Welcome

To Peak Dentistry the office of
Dr. Joseph and Dr. Gabrielle Ramellini
Thank you for selecting us.

To help us meet all your healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us and we will be happy to help.

Patient Information (Confidential)

Please Circle Dr. Mr. Mrs. Ms. Date _____

Name _____ E-mail _____
Last First Initial

By what name do you prefer to be addressed _____

Phone (H) _____ (C)_____ (W) _____

Mailing Address _____City_____State_____Zip_____

Street Address _____City_____ State_____Zip_____

Birthdate _____Soc. Sec. #_____

Patient's Employer _____Occupation _____

Business Address _____City_____State_____Zip_____

Whom may we thank for referring you? _____

Person to Contact in case of emergency _____Phone _____

Person Responsible for Bill if Other than Self

Name _____Relationship to Patient_____

Address _____Phone _____

Birthdate _____ Soc. Sec. # _____

Employer _____Occupation _____Work Phone _____

SIGNATURE _____

Financial Arrangements

For your convenience, we offer the following methods of payment.
Please check the option you prefer. Payment is due when services are rendered, unless other arrangements have been made prior to treatment.

__ Cash __Personal Check __ Credit Card

__ Cherry __ CareCredit

MEDICAL & DENTAL HISTORY

Name _____Today's Date_____

*This is your **confidential** medical history form. In order to render the best dental care, please fill out as accurately as you can. Any omissions may alter or hinder your treatment. If you are unsure of any of the questions, do not hesitate to have one of our staff or your doctor assist you.*

Thank you.

Please fill in and circle your answers:

What is your chief reason for seeking dental treatment?_____

_____

Are you having pain or discomfort at this time? Yes No

Do your gums ever bleed when you brush your teeth? Yes No

Do you have any areas where food gets caught between your teeth? If so, what area?_____ Yes No

Do you have any areas that are hard to floss? Yes No

Are you concerned about your breath? Yes No

Are any of your teeth sensitive to hot, cold, or pressure? Yes No

On a scale of 1 to 10 (10 being the best), how would you rate your dental health? _____

On a scale of 1 to 10 (10 being the best), how would you like your dental health to be? _____

If you could change something about the appearance of your teeth, what would it be? _____

_____

Would you like to have whiter teeth? Yes No

Who was your previous dentist?_____

Have you been hospitalized in the last two years? Yes No

Are you allergic to (itching, swelling of hands or eyes, rash) or are you made sick by penicillin, aspirin, codeine, anesthetics, or any other drugs or medication? *If yes, please list:*_____ Yes No

_____

When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are tired? Yes No

Have you had any unpleasant dental experiences? If yes, please explain: _____ Yes No

_____

Have you ever had any excessive bleeding requiring medical treatment? Yes No

Do you follow any special dietary restrictions, i.e. Vegan, Vegetarian, Paleo, etc? If yes, Yes No

_____

Does your jaw pop, click, or make grating noises when you chew? Yes No

Do you have more than one headache per month? Yes No

Do you use Tobacco products? If so, what type? _____ Yes No

Do you have any skin reactions to costume jewelry? Yes No

Are you currently taking any medication? If yes, please list: _____ Yes No

_____

Do you or have you ever had: (please circle if yes)

Heart disease or attack
Angina pectoris
High blood pressure
Mitral valve prolapse
Heart murmur
Rheumatic fever
Artificial heart valve
Heart pacemaker
Heart surgery
Psychiatric treatment
Artificial joint

Emphysema
Stroke
Kidney trouble
Tuberculosis (TB)
Asthma
Sinus trouble
Diabetes
Radiation treatment
Chemotherapy
Cortisone treatment

Hepatitis A (Infectious)
Hepatitis B (Serum)
Hepatitis C
AIDS
HIV positive
Blood transfusion
Drug addiction
Cold sores
Epilepsy or seizures
Fainting or dizziness

Is there anything else we would need to know regarding your medical health?

_____

_____

For women:

Are you pregnant? Yes No

Are you taking birth control pills? Yes No

I HEREBY CERTIFY that the above information is accurate and complete.

_____ _____

Your signature Date

Doctor notes:

_____

_____

_____

_____ _____

Doctor signature Date

Preparations before Patients are Scheduled

Patient Name: _____

Todays Date:_____ Surgery Date:_____

☐ Are you taking daily aspirin or blood thinners? (Check all that apply)

- ☐ Aspirin
- ☐ Coumadin (Warfarin)
- ☐ Plavix (Clopidogrel)
- ☐ Eliquis (Apixaban)
- ☐ Pradaxa (Dabigatran)☐☐
- ☐ Xarelto (Rivaroxaban)
- ☐ Savaysa (Edoxaban).

☐ Are you now or have you ever taken medication for Osteoporosis, Osteopenia or Metastic bone cancers, Myeloma or breast cancer(known as BisPhosphonates)? (Check all that apply)

- ☐Fosamax (Alendronate)
- ☐Reclast, Aclasta or Zometa (Zoledronic Acid)
- ☐Actionel or Atlerva (Risedronate)
- ☐Aredia (Pamidronate)
- ☐Didronel (Etidronate)
- ☐Xgeva (Denosumab)

Dates taken_____

How was it given?

