HEARTLAND PERIODONTICS, PA

Michael G. Kirsch, DDS, MS
Practice limited to Periodontics

Services provided:
Periodontics, Dental Implants and Oral Medicine

American Dental Association

American Academy
of Periodontology

Fellow of Pierre Fauchard,
an international dental
honor society
International Congress
of Oral Implantology

Thank you for allowing Heartland Periodontics the opportunity to provide for your periodontal and dental implant needs. Our staff is comprised of trained professionals who work as a team to ensure that your treatment with us is delivered with care, comfort and excellence.

We understand that coming to a specialist can cause patients to be apprehensive about dental treatment. To help lessen that feeling, please view our website that will help you get to know a little bit about Heartland Periodontics and Dr. Michael Kirsch. If you should have any questions prior to your appointment, please do not hesitate to call our office as we will be happy to answer any of your questions.

For your convenience our medical history and patient information forms are available here for you to download. Completing these forms and bringing them to your appointment will allow you the time to properly document any health concerns and will allow us to get better acquainted with you. Your well being is important to us while in our care; therefore, your answers will help us customize your treatment to protect your health.

As part of our commitment to excellence to you, our patient, we promise to treat you with the respect and understanding that you deserve. We look forward to the opportunity of meeting you soon.

Sincerely,

Michael G. Kirsch, DDS, MS

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email: gumdoc1@strato.net • www.heartlandperiodontics.com

WELCOME TO OUR OFFICE

Thank you for choosing our office. In order to provide you with the highest quality and most complete health care, we ask that you please complete the following information. In order to assure you of the confidentiality of your health information, please see our Notice of Privacy Policy.

Circle One:
(Dr., Mr., Mrs., Ms., Miss)

Last Name_____ Address_____

First Name_____ City/ State/Zip_____

Birth Date_____ Home Phone_____

Social Security #_____ Cell Phone_____

Employer_____ Work Phone_____

Address_____ City / State/ Zip_____

Email Address_____ Circle if email is work or personal

Name of Referring Dentist _____ Phone _____

In Case of Emergency_____ Phone _____

PERSON RESONSIBLE FOR ACCOUNT

Name_____ Daytime Phone_____

Address_____ City / State_____

DENTAL INSURANCE INFORMATION

Insurance Company_____ Insured's Employer_____

Company Address_____ Group #_____

City / State/ Zip_____ Policy #_____

Insured's Name _____ Relation:_____

Insured's Birth Date_____ Insured's Social Security #_____

I acknowledge that I have received a copy of this office's Notice of Privacy Policy. _____
Initials

Payment is due in full at the time of treatment unless prior arrangements have been approved. If this office agrees to accept my insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover.

_____ _____
Signature Date

MEDICAL HISTORY

Name _____ ***Birth date*** _____

Please circle any of the following which you have or have had in the past

Do you require antibiotics before dental treatment? Y N

PRE-MED DOSEAGE _____

Y N Heart Conditions (Murmur, Rheumatic heart disease, Congenital defect, Mitral Valve Prolapse, Coronary artery disease, Irregular heart beat, Congestive heart failure) , Heart Attack or other _____

_____

Y N Chest Pain (Angina)

Y N Heart Procedures – Stents, Catheterization, Angioplasty, Pacemaker, Bypass surgery, Prosthetic valve placement.

Type and Date of surgery _____

_____

Y N Stroke / TIA's Date: _____

Y N High Blood Pressure

Y N Blood Transfusions- Date _____

Y N Blood disorders (anemia, bleeding tendencies, etc)

Y N Stomach or Intestinal disease (GERD, Ulcers, Colitis, Diverticulitis, Hernia, Hiatal hernia)

Y N Diabetes (or family history of)

Date Diagnosed _____

Glucose level _____

Y N Cancer, Tumors, or Growths (include skin, benign etc)

Type diagnosed _____

Treatment _____

Y N Radiation therapy (X-ray treatments for Cancer)

Area of Treatment _____

Dose amount _____

Y N Chemotherapy Treatment for Cancer

Date of Treatment _____

Length of Treatment _____

Y N Fainting spells / Vertigo

Y N Frequent headaches or earaches

Y N TMJ (Jaw joint) problems or limited opening of mouth

Appliance? _____

Y N Organ Transplant _____

Date of Transplant: _____

Y N Kidney Disease / Stones

Y N Autoimmune disease such as Lupus, Pemphigus, Pemphigoid, Lichen Planus

Y N Pregnant or breast-feeding currently (Women only)

Y N Are you past Menopause (Women only)

Y N Glaucoma

Y N Thyroid Disease

Y N Liver Disease (Cirrhosis, Hepatitis, Etc)

Y N Respiratory (Lung) Disease (Emphysema, Asthma, COPD, Tuberculosis, etc)

Y N Cortisone or steroid type medications

Y N Prosthetic joints or valves (Hip replacements, etc) Type/Date_____

Y N Seizure Disorder (Epilepsy, traumatic)

Y N Arthritis (Rheumatoid, Osteo, Fibromyalgia, Gout)

Y N Allergies (hay fever, foods, materials, or medications)

_____

_____

Y N Sinus Problems

Y N Loss of Weight (without dieting)

Y N History of Surgery, especially several repeated Procedures in childhood

Y N Are you allergic to or unable to eat bananas, kiwis, avocados, chestnuts, tomatoes, potatoes, or hazelnuts?

