Peter L. Thompson, DDS
123 W 2nd St.
Portales, NM 88130

We would like to take the opportunity to welcome you and share some insights about what we do for our patients. Our purpose is to help people achieve the highest level of well-being appropriate for them and in so doing, to enhance the quality of their lives. In other words, we help you be or become as healthy as you choose. Instead of telling you how healthy you ought to be, we will try to help you understand your choices about dental health and then let you make a free and informed decision. Your first choice in this regard is how you would like to begin with us. There are five levels on which people may choose to be seen in our practice.

Please check the level of care you feel most appropriate for you at this time.

☐ Level 1...URGENT CARE
- People in crisis or with an emergency problem such as pain, swelling or bleeding that need our immediate help are at this level.

☐ Level 2...REMEDIAL CARE
- People who choose this level of care desire treatment only when something breaks or becomes uncomfortable. They usually want to correct immediate problems with as little effort and cost as possible.

☐ Level 3...SELF-CARE
- Patients who choose this level of care want a thorough examination and take an active part in the treatment and prevention of present and future disease problems. However: they usually choose repair solutions that are short range in nature.

☐ Level 4...COMPLETE DENTISTRY
- Patients at this level are similar to people described in level 3. They choose to have a thorough examination. However, they decide on a MASTER PLAN to formulate a long-term treatment plan for health and repair. These patients are very concerned about treating the causes of dental disease, not simply the effects. These patients want all dental treatment provided to be completed in the most lasting fashion as possible.

☐ Level 5...LOOK YOUR BEST
- People in this group are in the level 4 as far as dental health is concern, but also want to look their best at all times. They know that their smile is the first thing others notice about them and want to put their best foot forward. They are willing to make the investment necessary for dental health.

We hope these levels make sense to you. It is not uncommon for people to begin at one level and progress to another over time. Thank you for the opportunity to let us serve you and provide you with the best dentistry appropriate for you.

Whom may we thank for referring you to us?

- ☐ Billboard
- ☐ Family/Friend
- ☐ Yellow Pages
- ☐ Names & Numbers
- ☐ Radio
- ☐ Other_____

PETER L. Thompson DDS

Beautiful Smiles. Excellent Dentistry.

Patient Information

(Please Print)

Name_____ Date_____ Social Security Number_____
First MI Last

Email _____ Driver's License Number _____

Address _____ City _____ State_____ Zip _____

Birthdate _____ Home Phone #_____ Work Phone # _____

Cell Phone #_____ Do you prefer to receive calls at ☐ Home ☐ Work ☐ Cell ☐ Any

Are you: ☐ Minor ☐ Married ☐ Divorced ☐ Widowed ☐ Single ☐ Separated

You or your parent's employer_____ Occupation _____

Business Address _____ City _____ State_____ Zip _____

Spouse's or parent's name _____ Workplace_____ Work Phone #_____

If you are a student, name of school/college_____ City _____ State _____

Person to contact in case of an emergency _____ Phone # _____

Responsible Party

Name of person responsible for this account? _____

Relationship to patient_____ Phone # _____

Address _____ City _____ State_____ Zip_____

Name of employer_____ Work Phone # _____

Insurance Information

Name of insured _____ Relationship to patient_____

Birthdate _____ Social Security # _____ Date employed _____

Name of employer_____ Work Phone #_____

Address _____ City_____ State_____ Zip_____

Insurance Co _____ Group #_____ Employer #_____

Insurance Co Address _____ City _____ State_____ Zip_____

How much is your deductible?_____ How much have you used? _____ Max annual benefit? _____

On a Scale of 1-10 – How would you rate your smile? _____

What would make it a "10"? _____

Do you want us to discuss this? _____

HEALTH HISTORY

Date of last health care exam _____ What was this exam for? _____

Have you been hospitalized in the last 5 years? ☐ No ☐ Yes

If yes, reason _____

Are you currently receiving care? ☐ No ☐ Yes If yes, nature of care _____

Please list all the names and phone numbers of the physicians who are currently providing you care:

1. _____
2. _____
3. _____
4. _____

For the following questions circle yes or no. Your answers are for our records only and will be confidential. Please not that during you initial visit you will be asked some questions about your response. Our team may ask additional questions concerning your health.

