Terry L. Carano, DDS, PA
5938 W. Parker Rd., Ste. 200
Plano, TX 75093
(972)608-1811 Office * (972)608-1860 Fax
www.caranodentistry.com

PATIENT INFORMATION

Welcome to our office! To assist us in serving you, please complete the following confidential forms.

Date: _____

Patient name: _____ Preferred name: _____ Birth date: _____

If minor, parents names: _____

Email address: _____ Cell phone: _____ Daytime phone: _____

Mailing address: _____ City _____ State _____ Zip _____

Spouse's name: _____ Spouse's Cell phone: _____ ❑ Unmarried

Pharmacy Name: _____ Pharmacy phone: _____

Whom may we thank for referring you to our office? _____ ❑ Internet

DENTAL INSURANCE COMPANY: _____ PHONE#: _____

Subscriber Name: _____ Date of Birth: _____ Social Security#: _____

Subscriber ID#: _____ Employer: _____ Group#: _____

PATIENT SIGNATURE: _____ **DATE:** _____

DENTAL HEALTH HISTORY

Date of last dental cleaning: _____ Last full mouth x-rays: _____

Name of previous dental provider: _____ City/State: _____

How often do you brush? _____ How often do you floss? _____

Reason for seeing the Doctor today: _____

Are any of your teeth sensitive to:

Hot or Cold?	❑ yes	❑ no
Sweets?	❑ yes	❑ no
Biting/Chewing?	❑ yes	❑ no
Have you noticed any mouth odors or bad tastes?	❑ yes	❑ no
Do you frequently get cold sores or blisters?	❑ yes	❑ no
Do your gums hurt or bleed?	❑ yes	❑ no
Have your parents had gum disease or tooth loss?	❑ yes	❑ no
Have you noticed any loose teeth or a change in your bite?	❑ yes	❑ no
Does food become caught between your teeth?	❑ yes	❑ no

If yes, where? _____

Do you:

Clench or grind your teeth while awake or asleep?	❑ yes	❑ no
Bite your lips or cheeks regularly?	❑ yes	❑ no
Hold objects with your teeth(pencils, pens, nails)?	❑ yes	❑ no
Mouth breath while asleep or awake?	❑ yes	❑ no
Have tired jaws, especially in the mornings?	❑ yes	❑ no
Snore at night?	❑ yes	❑ no
Have interrupted breathing at night?	❑ yes	❑ no
Have unpleasant breath?	❑ yes	❑ no

Have you ever had:

Orthodontic treatment?	❑ yes	❑ no
Oral surgery?	❑ yes	❑ no
Periodontal treatment?	❑ yes	❑ no
Your teeth ground or bite adjusted?	❑ yes	❑ no
A bite plate or mouthguard?	❑ yes	❑ no
A serious injury to the head or mouth?	❑ yes	❑ no

If yes, describe: _____

_____

Have you experienced:

Clicking or popping of the jaw?	❑ yes	❑ no
Pain(joint, ear, side of face)?	❑ yes	❑ no
Difficulty opening/closing the mouth?	❑ yes	❑ no
Difficulty chewing on either side of your mouth?	❑ yes	❑ no
Head, neck or shoulder aches?	❑ yes	❑ no
Are you satisfied with the way your teeth look?	❑ yes	❑ no
Would you like to keep all of your teeth all of your life?	❑ yes	❑ no
Do you feel nervous about having dental treatment?	❑ yes	❑ no

If yes, what is your biggest concern? _____

_____

Have you ever had an upsetting dental experience? ❑ yes ❑ no

If yes, please describe: _____

_____

PATIENT SIGNATURE: _____ **DATE:** _____

MEDICAL HEALTH HISTORY

Name of your Medical Physician:_____Phone#: _____

Have you been under the care of a medical physician in the past two years? _____ If yes, for what reason? _____

Are you currently taking any medications(over-the-counter or prescription)?_____If yes, please list name and dosage

of each: _____

_____

Do you have or have you had any of the following?
(Please check any that apply)

