

Welcome to the office of Gary L. Llewellyn, D.D.S.

This form was created to help our team learn more about you, your wishes and needs.

Please read through and complete each section which pertains to you. Thank you.

REGISTRATION HISTORY - ADULT

PATIENT HISTORY

Date: _____ Name: _____ Birth Date: _____

Age: _____ Male _____ Female _____ Marital Status: _____ SS#: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

How Long: _____ Home Phone: _____ Business Phone: _____

Cell Phone: _____ Email: _____

Employer: _____ Position: _____ How Long: _____

Employer's Address: _____

Name of Spouse: _____ Spouse SS#: _____

Spouse's Employer: _____ Position: _____ How Long: _____

Spouse's Employer Address: _____ Phone: _____

Emergency Contact of nearest relative not living with you: _____ Phone: _____

Whom may we thank for referring you: _____

This account will be paid by: CASH CHECK CREDIT CARD DEBIT CARD

RESPONSIBLE PARTY

Persons responsible for paying this account other than the above named patient.

Responsible Party's Name: _____ SS#: _____

Relationship to Patient: _____

Birth Date: _____ Age: _____ Male _____ Female _____ Marital Status: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Responsible Party's Employer: _____

Position: _____ How Long: _____ Employer's Address: _____

Employer's Phone: _____

DENTAL INSURANCE INFORMATION

Subscriber's Name: _____ Birth Date: _____ SS#: _____

Subscriber's Employer: _____ Employer's Address: _____

Insurance Company: _____

Address: _____

Group #: _____ Have you used the dental insurance previously: Yes No

ID#: _____

SECONDARY INSURANCE INFORMATION

Subscriber's Name: _____ Birth Date: _____ SS#: _____

Subscriber's Employer: _____ I.D.#: _____

Employer's Address: _____

Insurance Company: _____ Phone: _____

Address: _____ Group #: _____

HEALTH HISTORY

General Health: EXCELLENT GOOD FAIR POOR Explain: _____

Physician: _____ Phone: _____

Address: _____

Are you presently taking any medicine or drugs: Yes No **If yes, list drug, dosage and frequency on the medication form.**

Allergic to Penicillin or any other drug: Yes No If yes, explain: _____

Ever been hospitalized in the past 5 years: Yes No If yes, explain: _____

Do you have excessive bleeding when cut: Yes No Have you ever taken a Biophosphonate to treat Osteoporosis? Yes No

(Women) Are you pregnant: Yes No If yes, how long: _____ Are you nursing? Yes No

(Women) Are you taking oral contraceptives: Yes No

If yes, did you know that antibiotics can decrease the effectiveness of birth control: Yes No

Check any the the following that you have presently:

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Chest Pains (Angina) |
| <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Abnormal Blood Pressure | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Anemia or Hemophilia | <input type="checkbox"/> Bruise Easy | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Swelling of the Ankles |
| <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Skin Rashes or Hives | <input type="checkbox"/> Kidney Trouble | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Sickle Cell Disease | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Hepatitis B |
| <input type="checkbox"/> Yellow Jaundice | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Cortisone Medicine | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Arthritis or Rheumatism | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Cancer or Tumor |
| <input type="checkbox"/> Venereal Diseases | <input type="checkbox"/> Radiation Therapy | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> HIV Positive/AIDS |
| <input type="checkbox"/> Genital Herpes | <input type="checkbox"/> Cold Sores | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Psychiatric Treatment |
| <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> Artificial Implants | <input type="checkbox"/> Others Explain: _____ | |

DENTAL HISTORY

Date of last visit to a dentist: _____ Dentist's Name: _____ Phone: _____

Did you have x-rays taken: Yes No Have you had all your teeth x-rayed in the past 3 years: Yes No

Do you wear full or partial dentures: Yes No If yes, how old are they: _____

Does any member of your family, including your parents, wear dentures: Yes No

Have you had orthodontic treatment: Yes No

Do you clench or grind your teeth during the day or night: Yes No

Have you ever had pain in your jaw joint or your face (in or about your face): Yes No

Orthodontic appliances/retainer worn now or ever before: Yes No

Does your jaw joint click or do you have difficulty opening your mouth widely: Yes No

Do you have an unpleasant odor, or taste, in your mouth: Yes No

Do your gums bleed when brushing: Yes No Have you had gum disease or pyorrhea: Yes No

Is your mouth or teeth sensitive to: Pressure Cold Hot

Does food catch between your teeth every time you eat: Yes No

Are you dissatisfied with the appearance of your teeth: Yes No If yes, how can we help: _____

Do you or any member of your family snore: Yes No

Have you ever been diagnosed with sleep apnea? Yes No

Do you wake up with morning headaches? Yes No

DON'T WAIT UNTIL IT HURTS!

