Anna M. Munné, D.D.S., P.A.

Periodontics • Implants

Diplomat of the American Academy of Periodontology

PATIENTS MEDICAL HISTORY

Date _____ Patient Name _____

Height _____ Weight _____ D/O/B _____ Age _____

Do you smoke? Yes No Have you ever smoked? ☐ Yes ☐ No ☐ Quit: When?_____

___cigarettes ___pipe ____chewing ___cigar ___snuff How much per day?_____

Alcohol use ☐ Yes ☐ No How many? _____ Day/ Week

Recreational drugs? ☐ Yes ☐ No Type_____ Frequency_____

Do you need pre-medication prior to a dental appointment? Y N Antibiotic used?_____

Current/Past Diseases:

- ☐ Heart pacemaker
- ☐ Mitral valve prolapse
- ☐ Heart surgery
- ☐ Psychiatric care
- ☐ Frequent chest pains
- ☐ Lupus erythematosus
- ☐ Shortness of breath
- ☐ Asthma
- ☐ Substance abuse
- ☐ Glaucoma
- ☐ Osteoporosis
- ☐ Chemotherapy
- ☐ Radiation therapy
- ☐ Liver disease
- ☐ Jaundice
- ☐ Blood transfusion
- ☐ Ulcers-gastritis
- ☐ Dizzy spells
- ☐ Kidney disease
- ☐ Convulsions
- ☐ AIDS/HIV+
- ☐ Osteopenia
- ☐ Arthritis
- ☐ Thyroid disease
- ☐ Implant prosthesis
- ☐ Tuberculosis
- ☐ Cancer
- ☐ Lung disease
- ☐ Hives/skin rash
- ☐ Ankle swelling
- ☐ Venereal diseases
- ☐ Cortisone therapy
- ☐ _____
- ☐ Heart Attack
- ☐ Anemia
- ☐ Hypertension
- ☐ Bleeding Disorder
- ☐ High Cholesterol
- ☐ Stroke
- ☐ Diabetes
- ☐ Hepatitis A, B, C
- ☐ Heart Murmur
- ☐ Bruise Easily
- ☐ _____

Diseases in your family_____

Prescription Medication	Non- Prescription Medication
_____	_____
_____	_____
_____	_____

Have you ever taken Fosamax, Actonel, or Boniva? ☐ Yes ☐ No When did you start? _____

How long was it taken? _____ Date finished: _____

Last Physical Exam _____ Physicians Name: _____

Allergies to:

Prescription Drug Allergies: _____

Non-Prescription Drug Allergies: _____

Surgical History w/ dates: _____

_____

General Anesthesia Complications: ☐ Yes ☐ No If Yes, Please Explain: _____

_____.

FOR WOMEN ONLY

Are you pregnant now? ☐ Yes ☐ No Trimester 1 2 3

Taking hormones/ birth control? _____

Have you reached menopause? ☐ Yes ☐ No Have you had a hysterectomy? ☐ Yes ☐ No

Are you anticipating pregnancy? ☐ Yes ☐ No Are you breastfeeding? ☐ Yes ☐ No

Gave birth to _____ children, ages _____

Did you have any complications during pregnancy?

_____

Do you experience frequent yeast infections? ☐ Yes ☐ No

Do you have any other disease, condition or problems not listed above that Anna Munne, DDS, PA should know about before proceeding with treatment?_____

_____.

I HEREBY AFFIRM THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE.

SIGNATURE	DATE
X_____	_____
X_____	_____
X_____	_____

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PATIENT DENTAL HISTORY

Date **Patient Name** **D/O/B**

_____ _____ _____

Referring Dentist/ Physician/ Relative_____

General Dentist_____ **How long?**_____

Primary reason for visit_____

Last cleaning _____ **How often?** _____**By whom?** _____

Last periodontal deep scaling_____ **By Whom?** _____

Periodontal disease diagnosed? When?_____ **By whom?**_____

Periodontal surgery? Where?_____ **When?**_____

By whom? _____

Dental implants? Where? _____ **When?**_____

By whom? _____

Gum grafts? Where?_____ **When?**_____

By whom?_____

Teeth extracted? Where?_____ **When?** _____

By whom? _____

Orthodontic treatment? Yes No **How long?**_____ **By whom?**_____

_____

Do you experience: _____gingival pain _____recession _____swelling
_____ Bad breath _____ulcerations _____abscesses _____bleeding

Do you experience sensitivity to: _____ pressure _____hot _____ cold
_____ Brushing _____sweets _____ biting

