KENWOOD DENTAL

DENTISTRY FOR YOU

PATIENT INFORMATION (CONFIDENTIAL) EMAIL__________________________ DATE______________

NAME____ CELL PHONE _________________
FIRST MI LAST

ADDRESS_____________________________________CITY_____________STATE____ ZIP ______________

SSN___________________________BIRTHDATE__________________ WORK PHONE _________________

CHECK APPROPRIATE BOX: ☐ MINOR ☐ SINGLE ☐ MARRIED ☐ WIDOWED

PATIENT OR PARENT'S EMPLOYER_____________________________ OCCUPATION_________________

BUSINESS ADDRESS ________________________ CITY______________ STATE ______________________

SPOUSE OR PARENT NAME________________EMPLOYER_____________ WORK PHONE_______________

WHOM MAY WE THANK FOR REFERRING YOU? ____

PERSON TO CONTACT IN CASE OF EMERGENCY_____________________PHONE____________________

RESPONSIBLE PARTY

NAME OF PERSON RESONSIBLE FOR THIS ACCOUNT____________________ RELATIONSHIP TO PATIENT______________

ADDRESS____ DAYTIME PHONE_________________

BIRTHDATE________________________________ SSN ____

EMPLOYER____ WORK PHONE__________________

IS THIS PERSON CURRETNLY A PATIENT IN OUR OFFICE? ☐ YES ☐ NO

INSURANCE INFORMATION

NAME OF INSURED____RELATIONSHIP TO PATIENT_____________

BIRTHDATE____________________ SSN _________________________________DATE EMPLOYED_________

NAME OF EMPLOYER________________UNION OR LOCAL #_______________WORK PHONE____________

EMPLOYER ADDRESS__________________________CITY________________STATE _____ZIP___________

INSURANCE COMPANY____________________ CUST.SERV. PHONE _____________ ID#________________

GROUP#________________ CLAIMS ADDRESS________________CITY_________ STATE___ZIP__________

DO YOU HAVE ADDITIONAL INSURANCE? ☐ YES ☐ NO IF YES, COMPLETE THE FOLLOWING

NAME OF INSURED____RELATIONSHIP TO PATIENT_____________

BIRTHDATE____________________ SSN _________________________________DATE EMPLOYED_________

NAME OF EMPLOYER________________UNION OR LOCAL #_______________WORK PHONE____________

EMPLOYER ADDRESS__________________________CITY________________STATE _____ZIP___________

INSURANCE COMPANY____________________ CUST.SERV. PHONE _____________ ID#________________

GROUP#________________ CLAIMS ADDRESS________________CITY_________ STATE___ZIP__________

X____
SIGNATURE OF PATIENT OR PARENT IF MINOR

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Health History Form

Patient Name (Last, First, MI) ____________________

Date of Birth (MM/DD/YYYY) ____________

	Yes	No
Do you have tuberculosis?	☐	☐
Are you pregnant?	☐	☐

Physician: Name: ____________________ Telephone: ____________

Pharmacy: ____________________________

Date of last physical examination: ____________________

Yes	No	**Cardiovascular**
☐	☐	High blood pressure
☐	☐	Heart attack
☐	☐	Heart murmur
☐	☐	Heart disease
Yes	**No**	**Hematologic**
☐	☐	Anemia
☐	☐	Abnormal bleeding
Yes	**No**	**Respiratory**
☐	☐	Asthma
☐	☐	Sleep apnea
☐	☐	Difficulty breathing
☐	☐	CPAP use?
Yes	**No**	**Endocrine**
☐	☐	Diabetes
☐	☐	Thyroid problem
Yes	**No**	**Renal**
☐	☐	Kidney disorder
☐	☐	Dialysis

