



ALLISON WATTS, D.D.S.

COMPREHENSIVE RESTORATIVE AND AESTHETIC DENTISTRY

Patient Name: _____

Appointment Date & Time: _____

In this section are forms which are very important!

Before your first visit, please take the time necessary to accurately fill them out.

We suggest that you complete these forms when you are not rushed so that you will be able to candidly reveal any concerns you may have about dentistry and set goals for your future dental health.

The more we know about you, the better we will be able to serve you.

Thank you.

Personal Information/Health History

Name: _____ Birthdate: _____ Age: _____

Who can we thank for referring you? _____ Special interests or hobbies? _____

Mailing Address: _____ Zip _____

Phones: Work: _____ Home: _____ Fax: _____

Cell: _____ Pager: _____ Email: _____

When is the best time to call you? _____ and where? _____

Occupation: _____ Employer & Address: _____

Single Married Divorced Widowed Spouse's name: _____

Who should we contact in case of an emergency? _____ Phone# _____

INSURANCE: If you have dental insurance, we will provide you with a receipt documentation that can be attached to your insurance company claim form for proper filing. You will receive a reimbursement directly for whatever you are entitled to. We will supply you with a form with some important questions to ask your insurance company prior to filing a claim.

Do you have a current medical problem? Yes No

If yes, please describe: _____

Are you currently under the care of a physician? Yes No

If yes, list Dr.'s and indicate what you are being treated for: _____

Family Physician: _____ Phone: _____

Have you been hospitalized or had a serious illness within the past 5 years? Yes No

If yes, please describe: _____

Heart History

Have you ever had heart trouble or any form of cardiovascular disease? Yes No

<input type="checkbox"/> Yes <input type="checkbox"/> No	Angina/Chest Pain (how often) _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of Breath
<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Attack (date) _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur
<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Surgery (date) _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure
	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Low blood pressure
	<input type="checkbox"/> Bypass	<input type="checkbox"/> Yes <input type="checkbox"/> No	Atherosclerosis
	<input type="checkbox"/> Prosthetic heart valve	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mitral Valve Prolapse
<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke (date) _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever (date) _____
<input type="checkbox"/> Yes <input type="checkbox"/> No	Other: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Congenital Heart Disease

Have you ever been advised to take preventive antibiotics before dental treatment? Yes No

Have you ever taken Fen Phen or Redux? Yes No

If yes, have you had tests to check for heart damage? Yes No

Do you have any risk factors for heart disease or stroke? Check all that apply:

Family history of heart disease High cholesterol High blood pressure Tobacco use Obesity

Do you have diabetes? Yes No A1C: >7.0 6.5-7.0 <6.5 Diabetic complications? Yes No
How do you monitor your blood sugar? _____ Physician for diabetes? _____

Family history of diabetes Yes No Any warning signs of diabetes? Yes No If yes, check all that apply:
 Frequent urination Excessive thirst Excessive hunger Weakness and fatigue Slow healing of cuts
 Unexplained weight loss

Health History (please check if you have ever had any of the following :

<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you in good health?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric care
<input type="checkbox"/> Yes <input type="checkbox"/> No	Has your health changed in the last year?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema/asthma/breathing problems
<input type="checkbox"/> Yes <input type="checkbox"/> No	Bleeding problems/bruise easily	<input type="checkbox"/> Yes <input type="checkbox"/> No	TB
<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis/liver disease/jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No	HIV positive/AIDS
<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney or bladder disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hip or joint replacement
<input type="checkbox"/> Yes <input type="checkbox"/> No	Joint pain or stiffness/arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Anemia
<input type="checkbox"/> Yes <input type="checkbox"/> No	Seizures/epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Drug or alcohol abuse
<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches/ringing in ears	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma/contact lenses
<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumors/cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid/parathyroid disease
<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation treatment/chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stomach or intestinal ulcers
<input type="checkbox"/> Yes <input type="checkbox"/> No	Pregnant: Month _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nursing?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Taking birth control pills _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prostate disorders

Have you ever been treated for any other illnesses not listed above? Yes No

If yes, please explain: _____

Are you allergic to any of the following medications?

