PATIENT TREATMENT RECORD

Account No. _____
Gender
Male ☐ Female ☐
Relationship to Responsible Party _____

Patient _____ (full name)
Address _____

City _____ St. _____ Zip _____

See Pg. 3
Ins. Cov. _____ ☐

Referred by _____

E-Mail Addr. _____

Responsible Party _____
Business Name & Addr. _____

S.S. No. (Responsible Party) _____

☐ Previous Addr. ☐ C/O Addr. ☐ Other _____

Phones: Home _____ Business _____ Cell _____ Other: _____

Payment Method: ☐ Insurance ☐ Cash ☐ Check ☐ Cr. Card

Office Use Only _____

MEDICAL HISTORY

Birth Date _____
S.S. No. _____

Primary Physician _____ Last visit date _____ Phone no. _____

Are you currently under the care of a doctor? ☐ Yes ☐ No If yes, explain _____

Have you been a patient in a hospital in the last 5 years? ☐ Yes ☐ No If yes, explain _____

Do you have, or have you had, any of the following? (please answer all questions)

	YES	NO
1. Heart Disease	☐	☐
2. Heart Attack	☐	☐
3. Angina (chest pain)	☐	☐
4. Cardiac Pacemaker	☐	☐
5. High Blood Pressure	☐	☐
6. Low Blood Pressure	☐	☐
7. Anemia	☐	☐
8. Rheumatic Fever	☐	☐
9. Heart Murmur	☐	☐
10. Diabetes	☐	☐
11. Stroke	☐	☐
12. Epilepsy	☐	☐
13. Thyroid Disease	☐	☐
14. Fainting	☐	☐
15. Seizures	☐	☐
16. Arthritis	☐	☐
17. Asthma	☐	☐
18. Do you smoke?	☐	☐
19. Emphysema	☐	☐
20. Tuberculosis	☐	☐
21. Sinus Trouble	☐	☐
22. Hay Fever	☐	☐
23. Kidney Disease	☐	☐
24. Liver Disease	☐	☐
25. Hepatitis	☐	☐
26. Jaundice	☐	☐
27. Leukemia	☐	☐
28. Excessive Bleeding	☐	☐
29. Blood Disorders	☐	☐
30. Radiation Treatment	☐	☐
31. Allergic to, or reaction to:		
a. Penicillin	☐	☐
b. Sulfa Drugs	☐	☐
c. Other Antibiotics: _____	☐	☐
d. Local Anesthetic	☐	☐
e. Novocain	☐	☐
f. Aspirin	☐	☐
g. Barbiturates	☐	☐
h. Other Sedatives: _____	☐	☐
i. Iodine	☐	☐
j. Latex Rubber	☐	☐
k. Other: _____	☐	☐
32. Sexually Transmitted Disease	☐	☐
33. Psychiatric Treatment	☐	☐
34. Do you wear Contact Lenses?	☐	☐
35. Have you taken any **steroid** medication within the last 2 years?	☐	☐
36. For Women: Are you pregnant?	☐	☐

37. Have you had Organ Transplant, or Artificial Bone/Joint, or Valve replacement? ☐ ☐ If yes, explain (below)

38. Have you tested **positive** for HIV/AIDS virus? ☐ YES ☐ NO 39. Are you taking any medications? ☐ YES ☐ NO If yes, list them (below)

40. Do you have any disease or conditions not listed above that you think I should know about? ☐ YES ☐ NO If yes, explain (below)

Comments: _____

Please continue to Dental History/Concerns on back page.

Changes in Medical Health, (please record above code number(s) relating to the changes).

DATE	PATIENT'S SIGNATURE	#	DATE	PATIENT'S SIGNATURE	#
		☐			☐
DATE	PATIENT'S SIGNATURE	#	DATE	PATIENT'S SIGNATURE	#
		☐			☐

HIPAA Acknowledgement (Patient) **X** _____ Date _____

DENTAL HISTORY / CONCERNS

Patient (full name)_____

Previous Dentist_____ Location_____ Last Visit Date_____

Treatment at last appointment_____

	YES	NO
1. **Do you require pre-medication?**	☐	☐
2. Do your gums bleed while brushing or flossing?	☐	☐
3. Are your teeth sensitive to hot or cold?	☐	☐
4. Are your teeth sensitive to sweets?	☐	☐
5. Do you feel pain in any of your teeth?	☐	☐
6. Do you have any sores or lumps in your mouth?	☐	☐
7. Have dental implants ever been discussed?	☐	☐
8. Have you ever received oral hygiene instruction?	☐	☐
9. Have you ever had any head, neck or jaw injuries?	☐	☐

