PATIENT INFORMATION

Dr./Mr./Mrs./Miss/Ms._____ Date_____
Last First Middle Date of Birth

Address_____
Number Street City State Zip Code Home Phone Number

Social Security # _____ E-mail Address_____

How may we contact you? ☐ All Methods ☐ E-Mail Only ☐ Phone Only ☐ Text Only

Employer _____ _____
Name Business Address Present Position

_____ _____
City State Zip Code Work Phone Number Cell Phone Number

Name of Spouse_____ Referred By_____

Person responsible for payment of this account:_____If different from patient, please provide the following:

Address_____
Number Street City State Zip Code Area Code Telephone

If you would like us to file any dental claims, please provide the following information:

Insured's Name_____Relationship to Patient_____Insured's SS#_____

Insured's Date of Birth:_____Insured's Employer_____Group #_____ID #_____

Insurance Company Name and Address_____Insurance Phone #_____

Emergency Contact _____
Name Relationship Telephone Number

Physician_____ Specialty_____

Please check YES or NO if you have or have had any of the following:

YES	NO		YES	NO		YES	NO	
☐	☐	High Blood Pressure	☐	☐	Drug Addiction	☐	☐	Measles
☐	☐	Low Blood Pressure	☐	☐	Emphysema	☐	☐	Mumps
☐	☐	Circulatory Problems	☐	☐	Epilepsy or Seizures	☐	☐	Mitral Valve Prolapse
☐	☐	Radiation Treatment	☐	☐	Fainting or Dizziness	☐	☐	Psychiatric Care/Mental Illness
☐	☐	AIDS	☐	☐	Glaucoma	☐	☐	Rheumatic Fever
☐	☐	HIV Positive	☐	☐	Hearing Problems	☐	☐	Scarlet Fever
☐	☐	Alcoholism	☐	☐	Hay Fever	☐	☐	Sickle Cell Disease
☐	☐	Anemia	☐	☐	Heart Disease or Attack	☐	☐	Sinus Trouble
☐	☐	Angina Pectoris	☐	☐	Heart Failure	☐	☐	Stroke
☐	☐	Ankles that swell	☐	☐	Heart Murmur	☐	☐	Thyroid Disease
☐	☐	Anorexia/Bulimia	☐	☐	Heart Pacemaker	☐	☐	Typhoid Fever
☐	☐	Arthritis	☐	☐	Hemophilia	☐	☐	Tuberculosis
☐	☐	Artificial Heart Valve	☐	☐	Excessive Bleeding	☐	☐	Ulcers
☐	☐	Artificial Joints (hip, knee)	☐	☐	Hepatitis A (infection)	☐	☐	Venereal Disease
☐	☐	Asthma/Respiratory Disease	☐	☐	Hepatitis B (serum)	☐	☐	Reaction to Local Anesthesia
☐	☐	Blood Transfusion	☐	☐	Herpes or Fever Blisters	☐	☐	Surgery (Minor or Major)
☐	☐	Bruise Easily	☐	☐	Kidney Problems/Disease			Types:_____
☐	☐	Chemotherapy	☐	☐	Liver Disease			Dates:_____
☐	☐	Diabetes	☐	☐	Lupus	☐	☐	Allergies to Medicine/Drugs
			☐	☐	Malignancies			List:_____

Please describe any current medical treatment, impending operations, or any other medical or dental information that may possibly affect your dental treatment. If you checked YES for any of the above, please describe in full detail:

_____
_____
_____
_____

Please list any medications you are taking: Medication_____ For_____
Medication_____ For_____
Medication_____ For_____

Have you ever taken bisphosphonates like Actonel, Fosamax, Aredia, Boniva, or Zometa? ☐ YES ☐ NO

Do you drink alcoholic beverages? ☐ YES ☐ NO _____drinks per day FOR WOMEN:

