: _____

Dental Insurance: _____ / / - -
Insurance Company Name of Policy Holder D.O.B. Social Security Number

Additional Insurance Information: _____
Please list any additional insurance companies and policies (if applicable)

Emergency Contact Information: _____ () _____
Name of person to be contacted in the event of an emergency Relationship to patient Area Code & Phone Number

Family Physician: _____
Name of your primary doctor and city (if other than Monument, CO)

Your general health condition: Poor: Fair: Good: Superman/woman: Are you taking any drugs/medications? No: Yes: (list below)

List drugs/medications: _____

Are you allergic to any medicines or materials? No: Yes: If yes, list: _____

Have you ever had an adverse reaction to local anesthesia? No: Yes: If yes, explain: _____

Have you ever had or been treated for any of the following? (check all that apply):

- | | | | | |
|---|---|--|--|---|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Anemia | <input type="checkbox"/> Cancer | <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Prolonged Bleeding | <input type="checkbox"/> Radiation Therapy | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stroke | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Implant Prosthesis |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> HIV / AIDS | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Congenital Heart Disease | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Fainting/Dizzy Spells | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Epilepsy |

Have you ever had a disease or medical condition not listed above? (if yes, describe below, and use the back of this page if you need more room):

Women only ► Are you pregnant? No: Yes: Maybe: If yes, what trimester? 1: 2: 3: Are you breast feeding? No: Yes:

Do you smoke or use tobacco? No: Yes: If yes, what type(s) and how often? _____

Date of last dental care: _____ / _____ / _____ Not sure: Date of last dental X-rays: _____ / _____ / _____ Not sure:

Is there anything about your mouth or teeth that bothers or concerns to you? (if yes, describe below, and use the back of this page if you need more room):

Are you satisfied with the way your teeth look, function and feel? Yes: No: (if no, explain below and use the back of this page if you need more room):

Signature of Patient or Guardian: _____ **Today's Date:** _____ / _____ / _____

If you have insurance: I authorize release of any information relating to dental claims and understand that I am responsible for all costs of dental treatment. I authorize payment directly to Dr. A. J. Gerathy Jr. of the group insurance benefits otherwise payable to me:

Signature of Patient or Guardian: _____ **Today's Date:** _____ / _____ / _____

FOR OFFICE USE ONLY:



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Notice of Privacy Practices

Purpose: This form presents information that federal law requires us to give our patients regarding our privacy practices. We must provide this Notice to each patient upon the date of our first service delivery, including services delivered electronically. We must make a good-faith attempt to obtain written acknowledgement of receipt of the Notice from the patient. We must also have the Notice available at the office for patients to request to take with them. We must post the Notice in our office in a clear and prominent location where it is reasonable to expect any patients seeking service from us to be able to read the Notice. Whenever the Notice is revised, we must make the Notice available upon request on or after the effective date of the revision in a manner consistent with the above instructions. Thereafter, we must distribute the Notice to each new patient at the time of service delivery and to any person requesting a Notice. We must also post the revised Notice in our office as discussed above.

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 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 January 1st, 2007, 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 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 providing treatment to you.
- **Payment:** We may use and disclose your health information to obtain payment for services we provide to you.
- **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 qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.
- **Your Authorization:** In addition to our use of your health information for treatment, payment or healthcare operations, 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.
- **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 (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 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 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.
- **Marketing Health-Related Services:** We will not use your health information for marketing communications without your written authorization.
- **Required by Law:** We may use or disclose your health information when we are required to do so by law.
- **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 health 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 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 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 will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you \$0.95 for each page, \$20.00 per hour for staff time to locate and 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. 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 Communication:** You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, 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, and it must explain why the information should be amended.) We may deny your request under certain circumstances.
- **Electronic Notice:** If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS:

If you would like 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 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.

Contact Officer:

Darcie Bissell

Telephone:

719.481.4949

Fax:

719.481.4989

E-mail:

info@monumentfamilydentistry.com

Address:

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

(Note: You have the right to decline to sign this form.)

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____ Date: ____/____/____
Patient or Guardian's Signature Month / Day / Year

FOR OFFICE USE ONLY:

We attempted to obtain the patient or guardian's written acknowledgment of receipt of our Notice of Privacy Practices, however could not obtain acknowledgement because:

- The patient or guardian declined to sign this form.
 - Communications barriers prevented us from obtaining acknowledgment.
 - An emergency situation prevented us from obtaining acknowledgment.
 - Other: _____
- _____
- _____
- _____



325 2nd St. (Northwest corner of Beacon Lite Road and 2nd St., 1 block west of the I-25 and Highway 105 interchange. Our office is in the north wing of the building)

Phone: 719.481.4949