<input type="checkbox"/> Yes <input type="checkbox"/> No	Penicillin	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nitrous oxide
<input type="checkbox"/> Yes <input type="checkbox"/> No	Erythromycin	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epinephrine
<input type="checkbox"/> Yes <input type="checkbox"/> No	Local anesthetic	<input type="checkbox"/> Yes <input type="checkbox"/> No	Latex
<input type="checkbox"/> Yes <input type="checkbox"/> No	Aspirin, ibuprofen, acetaminophen	<input type="checkbox"/> Yes <input type="checkbox"/> No	Codeine
<input type="checkbox"/> Yes <input type="checkbox"/> No	Sulfa	<input type="checkbox"/> Yes <input type="checkbox"/> No	Metals

Are you allergic to any other medications? Yes No

If yes, please explain: _____

Do you have any other allergies? Yes No

If yes, please explain: _____

Please indicate if you are taking medication for any of the following:

	NAME		NAME
Heart Medication	_____	Cortisone/Steroids	_____
Pain Medication	_____	Blood Pressure Medication	_____
Nitroglycerin	_____	Antibiotics	_____
Hormone replacement	_____	Thyroid	_____
Antidepressants/antianxiety	_____		

Have you ever taken any of the following? Antiseizure medicine Yes No _____ Still taking? Yes No
Calcium channel blockers Yes No _____ Still taking? Yes No
Immunosuppressants (cyclosporins, steroids, etc.) Yes No _____ Still taking? Yes No

Other Medications (prescription or over-the-counter) example: Advil _____

Supplements (herbal and vitamins) _____

Yes No Alcohol (_____) drinks per day

Yes No Tobacco: cigarettes/cigar/pipe/chewing (_____) per day for approximately (_____) years
I quit tobacco in _____ (year). I would like to quit Yes No

Yes No "Recreational" drugs such as cocaine, marijuana, stimulants or depressants may have a fatal

interaction with local anesthetics or other common dental medications. Please describe the use of any drugs or discuss in complete confidentiality with the doctor. _____

Thank you so much for accurately sharing this information with us. All information will be kept confidential.

To the best of my knowledge, all the preceding answers are true and correct. If I have any change in my health or medications, I will inform the doctor at my next appointment. If deemed advisable, I grant permission for my physician to be contacted for details and advice. I further authorize the taking of x-rays, photographs, or other diagnostic measures appropriate for a thorough evaluation.

Patient Signature _____ Date _____

Doctor Signature _____ Date _____

Dental History

Please describe the reason for your consultation today: _____

How long has this been going on and what other events apply to today's visit? _____

Why have you decided to deal with this now? _____

Have you consulted with any other dentist about this? Yes No If yes, what was discussed or done? _____

Who is your regular dentist or previous dentist? _____

Why did you leave your previous dentist? _____

What have you liked about previous dental visits? _____

What have you disliked about previous dental visits? _____

Do you feel that in the past you have required a lot of dental work? _____

Are you satisfied with your past dentistry? Yes No If no, why not? _____

Have you had professional instruction on home care (brushing and flossing)? Yes No

How often do you brush your teeth? _____

What kind of toothbrush do you use? Manual Electric Hard Medium Soft
Brand: _____

What kind of toothpaste do you use? _____ Mouthwash? _____

Do you brush vigorously, moderately, or softly? _____

Do you avoid any area of your mouth when brushing? Yes No _____

Do you use: Floss? Yes No How often? _____

Toothpicks? Yes No How often? _____

Irrigation? Yes No How often? _____

Other dental hygiene aides? _____

When was your last dental exam? _____ Cleaning? _____ Xrays? _____

Have you gone to the dentist regularly in the past? Yes No _____

How often do you have your teeth cleaned? _____ How long does it take? _____

Do you know extensive destruction of the bone under the gum can take place before the patient is aware of it?
 Yes No

Do you know black tartar has usually formed under the gums when your gums bleed? Yes No

Do you have any immediate family members that have had gum disease? Yes No

Have you ever had or been told that you (have):

Bleeding gums Yes Now Past No

Irritated, tender, or swollen gums Yes Now Past No

Receding gums Yes Now Past No

Gum disease (gingivitis) Yes Now Past No

Periodontal (gum) treatment Yes Now Past No

Loose or separating teeth Yes Now Past No

Change in the way your teeth fit together Yes Now Past No

Food collection between teeth Yes Now Past No
Unpleasant breath/Bad taste Yes Now Past No

