



Patient Information

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____ First Name _____ Middle Initial

Address _____

E-mail _____

City _____

State _____ Zip _____

Sex M F Age _____

Birthdate _____

Married Widowed Single Minor

Separated Divorced Partnered for _____ years

Patient Employer/School _____

Occupation _____

Employer/School Address _____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____



Dental Insurance

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? Yes No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to _____
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative

Please print name of Patient, Parent, Guardian or Personal Representative

Date _____ Relationship to Patient



Phone Numbers

Home (_____) _____ Work (_____) _____ Ext _____ Cell Phone (_____) _____

Spouse's Work (_____) _____ Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____ Relationship _____

Home Phone (_____) _____ Work Phone (_____) _____



Dental History

Reason for today's visit _____	Burning sensation on tongue <input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth breathing <input type="checkbox"/> Yes <input type="checkbox"/> No
_____	Chew on one side of mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth pain, brushing <input type="checkbox"/> Yes <input type="checkbox"/> No
Former Dentist _____	Cigarette, pipe, or cigar smoking <input type="checkbox"/> Yes <input type="checkbox"/> No	Orthodontic treatment <input type="checkbox"/> Yes <input type="checkbox"/> No
City/State _____	Clicking or popping jaw <input type="checkbox"/> Yes <input type="checkbox"/> No	Pain around ear <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last dental visit _____	Dry mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Periodontal treatment <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last dental X-rays _____	Fingernail biting <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to cold <input type="checkbox"/> Yes <input type="checkbox"/> No
Place a mark on "yes" or "no" to indicate if you have had any of the following:	Food collection between the teeth <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to heat <input type="checkbox"/> Yes <input type="checkbox"/> No
Bad breath <input type="checkbox"/> Yes <input type="checkbox"/> No	Foreign objects <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to sweets <input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding gums <input type="checkbox"/> Yes <input type="checkbox"/> No	Grinding teeth <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity when biting <input type="checkbox"/> Yes <input type="checkbox"/> No
Blisters on lips or mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Gums swollen or tender <input type="checkbox"/> Yes <input type="checkbox"/> No	Sores or growths in your mouth <input type="checkbox"/> Yes <input type="checkbox"/> No
	Jaw pain or tiredness <input type="checkbox"/> Yes <input type="checkbox"/> No	How often do you floss? _____
	Lip or cheek biting <input type="checkbox"/> Yes <input type="checkbox"/> No	How often do you brush? _____
	Loose teeth or broken fillings <input type="checkbox"/> Yes <input type="checkbox"/> No	

Dental Registration and History



Health History

Physician's Name _____ Date of last visit _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). Yes No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Respiratory Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting or dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis, Rheumatism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valves	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Skin Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No
Back Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis Type _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Special Diet	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding abnormally, with extractions or surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Feet or Ankles	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Neck Glands	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Circulatory Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital Heart Lesions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumor or growth on head or neck	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cortisone Treatments	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mitral Valve Prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcer	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cough, persistent or bloody	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nervous Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Veneral Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Weight Loss, unexplained	<input type="checkbox"/> Yes <input type="checkbox"/> No
Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No		
		Radiation Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Do you wear contact lenses? Yes No

Height: _____ Weight: _____

Women:

Are you pregnant? Yes No

Due date _____

Are you nursing? Yes No

Taking birth control pills? Yes No



Medications

List any medications you are currently taking and the correlating diagnosis:

Pharmacy Name _____

Phone (_____) _____



Allergies

<input type="checkbox"/> Aspirin	<input type="checkbox"/> Local Anesthetic
<input type="checkbox"/> Barbiturates (Sleeping pills)	<input type="checkbox"/> Penicillin
<input type="checkbox"/> Codeine	<input type="checkbox"/> Sulfa
<input type="checkbox"/> Iodine	<input type="checkbox"/> Other _____
<input type="checkbox"/> Latex	



Updates (To be filled in at future appointments)

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

For what conditions? _____

Are you taking any new medications? _____ If so, what? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

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

For what conditions? _____

Are you taking any new medications? _____ If so, what? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

Dental Hygiene Consent Form

Patient Name: _____

Date: _____

Treatment:

I understand that I am having the following dental treatment performed:

- Prophy Sealant Scaling Periodontal Treatment
 Fluoride X- rays Exam and Root Planning

- 1.) I hereby authorize Dr. Gluski's hygiene department to perform the procedures as explained to me by my hygienist.
- 2.) The procedure(s) necessary to treat the condition(s) have been explained to me and I understand the nature of the procedure(s) to be: dental prophylaxis (cleaning), scaling root planning (cleaning under the gums), x-ray(s), and topical fluoride treatment.
- 3.) Complications resulting from dental hygiene procedures (dental prophylaxis, scaling, root planning, and topical fluoride treatment) include, but are not limited to the following:
 1. Bleeding, discomfort, infection
 2. Sensitivity of teeth due to removal of deposits on teeth, and root planning
 3. Soft tissue reaction to fluoride treatment to include redness of tissues, nausea if swallowed
 4. Removal of loose or broken restorations (fillings) or crowns
 5. Complications related to local anesthesia although rare can include pain, swelling, bruising, infection, nerve damage, and unexpected allergic reactions
- 5.) Sealants Teeth. **Initial** _____
I understand that sealants are meant to help protect a tooth and to help prevent decay on the chewing surface of a tooth. A sealant is not guaranteed protection from decay. They may wear out and/or chip and may require periodic replacement. They are typically not covered by insurance.
- 6.) Periodontal Treatment. **Initial** _____
Periodontal disease can be a serious condition, causing gum and bone inflammation and/or loss and may lead to loss of permanent teeth. Possible treatment plans have been explained to me, including scaling and root planning, extraction of teeth and tooth replacement. I understand that the success of periodontal treatments depends on my continuing home care and/or more frequent cleaning appointments that may or may not be covered by my insurance.
- 7.) I understand that during the course of treatment the hygienist may discover other unforeseen conditions that may require different procedures than those planned. I authorize my hygienist to perform such other procedures that are deemed necessary in their professional judgment. I understand that no guaranteed results have been offered or promised, and I give my free and voluntary consent for treatment.