Y N Do you have a heavy persistent cough of 2-3 weeks duration, particularly one that brings up sputum or bloodied sputum?

Y N Infectious disease (AIDS, HIV, Herpes, Syphilis, Tuberculosis, Hepatitis A, B, or C or other)

Y N Substance abuse (alcohol, cocaine, drugs, etc)

Y N Do you take or have you ***ever*** taken any of the following: If yes for how Long? _____

Fosamax or Fosamax plus D (Alendronate), Actonel (Risedronate), Boniva (Ibandronate) Zometa (Zolendronic acid), Didronel (Etidronate disodium) Didrocal, Aredia (Pamidronate), Bonefos (Clondronate), Skelid (Tiludronate), Forteo (Teriparatide)

Y N Other _____

Have you experienced an allergic or unusual reaction to any of the following?

___Aspirin	___Sulfa drugs	___Penicillin	___Erythromycin
___Tetracycline	___Barbiturates	___Pain medication	___Acetaminophen
___Ibuprofen	___Latex	___Local anesthetic (Novocain)	___Codeine

Please list any other drugs or materials that you are allergic to: _____

Name _____

BP: _____/_____ Pulse _____
Date: _____ *initials:* _____

Continued Medical History

Your current physical health is: ___Excellent ___ Good ____ Fair ____ Poor

Are you currently under the care of a physician? Y N Please explain: _____

Please list all physicians and their specialty

Family physician: _____
Address: _____
Phone: _____

Physician: _____
Specialty: _____
Address: _____
Phone: _____

Physician: _____
Specialty: _____
Address: _____
Phone: _____

Physician: _____
Specialty: _____
Address: _____
Phone: _____

List <u>ALL</u> medications you are taking and reason. Include prescription, supplements, and over the counter.
(Include any blood thinning herbal medications or supplements such as: Vitamin E, garlic, fish oil, any oils, bilberry, bromelain, cat's claw, devil's claw, dong quai, evening primrose, feverfew, ginger (at high doses), ginkgo biloba, grape seed, ginseng, green tea, horse chestnut, and turmeric.)

	<u>Name of Medication</u>	**<u>Dosage</u>**	**<u>Reason</u>**

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

_____
Signature Date

Name _____ ***Date***_____

DENTAL HISTORY

Y N Did you visit your dentist within the last year?

How often do you have your teeth cleaned? _____

Last cleaning date _____

Y N Are you dissatisfied with the appearance of your teeth?

Y N Are you worried about having dental treatment?

Y N Would it bother you to lose your teeth?

Y N Would you be tremendously disturbed if you had to wear artificial teeth?

Y N Do your gums bleed easily?

Y N Do your gums feel tender?

Y N Does your mouth feel dry?

Y N Do you have difficulty swallowing?

Y N Do you clench or grind your teeth during the day or night?

Y N Do your teeth feel loose?

Y N Does your lower jaw click, snap, pop, or jump when you open?

Y N Are your teeth sensitive to hot, cold, or sweets?

Y N Do you use an electric Toothbrush? Brand _____

Y N Have you ever had orthodontic treatment? Date _____

Y N Have you ever had periodontal treatment? Date _____

Type – _____

Areas Treated _____

Y N Are you on any special diet? Explain _____

Y N Do you use tobacco in any form? Type_____

How Long ? _____

Special Considerations

Office Use Only

Consent to the Use and Disclosure of Health Information for Treatment, Payment or Healthcare Operations

I, _____, understand that as part of my health care, Heartland Periodontics, PA originates and maintains paper and/or electronic records describing my health and dental history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment and a means of communicating among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and review the competence of healthcare professionals.

I understand and have been provided with a ***notice of privacy practices*** that provide a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent
- The right to request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.528

I understand that Heartland Periodontics, PA is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Heartland Periodontics, PA reserves the right to change their notice and practices at any time provided such changes are applicable by law, and make the new Notice available upon request.

I wish to have the following restrictions to the use or disclosure of my health information:

_____

_____

_____

I understand that as part of Heartland Periodontics, PA's treatment, payment or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosure via fax. I fully understand and accept the terms of this consent.