Fillings Yes Now Past No
Crowns Yes Now Past No
Root canals Yes Now Past No
Loose or broken teeth Yes Now Past No
Loose or broken fillings Yes Now Past No
Ill-fitting dental restorations Yes Now Past No
Removable appliances Yes Now Past No
Lip or cheek biting Yes Now Past No
Jaw pain or tiredness Yes Now Past No
Snoring / Sleep Apnea Yes Now Past No
Sores, blisters or growths Yes Now Past No
Burning sensation on tongue Yes Now Past No
Dental Anesthetic (Novocaine) Yes No
Sedation/N2O Yes No
A bad dental experience Yes No
Missing Teeth Yes No
Oral surgery (extractions) Yes No

Why were they extracted? _____ When? _____

Have the teeth been replaced? Yes No With what? _____

Were you given tooth replacement options? Yes No If yes, what were they? _____

Do your teeth keep you from eating any specific foods? Yes No _____

Do you feel that you will lose your teeth and eventually have to wear full dentures? Yes No

Have you had orthodontics: Yes No Why? _____ When? _____

For how long? _____ Did you wear a retainer? _____ Are your teeth stable? _____

Do you have sensitivity in any area to: _____ hot What areas: _____
_____ cold Previous treatment: _____
_____ sweet Did it work? _____
_____ biting or chewing

Do you have any pain present in your: _____ teeth
_____ jaws
_____ gums
_____ face

Do you play any sports that may require protection of your mouth? Yes No _____

Are you aware that dental decay is essentially a childhood disease and that most adult tooth filling procedures are to replace broken fillings or temporary dentistry? Yes No

Have you ever whitened your teeth? Yes No If yes, what type? _____

What was the outcome? _____ Are you currently whitening? _____

Are you interested in improving color? _____

Are you happy with the appearance of your teeth? Yes No _____

How important are your teeth to you?
Please choose one of the following.

- ____ It is important that I keep them for the rest of my life.
- ____ I want to keep them if it is not too much trouble.
- ____ I don't know.

Do you have any concerns about dental treatment? Yes No

If yes, please explain: _____

Do you have any suggestions to help us make you more comfortable at your dental appointments?

What are your priorities and what is your timeline? _____

I would like to know my options to:

- Improve my smile
- Look younger
- Keep my teeth

The most important thing to me is:

- Health
- Function/Comfort
- Beauty

I am concerned about:

- Time
- Money
- Pain

What do you know/believe about biological dentistry? _____

What do you know/believe about the body's pH, how it is affected and how it affects your (oral) health? _____

What do you know/believe about how your teeth got the way they are? _____

How much of a role do you believe genetics plays in your (oral) health? _____%

How much of a role do you believe stress &/or lifestyle plays in your (oral) health? _____%

Would you be open to discussing the role of stress and lifestyle on your health? ___Yes ___No

Would you be open to discussing wellness and supplements that may be helpful for your health and well-being?
___Yes ___No

Would you be interested in life/wellness coaching through our office? We have three certified life coaches on staff that would love to help you lead the life you really want. ___Yes ___No

Thank you for taking the time to fill out these forms. We truly appreciate it and will use this information to serve you the best we know how. We look forward to meeting you and helping you sort out your options for a more healthy, attractive you.

Acknowledgment Of Receipt Of Notice Of Privacy Practices

I, _____ have received a copy of Allison Watts, DDS Notice of Privacy Practices.
(Name of Patient)

(Signature of Patient)

Staff will fill out this section if Patient's signature is not obtained.

Our office made a good faith effort to obtain **Acknowledgment of Receipt** of our Notice of Privacy Practices, but it was not obtained for the following reason:

_____ Patient refused to sign.

_____ Emergency situation kept us from obtaining the patient's signature.

_____ Language barriers kept us from obtaining the patient's signature.

_____ Other situation. _____

Notice of Privacy Practices

Allison Watts, D.D.S.

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. If you have any questions about this Notice please contact our Privacy Officer.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. We are required by Federal law to give you this **Notice** and to maintain the privacy of your health information. We must also abide by the terms of 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. Before we make significant changes in our privacy practices, we will change this Notice and make the new **Notice** available upon request.