Tobacco?_____ packs per day Are you pregnant: ☐ YES ☐ NO Due date_____

DENTAL HEALTH HISTORY

Previous Dentist _____ Specialty_____ Phone Number_____

Address_____

Date of last cleaning_____ Last full-mouth x-ray_____ Last dental examination_____

Why are you changing dentist?_____

What are your immediate dental concerns?_____

Have you ever experienced an unfavorable reaction to a dental procedure? _____ If so, please describe_____

Have you ever experienced any of the following:

☐ bleeding gums	☐ drifting teeth	☐ fever blisters	☐ loose teeth
☐ swelling of gums	☐ pain or soreness in gums	☐ bad breath or bad taste	☐ receding gums
☐ spaces between teeth	☐ food packing between teeth	☐ high or rough fillings	☐ pus around teeth

YES ☐ NO ☐ Have you lost any teeth? From what cause?_____

YES ☐ NO ☐ Do you have any growths or swelling in your mouth? How long have they existed?_____

YES ☐ NO ☐ Have you ever been told you have periodontal disease (gum disease)? When?_____

YES ☐ NO ☐ Are your teeth sensitive to: ☐ hot ☐ sweet ☐ tooth brushing ☐ cold ☐ biting ☐ pressure

YES ☐ NO ☐ Do you have pain or soreness around your eyes, ears, other parts of your face?_____

YES ☐ NO ☐ Have you ever been told you grind your teeth during sleep? How often?_____

YES ☐ NO ☐ Do you have clicking in jaw, popping while eating or yawning or have stiff neck muscles? How often?_____

YES ☐ NO ☐ Do you have difficulty opening your mouth widely or difficulty swallowing?_____

YES ☐ NO ☐ Do you have tension headaches? How often?_____ How controlled?_____

YES ☐ NO ☐ Are you dissatisfied with your teeth and their appearance? _____

YES ☐ NO ☐ Would you like your teeth to be whiter?_____

YES ☐ NO ☐ Would you like to know more information on how to enhance your smile?_____

YES ☐ NO ☐ Have you ever had your teeth straightened? When?_____

YES ☐ NO ☐ Do any members of your family including your parents, brothers or sisters wear dentures?_____

YES ☐ NO ☐ Do you want to learn how to control your dental disease and retain your teeth?_____

YES ☐ NO ☐ Do you get frustrated because you always have something that needs to be treated when you visit a dentist?_____

IF YOU ARE WEARING A PARTIAL OR COMPLETE DENTURE, PLEASE COMPLETE THE FOLLOWING:

How many complete or partial dentures have you had? Upper_____ Lower_____ How long have you worn your present denture?_____

Are you satisfied with the appearance?_____ comfort?_____ chewing ability?_____ speech?_____

I give permission for the use of photographs made in the process of examination and treatment to be used for the purpose of research, education, advertising, promotion, or publication in professional and medical journals.

I give consent and disclosure of my health information to carry out treatment, payment activities, and healthcare operations. If any change occurs in my health, I am to report it to the dental office as soon as possible. If I am unable to keep my appointments and a 24 hour notice is not given, I realize a fee may be charged for the lost time.

I have read, understood and answered all the previous questions truthfully and to the best of my knowledge.

_____ _____

Signature of Patient, Parent or Guardian Date

Medical Update

I have read my MEDICAL HISTORY and confirm that it adequately states past and present conditions.

Date _____ Exceptions_____ Patient's Signature _____

Date _____ Exceptions_____ Patient's Signature _____

Date _____ Exceptions_____ Patient's Signature _____

Date _____ Exceptions_____ Patient's Signature _____

SMILE ANALYSIS

Name _____ Date _____

YES ☐ NO ☐ Do you dislike the appearance of your teeth or smile?
YES ☐ NO ☐ Are you self-conscious about smiling in front of people?
YES ☐ NO ☐ Do you photograph better from one side of your face? If yes, which side? Left – Right
YES ☐ NO ☐ Do you ever put your hand up to cover your smile?
YES ☐ NO ☐ Do you look at magazines and wish you had a smile as pretty as the models?