If yes, explain_____

10. Have you ever experienced any of the following problems in your jaw? ☐ YES ☐ NO If yes, check all that apply (below)

☐ Clicking ☐ Jaw locking ☐ Difficulty in opening or closing ☐ Pain (joint, ear, side of face, headaches)

11. Have you ever been treated by a Periodontist / Orthodontist / Endodontist? ☐ YES ☐ NO If yes, explain_____

DENTAL CONCERNS

	YES	NO
1. Do you feel uncomfortable about your smile?	☐	☐
2. Do you cover your mouth when you talk or smile?	☐	☐
3. Would you like whiter teeth?	☐	☐
4. Do you like the shape of your teeth?	☐	☐
5. Do you have spaces between teeth that bother you?	☐	☐
6. Are your teeth too crowded?	☐	☐
7. Can you see dark restorations in your teeth when you smile?	☐	☐

8. Do you have other dental concerns? ☐ YES ☐ NO If yes, explain_____

CLINICAL FINDINGS (office use only)

Occlusion_____ Lymph Nodes_____

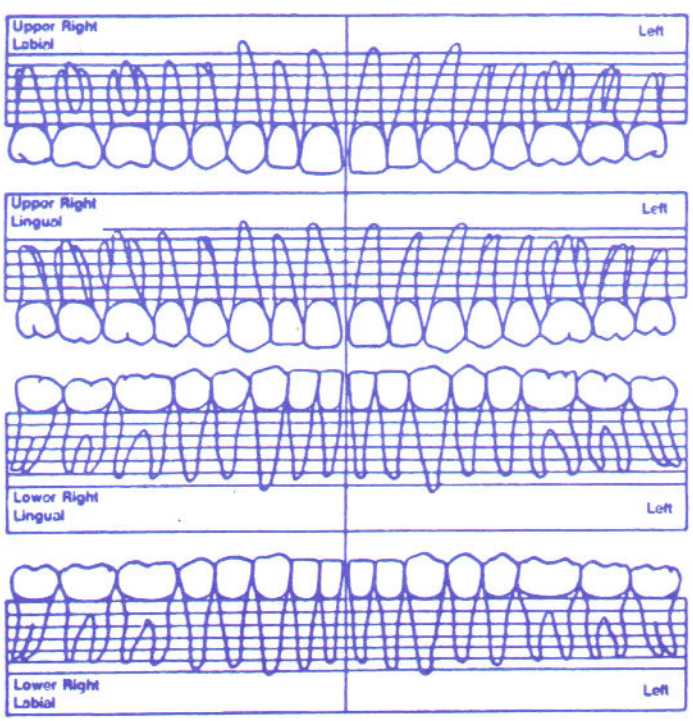
TMJ_____ Buccal Mucosa_____

Palate_____ Periodontium_____

Tongue_____ Hygiene_____

Notes:_____

PERIODONTAL CHART (office use only)



Notes: _____

JOE L. VALLES D.D.S.
DOMINGO VALLES D.D.S.
500 CENTRAL AVE SE
ALBUQUERQUE, NM 87102
(505)243-3535

OFFICE POLICY AND PATIENT INFORMATION

WELCOME to our practice. We appreciate the trust you have placed in us. One of our primary concerns will be to make you feel comfortable in our office. We will make every effort to insure successful treatment.