Yes	No	**Musculoskeletal**
☐	☐	Arthritis
☐	☐	Artificial joint
☐	☐	Osteoporosis
☐	☐	Fibromyalgia
☐	☐	Sjogren's Syndrome
Yes	**No**	**Gastrointestinal**
☐	☐	Acid reflux/GERD
☐	☐	Stomach ulcer
Yes	**No**	**Hepatic**
☐	☐	Liver disease
☐	☐	Hepatitis
Yes	**No**	**Neurologic**
☐	☐	Epilepsy/seizures
☐	☐	Headaches
Yes	**No**	**Infections**
☐	☐	HIV positive/AIDS
☐	☐	Sexually transmitted disease

Yes	No	**Mental Health**
☐	☐	Depression
☐	☐	Anxiety
☐	☐	Eating disorders
☐	☐	Dementia
☐	☐	Sleep disorder
Yes	**No**	**Allergies**
☐	☐	Local anesthetic
☐	☐	Antibiotics
☐	☐	Aspirin/Ibuprofen
☐	☐	Acetaminophen/Tylenol
☐	☐	Codeine/narcotics
☐	☐	Metals
☐	☐	Latex
☐	☐	Other: ____________
Yes	**No**	**Other**
☐	☐	Cancer
☐	☐	Tobacco use
☐	☐	Alcohol use
☐	☐	Chemical dependency

Please list any medications:

____

____

____

Please list any hospitalizations you have had:

____

(Please continue on opposite side)

Dental Information

Yes	No	
☐	☐	Is it important for you to keep your teeth?
☐	☐	Are you satisfied with the appearance of your teeth?
☐	☐	Are you satisfied with the function of your teeth?
☐	☐	Does food frequently get caught between your teeth?
☐	☐	Do your gums often bleed while brushing?
☐	☐	Have you noticed loosening of your teeth?
☐	☐	Have you injured your head, neck or jaw?
☐	☐	Do you have dry mouth?
☐	☐	Have you had a change in your ability to taste?

Yes	No	Problems of the jaw – Have you noticed:
☐	☐	Clicking of the jaw?
☐	☐	Pain (joint, ear, side of face)?
☐	☐	Difficulty opening or closing?
☐	☐	Difficulty chewing?

Yes	No	Oral habits: Do you:
☐	☐	Clench or grind your teeth?
☐	☐	Bite your lips or cheek frequently?

Yes	No	Have you had:
☐	☐	Orthodontic treatment (braces)?
☐	☐	Oral surgery?
☐	☐	Gum treatment?
☐	☐	Your bite adjusted?
☐	☐	A bite plane/guard or other appliance?

Yes	No	Do you currently have:
☐	☐	Dental pain?
☐	☐	Sores or swellings in your mouth?
☐	☐	A partial/full dental or dental implants?
☐	☐	Do you supplement your diet with fluoride?
☐	☐	Have you had any difficulty with dental treatment?

Date of last dental x-rays________________________________

How often do you brush your teeth? _____________________

How often do you floss? ______________________________

Date of last dental treatment: ___________________________

Date of last teeth cleaning: ____________________________

Reason for today's dental visit? ____

Please explain if you answered "yes" to, or are uncertain about, any of the above items.

____

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____

To the best of my knowledge, the preceding information is complete and correct.

____ ____________________

Signature – Patient (or parent/guardian if patient is under 18) **Date**

KENWOOD DENTAL
DENTISTRY FOR YOU

NOTICE OF PRIVACY PRACTICES

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 ____04/14/03___, 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 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 or 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 for your 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 us 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.

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, 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. We may charge you a reasonable cost-based fee for expenses such as copies and staff time. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format.

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, 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 website or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us at the address or phone number provided on this website.

If you are concerned that we may have violated your privacy rights, 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 on this website. 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: **Kyle D. Kolquist, D.D.S.**

Telephone: **218-728-4288** Fax: **218-724-8624**

Address: **1630 Kenwood Ave. Duluth, Minnesota 55811**

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KENWOOD DENTAL
DENTISTRY FOR YOU

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgment

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

____
Please Print Name

____
Signature

____
Date

For Office Use Only

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

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Other (Please Specify)

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