- ☐Injection
- ☐IV
- ☐Pill

☐Any other drugs for blood or bone not listed above?_____

Dates taken_____

How was it given?

- ☐Injection
- ☐IV
- ☐Pill

☐ I am not taking any of the above medications

Signature: _____

Office Use

☐ Vitals BP _____/_____ Pulse_____ BPM Pulse Oximeter_____%

Consider Medical consult if BP over 160/100

☐ Informed consents signed

☐ Med Consult Sent to Dr._____

AUTHORIZATION TO RELEASE HEALTH INFORMATION

Communications between Patients and their Families, Friends, or Caregivers

This form allows _____ to communicate information
(Name of Practice)
about your care (e.g., appointments, labs, medication, treatment plans, billing information) to you and those you list on this form. Signing this form is optional, is not required to receive treatment, and does not expire until you end it in writing.

Patient Name: _____
(Last) (First) (Middle Initial)

Date of Birth: _____ **Main Contact Number:** (___) _____
mm/dd/yyyy ☐ Home ☐ Cell* ☐ Work

Mailing Address: _____
(Street)

_____
(City) (State) (Zip)

COMMUNICATING WITH YOU

PHONE

☐ Main Contact Number Above

☐ Other: (___) _____
☐ Home ☐ Cell* ☐ Work

DETAILED MESSAGES PERMITTED

☐ text (SMS)* ☐ voicemail/answering machine ☐ None

☐ text (SMS)* ☐ voicemail/answering machine ☐ None

EMAIL*

☐ _____

☐ All information from this practice
☐ Appointment information only (request/confirm/cancel)
☐ Data breach notifications
☐ Billing/insurance information

COMMUNICATING WITH YOUR FAMILY, FRIENDS, OR CAREGIVERS

☐ This practice may communicate to the family members, friends, or caregivers listed below.

Spouse/Partner: _____
First and Last Name

Phone: (___) _____

Email:* _____

Other: _____
First and Last Name

Phone: (___) _____

Email:* _____

Relationship: _____

Check the box next to each type of information this practice may share.

☐ All information ☐ Prescriptions ☐ Appointments (request/confirm/cancel) ☐ Billing/Insurance

☐ Other: _____

Do not include:

☐ Mental health records ☐ Communicable diseases (e.g., HIV/AIDS) ☐ Alcohol/drug abuse treatment

* I understand that emails and texts are not always secure ways to communicate and could be intercepted and read by a third party. I am willing to accept this risk.
This practice is not responsible for the privacy or security of your health information once it is sent to you, or the recipient(s) listed above.

YOUR PHOTOS & MULTIMEDIA

	Photos/Images may be used/posted:
☐ Photo received from you or personal representative	☐ In office
☐ Photo taken by staff (e.g., pre/post procedure)	☐ On office's website
☐ Other:_____	☐ Other: _____

PATIENT RIGHTS & SIGNATURE

- You can end this authorization at any time in writing. See our Notice of Privacy Practices for exceptions. A termination will not apply to any releases of information that happen before we receive a written termination from you.
- The recipient of the information could use or release it in a way that federal or state laws do not protect. This practice is not responsible for the privacy or security of your health information after it is sent to those listed on this authorization.
- You can review or copy the information that will be used or released as described in this authorization.
- You do not have to sign this authorization to receive treatment from this practice.
- You understand that the information that will be used or released might include a communicable disease diagnosis such as HIV or a diagnosis related to mental health or substance abuse unless you exclude it above.
- All changes or updates to this form must be made in writing and signed by you (patient) or your personal representative. Minor edits (e.g., new phone number) can be made on this form, initialed, and dated instead of requiring a new form.

_____ _____

Patient/Personal Representative Signature **Date:** **mm/dd/yyyy**

Printed name and description of Personal Representative's authority (e.g., healthcare power of attorney)
(Attach documentation to support the personal representative's authority if not already on file with the practice)

_____

FOR OFFICE USE & REFERENCE ONLY

☐ This authorization has been terminated: _____
mm/dd/yyyy

The termination must be in writing and filed with the original authorization.

Date original signed authorization received: _____
mm/dd/yyyy

☐ Copy of original authorization provided to patient/personal representative (check if yes)

Notes: _____

_____

_____

It is recommended that the practice review this form with the patient or their personal representative periodically for changes (e.g., annually with insurance verification).

For Office Use Only

PEAK DENTISTRY

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

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 August 29, 2016, 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 affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us 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 your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also 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.

See other side

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 voicemail messages, postcards, 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. You may also request access by sending us a letter to the address at the end of this Notice.)

Disclosure 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 may charge you a reasonable, cost-based fee for responding to these additional requests.

Restrictions: 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 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.

Contact Officer: Elise Carlisle
Telephone: 828-627-1800
Fax: 828-627-1875
E-Mail: info@peakdentistrync.com
Address: 40 Nelson St.,
Clyde, NC 28721