- Are your gums red, swollen or tender? Yes No
- Are your gums pulling away from your teeth? Yes No
- Do you see puss between your teeth and gums when the gums are pressed? Yes No
- Are your permanent teeth loose and separating? Yes No
- Is there a change in the way your teeth fit together when you bite? Yes No
- Is there any change in the fit of your partial dentures? Yes No
- Do you have persistent bad breath? Yes No

HELP US LEARN MORE ABOUT YOU

What can we do in order to help you feel more comfortable during your time with us?

What do you want to accomplish during your appointment time during your initial visit?

What concerns do you have about your teeth?

What concerns do you have about your smile?

Have you had any problems related to any previous dental visits?

Do you wish your teeth could be whiter? Yes No

Do you wish your teeth could be straighter? Yes No

Please add anything you feel is important for the doctor to know:_____

I authorize all of the above information to be used as needed by the Dental Office to facilitate my dental treatment. I understand that I am financially responsible for the dental expenses. I understand that I am financially responsible for all charges whether or not paid by said insurance within 60 days of service. I hereby authorize said assignee to release all information necessary to secure the payment of said benefits. The undersigned agrees that all past due accounts shall be charged a monthly billing fee on the unpaid balance commencing thirty (30) days after billing, the undersigned shall assume all responsibility for all collection agency fees charged to us, attorney fees, court costs and other costs incurred while collecting the amount due.

Signature _____ Date _____

ASSIGNMENT OF BENEFITS

I, _____ hereby assign all dental benefits to Gary L Llewellyn, D.D.S. I understand that I am financially responsible for all charges whether or not paid by said insurance within 60 days of service. I hereby authorize said assignee to release all information necessary to secure the payment of said benefits. The undersigned agrees that all past due accounts shall be charged a monthly billing fee on the unpaid balance commencing thirty (30) days after billing. The undersigned shall assume all responsibility for all collection agency fees charged to us, attorney fees, court costs and other cost incurred while collecting the amount due.

Signature _____ Date _____

Gary L. Llewellyn, D.D.S.

This form was created to help our team learn more about you and your needs.

Please list all your medications on this form. Thank you.

MEDICATION FORM

DRUG NAME	DOSAGE & FREQUENCY	REASON FOR TAKING MEDICATION
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		
16.		
17.		
18.		
19.		
20.		
21.		
22.		
23.		
24.		
25.		

MEDICAL HISTORY UPDATE

Patient Name	Telephone
--------------	-----------

MEDICAL HISTORY UPDATE

Date: _____

Has there been any change in your health since your last dental appointment? Yes No

For what conditions? _____

Are you taking any new kind of medication at this time? Yes No

If so, what _____

Do you have any allergies or adverse reactions to any medications? Yes No

If so, what _____

Patient Signature

Hygienist or Doctor Signature

Patient Name	Telephone
--------------	-----------

MEDICAL HISTORY UPDATE

Date: _____

Has there been any change in your health since your last dental appointment? Yes No

For what conditions? _____

Are you taking any new kind of medication at this time? Yes No

If so, what _____

Do you have any allergies or adverse reactions to any medications? Yes No

If so, what _____

Patient Signature

Hygienist or Doctor Signature

Patient Name	Telephone
--------------	-----------

MEDICAL HISTORY UPDATE

Date: _____

Has there been any change in your health since your last dental appointment? Yes No

For what conditions? _____

Are you taking any new kind of medication at this time? Yes No

If so, what _____

Do you have any allergies or adverse reactions to any medications? Yes No

If so, what _____

Patient Signature

Hygienist or Doctor Signature

Gary L. Llewellyn, D.D.S.

6211 W. 30th Street, Suite G
Speedway, Indiana 46224
(317) 291-7550

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION. PLEASE REVIEW 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 03-01-03, 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 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 effect any use or disclosures permitted by you 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 you incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgement disclosing only health information that is directly relevant to make reasonable inferences of you 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 telephone calls, voicemail messages, email, paging, postcards and/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 \$15.00 for the first 10 pages of patient records and \$.25 for additional pages, if radiographs are copied a reasonable fee will be accessed for record duplication 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 in this Notice for a full explanation of our fee structure.

Disclosing 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 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 want 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 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 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 information 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.

Contact:

Gary L. Llewellyn, DDS
6211 West 30th Street, Suite G
Speedway, Indiana 46224
(317) 291-7550

Gary L. Llewellyn, D.D.S.

6211 W. 30th Street, Suite G

Speedway, Indiana 46224

(317) 291-7550

**ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES**

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

****You May Refuse to Sign This Acknowledgement****

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

(Signature)

(Date)

Authorization to Release Information

Purpose: This form is used to obtain authorization to release information regarding yourself covered under the Privacy Act to people other than yourself.

I, _____, authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself.

(Please Print Name)

Relationship

(Please Print Name)

Relationship

(Please Print Name)

Relationship

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)
