

# 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:**

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

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 \_\_\_\_\_

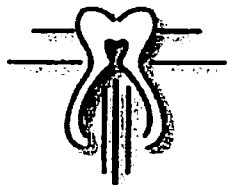
Did you have any complications during pregnancy? \_\_\_\_\_

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? \_\_\_\_\_

\_\_\_\_\_

<b>I HEREBY AFFIRM THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE.</b>	
<b>SIGNATURE</b>	<b>DATE</b>
X _____	_____
X _____	_____
X _____	_____



# Anna M. Munné, D.D.S., P.A.

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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 \_\_\_\_\_

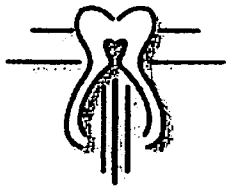
**I HEREBY AFFIRM THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE.**

\_\_\_\_\_  
**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, MasterCard 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.**

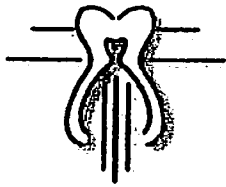
While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems affect timely payment of your account. If such problems should arise, we encourage you to contact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



**Anna M. Munné, D.D.S., P.A.**

**Periodontics • Implants**

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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.

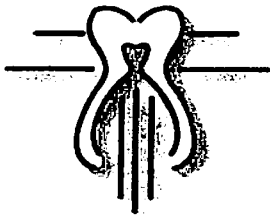
\_\_\_\_\_  
Print Patient's Name

\_\_\_\_\_  
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:

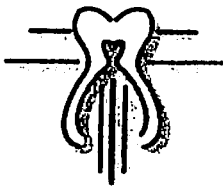
- we may have violated your privacy rights,
- we made a decision about access to your health information incorrectly,
- our response to a request you made to amend or restrict the use or disclosure of your health information was incorrect, or
- we should communicate with you by alternative means or at 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](http://www.tsbde.state.tx.us) or call 512-463-6400.**

Contact Information:



**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)

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**For Office Use Only**

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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)

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