_____ _____

Patient's Signature Parent/Guardian

_____ _____

Date Office Use (received by/date)

outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the dental care and services we provide. We will also provide your restorative dentist, physician, or subsequent health care provider with various reports that should assist him or her in treating you while they provide co-therapy and/or subsequent treatment needs.

Super-confidential information regarding HIV testing, results, alcohol or substance abuse diagnosis and treatment, or psychotherapy and mental health records will NOT be disclosed unless you have signed our consent form specifically stating the type of super-confidential information we are allowed to disclose. This information may only be released if authorized under Special Rules (e.g. we are required by law to disclose it). We will comply with state and federal law that required us to warn the recipient in writing that re-disclosure is prohibited.

We will use your health information for payment. For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

Notification/Communication with family: Health professionals, using their best judgment, may disclose to a family member, or other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Courtesy Contacts: We will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you or your family. These communications are an important part of our philosophy of partnering with our patients to be sure they receive the best preventive and restorative care modern dentistry can provide. They may include postcards, folding postcards, letters, telephone reminders, or electronic reminders such as e-mail (unless you tell us that you do not want to receive these reminders).

Workers Compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public Health and National Security: Personal health information regarding communicable diseases or adverse incidents will be disclosed to public health agencies only in accordance with the law.

Education and Research: Personal health information and clinical photographs will be disclosed for educational research only after it has been de-identified or as otherwise authorized in accordance with the law.

Correctional Institution: Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals

Domestic Violence, Crime, Missing persons, and Medical Examiners, Law enforcement: Personal health information will be disclosed only in accordance with the applicable law.

For More Information or to Report a Problem:
If you have questions and would like additional information, you may contact the designated Medical Records Custodian.

If you believe your privacy rights have been violated you can file a complaint with Heartland Periodontics, PA' Privacy Officer or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights. The address for the OCR is listed below:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, DC 20201

NOTICE OF PRIVACY POLICIES

HEARTLAND PERIODONTICS, PA
Michael G. Kirsch, DDS, MS

NOTICE OF PRIVACY PRACTICES FOR HEARTLAND PERIODONTICS

Heartland Periodontics, PA has always been concerned with protecting personal health information and the confidentiality of that information. New Federal (HIPAA – Health Insurance Portability and Accountability Act) laws have been enacted to further insure that information transmitted via computer or other electronic pathways is also protected and to inform you the patient as to how this information may be used and disclosed.

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Introduction

Heartland Periodontics, PA is committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect, and how or when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective April 14, 2003 and applies to all protected health information as defined by State and Federal regulations.

Understanding Your Health Record/Information

Each time you visit Heartland Periodontics, PA a record of your visit is made. Typically, this record contains an updated medical history, review of medications, symptoms, radiographs (x-rays), examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a

- Basis for planning your care and treatments.
- Means of communication among the many health professionals who contribute to your care.
- Legal document describing the care you have received.
- Means by which you or a third-party payer can verify that services billed were actually provided.
- A tool in educating health professionals.
- A source of information for public health officials charged with improving the health of this state and the nation.
- A source of data for our planning and marketing.
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Patients Health Information Rights

You have the right to:

- Obtain a paper copy of this notice of information practices upon request.
- Inspect and obtain a copy of your health record as provided for in 45 CFR 164.528
- Amend your health record as provided in 45 CFR 164.528,
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528
- Request communications of your health information by alternative means or at alternative locations
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.528
- Revoke your consent or authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities

Heartland Periodontics, PA is required to:

- Maintain the privacy of your health information
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- Abide by the terms of this notice,
- Notify you if we are unable to agree to a requested restriction, and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our privacy practice and the terms of this Notice at any time provided such changes are applicable by law. We shall make the new provisions effective for all protected health information we maintain. Should our information practices change, we will change this Notice and make the new Notice available upon request. You may request a copy of our Notice of Privacy Policies at any time.

We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue using or disclosing your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

Business Associates: There are some services provided in our organization through contacts with business associates. Examples include companies for electronic insurance claims submission, and laboratory tests. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and/or bill you or your third-party payer for services rendered. Business associates and other third-parties (if any) receiving personal health information are prohibited from re-disclosing it unless required to do so by law or the patient (or patients legal representative) gives prior express written consent to the re-disclosure. Nothing in the Business associate agreement is intended to, or shall it be construed to allow the business associate to violate this re-disclosure prohibition.

Examples of Disclosures for Treatment Payment and Health Operations

We will use your health information for treatment. For example, information obtained by an assistant, hygienist, dentist, or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. Your dentist will document in your record his or her expectations of the members of your health care team. Members of your health care team will then record the actions they took and their observations. In that way, the dentist will know how you are responding to treatment

We will use your health information for regular health operations. For example: Members of the dental health team, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and