Do you have any loose teeth? _____ **Where?** _____

Are you aware of any grinding or clenching? _____

Do you wear a mouthguard? _____ Hard Soft

Do your jaws: _____ click? _____ pop? **Are they painful?** Yes No

Do you have earaches? Yes No

TMJ treatment? _____ **By whom?**_____

What do you think about dentures? _____

Oral Health Care

How many times a day do you brush? 1 2 3 4
Times during the day? AM Noon Bedtime
Type of toothbrush Handheld Electric

How many times a day do you floss? 0 1 2 3
Times during the day? AM Noon Bedtime

Fluorides_____ **Mouthwash** _____ **Other** _____

I HEREBY AFFIRM THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE.

_____ _____
SIGNATURE **DATE**

_____ _____
PRINT NAME **PARENT/GUARDIAN**

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PATIENT PERSONAL INFORMATION

FIRST NAME _____ **MI** _____ **LAST NAME** _____ **NICKNAME** _____

HOME ADDRESS _____

CITY _____ **STATE** _____ **ZIP** _____

PLEASE CIRCLE DAYTIME TELEPHONE NUMBER

HOME PHONE (___)_____ **CELL PHONE** (___)_____ **WORK PHONE** (___)_____

EMAIL ADDRESS _____ **DATE OF BIRTH** ___/___/___ **AGE** _____ **SEX** _____ **MARITAL STATUS** S M D W

SOCIAL SECURITY NUMBER ___-___-_____ **DRIVER'S LICENSE #** _____ **OCCUPATION** _____

EMPLOYER _____ **ADDRESS** _____

NAME OF SPOUSE/RELATIVE (EMERGENCY CONTACT) _____ **PHONE NUMBER** _____

RESPONSIBLE FOR ACCOUNT

FIRST NAME _____ **LAST NAME** _____ **RELATION TO PATIENT** _____

HOME ADDRESS _____ **SOCIAL SECURITY NUMBER** _____ **EMPLOYER** _____

DENTAL INSURANCE INFORMATION

INSURED'S NAME

INSURED SOCIAL SECURITY NUMBER & SUBSCRIBER ID #

DATE OF BIRTH

INSURANCE COMPANY

PHONE NUMBER

GROUP NUMBER AND NAME

RELATION TO INSURED

MEDICAL INSURANCE INFORMATION

INSURED'S NAME

INSURED SOCIAL SECURITY NUMBER & SUBSCRIBER ID NUMBER

INSURANCE COMPANY

PHONE NUMBER

GROUP NUMBER AND NAME

I HEREBY AFFIRM THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE.

SIGNATURE

DATE

PRINT NAME

PARENT/GUARDIAN

Anna M. Munné, D.D.S., P.A.
Periodontics • Implants • Root Canals

FINANCIAL POLICY AGREEMENT

We are committed in providing you with the best possible care. If you have dental or medical insurance, we are most happy in helping you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

Payment for services is due at the time services are rendered unless payment arrangements have been approved in advance by our staff. We accept cash, checks, Debit Cards, Discover, Visa, Master Card and American Express. We will be happy to help you process your insurance claim form for your reimbursement. When scheduling an appointment with our office we require a 48-hour notice prior to your appointment. . Otherwise, there will be a $100.00 missed appointment fee applied to your account **Treatments are paid in full at the Pre-op appointment**. We require a 1-week notice for a cancellation of a treatment appointment or 20% of the treatment fee will be non-refundable. Additionally, returned checks are a $35.00 fee. Balances older than 30 days are subject to additional collection fees.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance.

YOU MUST REALIZE THAT:

- Your insurance is a contract between you, your employer and the insurance company.

WE ARE NOT A PARTY TO THAT CONTRACT.

- You are responsible for all charges incurred. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

WE MUST EMPHASIZE THAT AS A MEDICAL PROVIDER,
OUR RELATIONSHIP
IS WITH YOU, NOT YOUR INSURANCE COMPANY.

While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems affect timely payment of your account. If such problems should arise, we encourage you to contact our office promptly for assistance in the management of your account.

If you should have any questions regarding this information, we encourage you to ask questions. Please do not hesitate discussing any concerns. We are here to help you!