Please answer these questions in front of a full-face, close-up mirror with good lighting.

In a full smile, how far back does your smile go? How many front and back teeth show? _____
YES ☐ NO ☐ In a full smile, do your back teeth have stain and discolorations? Comment: _____
YES ☐ NO ☐ Are your front teeth uneven in appearance? Comment: _____
YES ☐ NO ☐ Do you dislike the color of your teeth? ☐ Too light ☐ Too dark ☐ Too varied
YES ☐ NO ☐ Do you have white or brown stains? Comment: _____
YES ☐ NO ☐ Is one tooth darker than another? Comment: _____
YES ☐ NO ☐ Do you notice a difference of color between the color of your fillings and your teeth?
YES ☐ NO ☐ Do you feel your teeth are too crowded? Comment: _____
YES ☐ NO ☐ Does the shape of your teeth bother you? Too Long ☐ Too Wide ☐ Too Narrow ☐ Too Round
YES ☐ NO ☐ Are your teeth notched at the gumline? Comment: _____
YES ☐ NO ☐ Are the edges of your teeth chipped or worn? Comment _____
YES ☐ NO ☐ Do you have spaces between your teeth that bother you?
YES ☐ NO ☐ Do your gums show when you are smiling? Comment: _____
YES ☐ NO ☐ Would you like to widen your smile?
YES ☐ NO ☐ Do your gums bleed when you brush or floss your teeth? Comment: _____
YES ☐ NO ☐ Have your gums receded from the necks of your teeth? Comment: _____
YES ☐ NO ☐ Have you ever had orthodontic treatment? If yes, please describe the treatment and dates:

_____

Have you ever had cosmetic dental treatment? If yes, please describe treatment and approximate dates:

_____

_____

In general, how do you feel about your smile?

_____

_____

If you could alter your smile, what would you most like to change?

_____

_____

How long has your smile been bothering you?

_____

MABRITO DENTAL

Dr. Craig A. Mabrito & Mabrito Dental Partners

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE

THIS FORM ACKNOWLEDGES THAT THE PRIVACY PRACTICES NOTICE HAS BEEN PROVIDED TO YOU BY THIS OFFICE. YOU ARE ENTITLED TO KEEP THE FOLLOWING COPY.

I also authorize Mabrito Dental, when necessary, to send emails to me and associated professionals containing x-rays, photos or dental information and these emails are not secure or encrypted.

I, _____, have received a copy of this office's Notice of
(Print name)
Privacy Practices.

_____ _____
(Signature) (Date)

CONSENT FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

ANY INDIVIDUAL OVER THE AGE OF 18 IS REQUIRED TO AUTHORIZE DISCLOSURE OF PROTECTED HEALTH INFORMATION (EVEN TO PARENTS OR SPOUSES). YOU MAY ALSO AUTHORIZE DISCLOSURE TO ANY OTHER INDIVIDUALS ASSISTING IN COMMUNICATION, SCHEDULING OR FINANCIAL ARRANGEMENTS.

I, _____, give my consent for this office to disclose
(Print name)
protected health information to the following individuals:

_____ _____
(Name) (Relationship)

_____ _____
(Name) (Relationship)

_____ _____
(Name) (Relationship)

_____ _____
(Patient Signature) **(Date)**

Dr. Craig A. Mabrito & Mabrito Dental Partners

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 immediately 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 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 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 you 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.

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 t 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 authorize 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).

Email communication: We may use email when necessary to communicate with you and also with dental specialists. These emails may contain x-rays or photos and are not secure or encrypted.

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 that 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. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. 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 will 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 a full explanation of our fee structure.)

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. 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.

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).

Alternative Communication: You have the right to request that we communicate with you about your heath 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:

Nancy Bohrer
C/o Mabrito Dental Partners
1233 West Loop South
Suite 1225
Houston, Texas 77027
713-528-0567
E-mail: Nancy@Mabrito.com