- ❑ Abnormal bleeding after extractions, surgery, or trauma
- ❑ AIDS or HIV positive
- ❑ Alcoholism
- ❑ Allergies or hives
- ❑ Anemia or blood disorders
- ❑ Arthritis
- ❑ Artificial joint(s)
- ❑ Asthma
- ❑ Blood transfusion
- ❑ Cancer or tumor
- ❑ Chemo/Radiation Therapy
- ❑ Diabetes
- ❑ Emotional condition(s)
- ❑ Emphysema
- ❑ Epilepsy, seizures, or fainting spells
- ❑ Glaucoma
- ❑ Hay fever or sinus trouble
- ❑ Heart Conditions:
  - ❑ Chest pain
  - ❑ Heart attack /surgery
  - ❑ Heart murmur, mitro valve prolapse, heart defect
  - ❑ Heart valve replacement
  - ❑ Pacemaker
  - ❑ Rheumatic heart disease
- ❑ Hemophilia
- ❑ Hepatitis or other liver disease
- ❑ Herpes or cold sores
- ❑ High or low blood pressure
- ❑ Kidney disease
- ❑ Migraine headaches or frequent headaches
- ❑ Neurological Disorder
- ❑ Psychiatric/Psychological Care
- ❑ Rheumatic fever
- ❑ Sickle cell
- ❑ Stroke
- ❑ Thyroid Disease
- ❑ Tuberculosis or other lung problems
- ❑ Ulcers

Do you smoke or use chewing tobacco? ❑ yes ❑ no

Are you allergic to, or have you reacted adversely to any of the following?

- ❑ Aspirin
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Codeine or other narcotics
- ❑ Cortisone Medication
- ❑ Latex materials
- ❑ Local anesthetics ("Novocaine")
- ❑ Penicillin or other antibiotics
- ❑ Sulfa drugs
- ❑ Other:_____

Are you taking any of the following?

- ❑ Antibiotics or sulfa drugs
- ❑ Anticoagulants (blood thinners)
- ❑ Antidepressants or tranquilizers
- ❑ Aspirin
- ❑ Cortisone or other steroids
- ❑ High blood pressure medicine
- ❑ Insulin, Orinase, or other diabetes drug
- ❑ Nitroglycerin
- ❑ Osteoporosis (bone density) medicine
- ❑ Other:_____

_____

Women:

- ❑ Pregnant / May be pregnant
  Expected delivery date: _____
- ❑ Taking hormones or contraceptives

PATIENT SIGNATURE:_____

DATE: _____

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Appointment Changes and Cancellations

When you schedule an appointment with our office, we reserve a specific amount of time for your particular dental procedure. Treatment records are reviewed and special instruments are readied for your visit. Therefore, we ask that if you *must* change an appointment, please give us *at least* 48 hours notice. This courtesy makes it possible to give your reserved room to another patient who would like it.

There is a charge of $125 for not showing up for scheduled appointments and for making changes to reserved appointments without *at least* 48 hours' notice. **Repeated cancellations or missed appointments will result in loss of future appointment privileges.**

Sincerely,

Dr. Terry Carano

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CONSENT FORM

I, _____, consent to be a patient at the above named office and agree to a radiographic and clinical examination. **I also understand and consent to the following:**

1. I will provide a thorough and complete medical history, supply a full list of my medications with dosages, and consent to my dentist communicating with my medical practitioners in respect to my health history. I understand it is imperative that any changes in my medical condition or medications must be disclosed to this office.

2. I am welcome to ask questions about any aspect of my dental care and can request additional information to clarify any questions I still have. Our office encourages every patient to understand their treatment options and all procedures recommended by Dr. Carano.

3. I understand that full payment is due at the time services are provided unless financial arrangements have been made in ***advance***. I understand that even if an insurance pre-estimate is given or a procedure has been pre-approved, I am responsible for ***any*** costs that my insurance does not cover.

4. I understand that a service charge of 1.5% per month on any unpaid balance exceeding 30 days will be charged unless previous arrangements have been made.

5. As explained in the office policy regarding appointment changes/cancellations, I understand that a fee of $125 will be charged for all missed and rescheduled appointments ***unless*** at least 48 hours' notice is given.

PATIENT SIGNATURE: _____ **DATE:** _____

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU AS A PATIENT 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

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 web site and our privacy practices, our legal duties, and your rights concerning your health information. We are required to follow the privacy practices we describe in this notice while it is in effect. This notice takes effect 9/1/2010, 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 that any applicable law permits the changes. We reserve the right to make the changes in our privacy practices and the content of our notice effective for all health information that we maintain, including health information we created or received prior to any changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available to you upon request.

You may request a paper copy of this 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.

OUR USES AND DISCLOSURES OF YOUR 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, 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.

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, or letters).

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 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 9/1/2010). 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 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). 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 to our office. 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.

CONTACT THE DENTAL OFFICE AT:

Contact Name: Dr. Terry Carano
Address: 5938 W. Parker Rd., Ste. 200
Plano, TX 75093
Office phone: (972)608-1811
Email: tcarano@ont.com

Your signature below acknowledges your receipt of our Notice of Privacy Practices

Patient Name:_____ Date:_____