- **OFFICE MANAGEMENT:** Our office hours are Monday through Thursday, 9:00 am to 5:00 pm by appointment only.
- **TELEPHONE SERVICE :** From 9:00 am to 5:00 pm you may reach us at the office number (505) 243-3535. After hours in case of a true emergency, you may reach Dr. Valles at home: 836-1847.
- **CANCELLATION NOTICE:** 1) You are **expected to keep regularly scheduled appointments and must cancel 24 hours in advance** or you may be billed $20:00 for each hour you were scheduled. 2) It is also **your responsibility to inform us of any changes in your address or phone numbers**. 3) **If your appointment cannot be confirmed it will be cancelled in order to accommodate emergencies or other required treatment for our patients.**
- **BILLING:** We feel our fees are reasonable. Charges are payable at the time of service for every appointment with no exceptions. To keep our costs down we do not bill, unless special arrangements are made with the Office Manager and Doctor. A finance charge will be imposed if full payment is not received within 30 days of the billing date. The finance charge is computed by multiplying the balance times 1.5%(an annual rate of 18%).
- **INSURANCE:** As a courtesy to our patients, we will complete and file insurance claims relative to dental treatment. However, our professional services are rendered to you, not the insurance company. Therefore, you are directly responsible to us for the obligation of payment for treatment. You will then be variably reimbursed by your insurance company. There is a great variety in types of dental insurance coverage offered, Please remember, dental insurance is not designed to be a “PAY-ALL”. There may be a deductible involved, there may be a co-insurance factor and there may be a yearly maximum to be considered. All these factors combine to reduce the benefits you will ultimately receive. We urge you to read your policy thoroughly as you will be responsible for the payment of your deductible and your portion of treatment costs at the time of service. We will do our utmost to see that you receive maximum benefits within the structure of your particular group dental plan.
- **NOTE:** After hour visits, written reports, and professional consultation outside the office will be billed on the basis of time and complexity.

JOE L. Valles D.D.S.

PATIENT SIGNATURE:_____DATE:_____

JOE L. VALLES, D.D.S.
DOMINGO VALLES, D.D.S.
500 CENTRAL AVE SE
ALBUQUERQUE, NM 87102
(505) 243-3535

Privacy Officer: ALMA BARRERA, OFFICE MANAGER **Effective date: April 1, 2003**

Notice of Privacy Practices

This Notice describes how medical information about you may be used and disclosed And how you can get access to this information. Please review it carefully.

We care about our patients' privacy and strive to protect the confidentiality of you medical information at this practice. New federal legislation requires that we issue this official notice of our privacy practices. You have the right to the confidentiality of your medical information, and this practice is required by law to maintain the privacy of that protected health information. This practice is required to abide by the terms of the Notice of Privacy Practices currently in effect, and to provide notice of its legal duties and privacy practices with respect to protected health information. If you have any questions about this Notice, Please contact the Privacy Officer at this practice.

Who Will Follow This Notice

Any health care professional authorized to enter information into your medical records, all employees, staff and other personnel at this practice who may need access to your information must abide by this Notice. All subsidiaries, business associates (e.g. a billing service), sites and locations of this practice may share medical information with each other for treatment, payment purposes or health care operations described in this Notice. Except where treatment is involved, only the minimum necessary information needed to accomplish the task will be shared.

How We May Use and Disclose Medical Information About You

The following categories describe different ways that we may use and disclose medical information without your specific consent or authorization. Examples are provided for each category of uses or disclosures. Not every possible use or disclosure in a category is listed.

For Treatment. We may use medical information about you to provide you with medical treatment or services. Example: In treating you for a specific condition, we may need to know if you have allergies that could influence which medications we prescribe for the treatment process.

For Payment. We may use medical and disclose medical information about you so that the treatment and services you receive from us may be billed and payment may be collected from you, and insurance company or a third party. We may need to send your protected health information, such as your name, address, office visit date, and codes identifying your diagnosis and treatment to your insurance company for payment.

For Health Care Operations. We may use and disclose medical information about you for health care operations to assure that you receive quality care. Example: We may use medical information to review our treatment and services and evaluate the performance of our staff in caring for you.

Other Uses or Disclosures That Can Be Made Without Consent or Authorization

- As required during an investigation by law enforcement agencies
- To avert a serious threat to public health or safety
- As required by military command authorities for their medical records
- To workers' compensation or similar programs for processing of claims
- In response to a legal proceeding
- To a coroner or medical examiner for identification of a body
- If an inmate, to the correctional institution or law enforcement official
- As required by the US Food and Drug Administration (FDA)
- Other healthcare providers' treatment activities
- Other covered entities' and providers' payment activities
- Other covered entities' healthcare operations activities (to the extent permitted under HIPAA)
- Uses and disclosures required by law
- Uses and disclosures in domestic violence or neglect situations
- Health oversight activities
- Other public health activities

We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

Uses and Disclosures of Protected Health Information Requiring Your Written Authorization

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you give us authorization to use or disclose medical information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will thereafter no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your authorization, and that we are required to retain our records of the care we have provided you.