_____ _____

Patient Signature Parent or Guardian Signature

_____

Date

4817 Main, Suite 200 Houston, TX 77002 Phone (713) 795-4666 Fax (713) 795-5514

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RELEASING CONFIDENTIAL INFORMATION TO YOUR INSURANCE COMPANY

Date_____

To be able to file with your insurance company, we must have your current insurance card on the day you are seen. **We are not able to file without an insurance card.** If you do not have your card, you will receive an itemized receipt so you can file the claim yourself. If the card that you present is not current or does not contain correct information, you will be responsible for filing your own insurance. We will not be able to refile the claim again later.

I, _____, authorize Anna M. Munné, D.D.S., P.A., to release confidential information regarding my medical and dental records to my insurance carrier for the purpose of obtaining partial reimbursement from my insurance benefits.

_____ _____

Print Patient's Name **Patients Signature**

_____ _____

Parent or Guardian **Witness**

Anna M. Munné, D.D.S., P.A.

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 at Anna M. Munné's Office, D.D.S., P.A.

Federal and state law requires us to maintain the privacy of your health information. That law also requires us 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 we describe in this notice while it is in effect. This notice takes effect July 29, 2009, 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 applicable law permits the changes. 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 health care operations. For example:

Treatment: We may use your health information for treatment or disclose it to a dentist, physician or other health care provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you. We may also disclose your health information to another health care provider or entity that is subject to the federal Privacy Rules for its payment activities.

Health Care Operations: We may use and disclose your health information for our health care operations. Health care operations include quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, and certification, licensing or credentialing activities. We may disclose your health information to another health care provider or organization that is subject to the federal privacy rules and that has a relationship with you to support some of their health care operations. We may disclose your information to help these organizations conduct quality assessment and improvement activities, review the competence or qualifications of health care professionals, or detect or prevent health care fraud and abuse.

On Your Authorization: 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 uses 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 may disclose your health information to a family member, friend or other person to the extent necessary to help with your health care or with payment for your health care. Before we disclose your health information to these people, we will provide you with an opportunity to object to our use or disclosure. If you are not present, or in the event of your incapacity or an emergency, we will disclose your medical information based on our professional judgment of whether the disclosure would be in your best interest. We may 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. We may use or disclose information about you to notify or assist in notifying a person involved in your care, of your location and general condition.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, letters, or e-mail messages).

Marketing: We will not use your health information for marketing communications without your written authorization.

Disaster Relief: We may use or disclose your health information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

Public Benefit: We may use or disclose your medical information as authorized by law for the following purposes deemed to be in the public interest or benefit:

- as required by law;
- for public health activities, including disease and vital statistic reporting, child abuse reporting, FDA oversight, and to employers regarding work-related illness or injury;
- to report adult abuse, neglect, or domestic violence;
- to health oversight agencies;
- in response to court and administrative orders and other lawful processes;
- to law enforcement officials pursuant to subpoenas and other lawful processes, concerning crime victims, suspicious deaths, crimes on our premises, reporting crimes in emergencies, and for purposes of identifying or locating a suspect or other person;
- to coroners, medical examiners, and funeral directors;
- to an organ procurement organizations;
- to avert a serious threat to health or safety;
- in connection with certain research activities;
- to the military and to federal officials for lawful intelligence, counterintelligence, and national security activities;
- to correctional institutions regarding inmates; and
- as authorized by state worker's compensation laws.

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 request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge you a reasonable cost-based fee that may include labor, copying costs, and postage. 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 may- but are not required to- 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 more information about fees.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information over the last 6 years (but not before April 14, 2003). That list will not include disclosures for treatment, payment, health care operations, as authorized by you, and for certain other activities. 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. Contact us using the information listed at the end of this notice for more information about fees.

Restriction: You have the right to request that we place additional restrictions on our use 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). Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. Your request is not binding unless our agreement is in writing.

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. You must specify in your request the alternative means or location, and provide satisfactory explanation how you will handle payment 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 we should amend the information. We may deny your request under certain circumstances.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us using the information listed at the end of this notice.

If you believe that:

- we may have violated your privacy rights,
- we made a decision about access to your health information incorrectly,
- our response to a request you made to amend or restrict the use or disclosure of your health information was incorrect, or
- we should communicate with you by alternative means or at alternative locations, you may contact us using the information listed below. 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.

Other complains can be addressed to The Texas State Board of Dental Examiners at www.tsbde.state.tx.us or call 512-463-6400.

Contact Information:

Anna M. Munné, D.D.S., P.A. 4817 Main, Suite 200 Houston, TX 77002 T: 713-795-4666 F: 713-795-5514 info@drmunne.com

Anna M. Munné, D.D.S., P.A.

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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

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 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)

_____

_____

_____