I certify that I have read or had explained to me and fully understand the terms within the above consent and voluntarily give my consent to the planned treatment.

Patient Signature

Date

Signature of parent or legal guardian if patient is a minor

Date

Date: _____

X-rays _____

Prophy Adult _____ Child _____

SRP Quads _____

Perio Maintenance _____

Exam _____ Sealants _____

Fluoride _____

Patient Signature _____

Staff Initials _____

Date: _____

X-rays _____

Prophy Adult _____ Child _____

SRP Quads _____

Perio Maintenance _____

Exam _____ Sealants _____

Fluoride _____

Patient Signature _____

Staff Initials _____

Date: _____

X-rays _____

Prophy Adult _____ Child _____

SRP Quads _____

Perio Maintenance _____

Exam _____ Sealants _____

Fluoride _____

Patient Signature _____

Staff Initials _____

Date: _____

X-rays _____

Prophy Adult _____ Child _____

SRP Quads _____

Perio Maintenance _____

Exam _____ Sealants _____

Fluoride _____

Patient Signature _____

Staff Initials _____

Date: _____

X-rays _____

Prophy Adult _____ Child _____

SRP Quads _____

Perio Maintenance _____

Exam _____ Sealants _____

Fluoride _____

Patient Signature _____

Staff Initials _____

Date: _____

X-rays _____

Prophy Adult _____ Child _____

SRP Quads _____

Perio Maintenance _____

Exam _____ Sealants _____

Fluoride _____

Patient Signature _____

Staff Initials _____

Dental Treatment Consent Form

Kenneth S. Gluski D.D.S., P.C.

Patient Name: _____

Date: _____

- 1.) **X-rays** I hereby consent to x-rays during my treatment.

Initial _____

- 2.) **Changes in Treatment Plan**

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on my teeth that were not discovered during examination. I give my permission to the Dentist to make any/all changes and additions as necessary.

Initial _____

- 3.) **Extractions** Alternatives to removal have been explained to me (root canal therapy, crowns, and periodontal surgery) and I authorize the Dentist to remove the following teeth _____ and any others necessary. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue, and surrounding tissue that can last for an indefinite period of time or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility. **Initial** _____

- 4.) **Crowns, Bridges, and Caps**

I understand that it's not always possible to match the color of the natural teeth exactly with artificial teeth. I understand that I may be wearing temporary crowns, which may come off easily. I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes to my new crown, bridge, or cap (including shape, fit, size, and color) will be before cementation.

Initial _____

- 5.) **Dentures, Complete or Partial**

I realize that full or partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The problems of wearing these appliances have been explained to me, including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new denture (including shape, fit, size, placement, and color) will be the "teeth-in-wax" try-in visit. I understand that most dentures require relining approximately 3 to 12 months after the initial placement. The cost for this is NOT included in the initial denture fee. **Initial** _____

- 6.) **Endodontic Treatment (Root Canal)**

I realize there is no guarantee that root canal treatment will save my tooth, and those complications can occur from the treatment, and that occasionally filling material is cemented to the tooth or extends through the root which does not necessarily affect the success of the treatment. Occasionally additional surgical procedures may be necessary following root canal treatment. **Initial** _____

- 7.) **Fillings** I understand that care must be exercised in chewing on a filling especially during the first 24 hours to avoid breakage. I understand that a more expensive filling that was initially diagnosed may be required do to additional decay. I understand that significant sensitivity is a common aftereffect of a newly placed filling.

Initial _____

I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been by anyone regarding the dental treatment which I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

Signature of Patient _____ Date _____

Signature of Parent/Guardian if patient is a minor _____ Date _____

Date _____

Fillings _____ Bridges _____ Crowns _____

Root Canals _____ Extractions _____ Local Anesthesia _____

Impacted teeth repair _____ X-rays _____ Other _____

Sign _____ Staff Initials _____

Date _____

Fillings _____ Bridges _____ Crowns _____

Root Canals _____ Extractions _____ Local Anesthesia _____

Impacted teeth repair _____ X-rays _____ Other _____

Sign _____ Staff Initials _____

Date _____

Fillings _____ Bridges _____ Crowns _____

Root Canals _____ Extractions _____ Local Anesthesia _____

Impacted teeth repair _____ X-rays _____ Other _____

Sign _____ Staff Initials _____

Date _____

Fillings _____ Bridges _____ Crowns _____

Root Canals _____ Extractions _____ Local Anesthesia _____

Impacted teeth repair _____ X-rays _____ Other _____

Sign _____ Staff Initials _____

HIPAA Notice of Privacy Practices

Dr, Kenneth S. Gluski, D.D.S., P.C. 1025 Rosenberg
Galveston, Texas 77550 (409) 765-9190

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location: You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes, object or withdraw as provided in this notice. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: _____ **Signature:** _____ **Date:** _____