Your Individual Rights Regarding Your Medical Information

Complaints. If you believe your privacy rights have been violated, you may file a complaint with the Privacy Officer at this practice or with the Secretary of the department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized or discriminated against for filing a complaint.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations or to someone who is involved in your care or the payment for your care. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment. To request restrictions, you must submit your request in writing to the Privacy Officer at this practice. In your request, you must tell us what information you want to limit.

Right to Request Confidential Communications. You have the right to request how we should send communications to you about medical matters, and where you would like those communications sent. To request confidential communications, you must make your request to the Privacy Officer at this practice. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted. We reserve the right to deny a request if it imposes an unreasonable burden on the practice.

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually this includes medical and billing records but does not include psychotherapy notes, information compiled for use in a civil, criminal, or administrative action or proceeding, and protected health information to which access is prohibited by law. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Privacy Officer at this practice. If you request a copy of the information, we reserve the right to charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by this practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend. If you feel that medical information we have abut you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at this practice. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if the information was not created by us, is not part of the medical information kept at this practice, is not part of the information which you would be permitted to inspect a copy, or which we deem to be accurate and complete. If we deny your request for amendment, you have right to file a statement of disagreement with us. We may prepare a rebuttals will be kept on file and sent out with any future authorized requests for information pertaining to the appropriate portion of your record.

Right to an accounting of Non-Standard Disclosures. You have the right to request a list of the disclosures we made of medical information about you, To request this list, you must submit your request to the Privacy Officer at this practice. Your request must state the time period for which you want to receive a list of disclosures that is no longer than six years, and may not include dates before April 14, 2003. Your request should indicate in what form you want the list(example: on paper or electronically). The first list you request within a 12-month period will be free. For additional lists, we reserve the right to charge you for the cost of providing the list.

Right to a Paper copy of This Notice. You have the right to a paper copy of this Notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy. To obtain a paper copy of the current Notice, please request one in writing form the Privacy Officer at this practice.

Changes To This Notice

We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice, with the effective date in the upper right corner of the first page.

Joe L. Valles DDS
Domingo Valles D.D.S.
500 Central Ave SE
Albuquerque, NM 87102
(505) 243-3535

Notice of Privacy Practices
Patient Acknowledgement

Patient Name: _____ Date Of Birth: _____

I have received and understand the practice's Notice of Privacy Practices written in plain language. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, and the practice's legal duties with respect to my protected health information. This includes but is not limited to:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment, and health care operations.
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
    1. The right to complain to this practice and to the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint.
    2. The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.
    3. The right to receive confidential communications of protected health information.
    4. The right to inspect and copy protected health information.
    5. The right to amend protected health information.
    6. The right to receive an accounting of disclosures of protected health information.
    7. The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. If changes occur, this practice will provide me a revised Notice of Privacy Practices upon request.

Signature of Patient or guardian: _____ Date: _____

Relationship to patient: _____

Joe L. Valles
Domingo Valles
500 Central Ave SE
Albuquerque, NM 87102
(505) 243-3535

HIPPA
Notice of Privacy Practices
Patient Signature Sheet

I have received and understand the Notice of Privacy Practices written in plain language.

Signature of Patient or Guardian _____
Date:_____

Relationship to patient:_____

I have received and understand the Notice of Privacy Practices written in plain language.

Signature of Patient or Guardian _____
Date:_____

Relationship to patient:_____

I have received and understand the Notice of Privacy Practices written in plain language.

Signature of Patient or Guardian _____
Date:_____

Relationship to patient:_____
I have received and understand the Notice of Privacy Practices written in plain language.

Signature of Patient or Guardian _____
Date:_____

Relationship to patient:_____
I have received and understand the Notice of Privacy Practices written in plain language.

Signature of Patient or Guardian _____
Date:_____

Relationship to patient:_____

Insurance Information

In order to maximize your insurance coverage we need the correct information below. In the event that you have taken x-rays in another office we can request copies of them. If you have taken x-rays in another office that we <u>are not</u> made aware of and your insurance denies coverage for our x-rays you will be responsible for payment in full.

Do you have insurance?_____ What insurance company?_____

Who carries the insurance yourself or your spouse?_____

Do you have coverage for dependents?_____

Where is the primary insurance holder employed?_____

Social Security Number of employee_____-_____-_____

Employee birthdate_____

Have you been seen in another office within the last three years?_____

If yes when?_____What office?_____

Have you had dental x-rays taken anywhere in the last three years?_____

If yes when?_____What office?_____