How We May Use and Disclosure Your Protected Health Information

When we give you our **Notice of Privacy Practices**, you will be asked to sign an **Acknowledgement Of Receipt**. Once you have received our **Notice** and signed the **Acknowledgement**, we will use your protected health information for treatment, payment and health care operations. We may use or disclose your protected health information in an emergency treatment situation. If this happens, we will try to obtain your signature on the Acknowledgement Of Receipt as soon as reasonably practicable after the delivery of treatment. The following examples show the types of uses and disclosures of your protected health information that our office is permitted to make.

Treatment: Your protected health information may be used and disclosed by our office and others outside of our office that are involved in your dental care. We will use and disclose your protected health information to other dentists and physicians to provide, coordinate, or manage your health care. For example, your protected health information may be provided to another dental specialist to whom you have been referred to ensure that the necessary information is available to diagnose or treat you.

Payment: Your protected health information may be used and disclosed to pay your health care bills. Your protected health information will be used to obtain payment for services we provide to you. This may include certain activities that your insurance plan may undertake before it approves or pays for the services we recommend.

Healthcare Operations: We may use or disclose your protected health information in order to support the business activities of our practice. Healthcare operations include quality assessment activities, employee review activities, licensing or credentialing activities, conducting training and conducting auditing or review activities. For example, we may use a sign-in sheet at the reception desk where you will be asked to sign your name and indicate your doctor. We may also call your name in the waiting room when your doctor is ready to see you. We may send you reminder postcards or telephone you to remind you of an appointment. We may also send you a newsletter about our practice and the services we offer. You may contact our Privacy Officer to request that these materials not be sent to you.

Business Associates: We will share your protected health information with third party Business Associates that perform various activities for our practice. Whenever we disclose your protected health information to a business associate, we will have a written contract that that will protect the privacy of your protected health information.

Your Written Authorization Is Required For Other Uses Of Your Protected Health Information

CLAYDESTA CENTER 6 DESTA DRIVE SUITE 2700 MIDLAND, TX 432.682.0188

Any other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization at any time, in writing, except to the extent that our office has already released your health information as provided for in your authorization.

Use and Disclosure Permitted Without Authorization But With An Opportunity To Object

Family Members and Friends: Unless you object, we may disclose to your family member, a relative, a close friend or any other person you select, your protected health information to the extent necessary to help with your dental care or with payment for the

services we have provided. We will also use our professional judgment and common practice to make reasonable decisions in your best interest in allowing a person to pick up dental supplies, x-rays, prescriptions or other similar forms of health information.

Other Disclosures That May Be Made Without Your Authorization

Required By Law: We may use or disclose your protected 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 that of other persons.

Military Personnel and National Security: We may disclose the health information of Armed Forces personnel when requested by command military authorities. We may disclose to authorize federal officials health information required for lawful intelligence, counterintelligence and other national security activities.

Worker's Compensation & Health Oversight Activities: We may disclose your protected health information to comply with Worker's Compensation Laws and to health oversight agencies when conducting investigations or inspections as authorized by law.

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required, to the Department of Health and Human Services when determining our compliance.

Your Have The Following Rights

Inspect and copy your protected health information. 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 the request in writing to obtain access to your health information. You may obtain access by sending a letter to our Privacy Officer listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses. If you prefer, we will prepare a summary or an explanation of your health information for a fee.

Request a restriction of your protected health information. 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.

Request alternative communications. 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.

Request an amendment your health information. You have the right to request that we amend or correct your health information. Your request must be in writing. The request must explain why the information should be amended or corrected. We may deny your request under certain situations.

Receive an accounting of disclosures we have made of your health information. You have the right to an accounting of disclosures of your health information that occurred after April 14, 2003. This accounting will be for purposes other than treatment, payment or healthcare operations, or disclosures we may have made to you, to family members or friends involved in your care. The right to receive this information is subject to some exceptions. If you request this accounting more than once in a 12 month period, we may charge you a reasonable, cost based fee.

Make a complaint about our privacy practices. If you are concerned that we have violated your privacy rights, you may file a complaint with our Privacy Officer using the contact information listed at the bottom of this page. You may also file a written complaint with the Department of Health and Human Services. We will provide you with their address upon request. We will not retaliate against you for making a complaint or change the way we treat you.

To obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

Effective Date: _____

Privacy Officer: Lisa Alvarado **Telephone:** (432) 682-0188

Address: 6 Desta Drive Suite 2700 Midland, TX 79705