Heart Murmur (mitral valve prolapse)	No	Yes	Psychosis	No	Yes
Anemia	No	Yes	Sore/Enlarged Lymph Nodes	No	Yes
Diabetes	No	Yes	Previous Biopsies	No	Yes
Epilepsy	No	Yes	Slow- Healing Mouth Sores	No	Yes
Hepatitis, Any Form	No	Yes	Other Infections	No	Yes
Rheumatic Fever	No	Yes	Recurrent Illnesses	No	Yes
Asthma	No	Yes	Joint Replacement	No	Yes
HIV Positive or AIDS Related Complex	No	Yes	Glaucoma	No	Yes
Emphysema or other Respiratory Illnesses	No	Yes	Abnormal Bleeding from a cut	No	Yes
Abnormal Heart Condition	No	Yes	Liver Disease (including Jaundice)	No	Yes
Kidney	No	Yes	Unintentional Weight Loss/Gain	No	Yes
Heart (Surgery, Disease, Attack)	No	Yes	Latex Sensitivity	No	Yes
Venereal Disease	No	Yes	H.I.V. Infection/AIDS	No	Yes

One or more of the following symptoms may be indicative of Musculoskeletal Dysfunction of the head and neck. If you have any of the following symptoms, please indicate by circling the appropriate areas. (L = Left, R = Right)

Pain in the jaw joint	L	R	Pain in Tongue	No	Yes
Pain in ear	L	R	Loud Snoring	No	Yes
Pain around eyes	L	R	Mouth Breather at Night	No	Yes
Pain in lower jaw	L	R	Awaken with a Dry Mouth	No	Yes
Pain in upper jaw	L	R	Inability to Open Mouth	No	Yes
Pain in neck	L	R	Difficulty Swallowing	No	Yes
Pain in Shoulder	L	R	Constantly Tired	No	Yes
Pain in forehead	L	R	Dizziness (Vertigo)	No	Yes
Pain in temples	L	R	Difficulty Chewing	No	Yes
Pain in facial muscles	L	R	Facial muscle twitch	L	R
Clicking or popping sound in joint	L	R	Grating sound in joint	L	R
Ringing sound in ears	L	R	Fullness, pressure blockage in ears	L	R

Are you required to Pre- Medicate before dental treatment? ☐ No ☐ Yes

Women:

Are you Pregnant?	☐ No	☐ Yes
If no, are you planning a pregnancy in the near future?	☐ No	☐ Yes
Are you a nursing mother?	☐ No	☐ Yes
Are you taking birth control pills?	☐ No	☐ Yes

Abnormal Blood Pressure? ☐ No ☐ Yes

If yes, what is it usually? S_____ /D_____

Are you allergic or have you had a reaction to:

a. Local anesthetics ☐ No ☐ Yes

b. Penicillin or other antibiotics ☐ No ☐ Yes

c. Aspirin ☐ No ☐ Yes

d. Codeine, Valium or other sedatives ☐ No ☐ Yes

e. Other_____

Are you a smoker? ☐ No ☐ Yes

If so, how much do you smoke per day?_____

What are your chief complaints? List from most to least important.

a. _____

b. _____

c. _____

Other symptoms (please write in) _____

_____

Please list any medications you are currently taking.

1. _____ 2. _____

3. _____ 4. _____

4. _____ 6. _____

FINANCIAL AGREEMENT

I, the patient/guardian, agree to be and hereby am fully responsible for total payment for procedures in this office. I understand that payment for dental services is due regardless of the benefits paid by my insurance company, and that if denied in part or in whole, payment in full becomes my responsibility. I understand that if I cancel or no show for an appointment with less than 24 hours notice, a fee will be charged. Any outstanding balance over 90 days will be turned over to a collection agency. At that time, I understand I will be responsible for the collection fee in the recovery of this debt. I also understand that should credit be extended to myself or family by this dental office, a credit check will be made and I authorize release of all information needed to obtain my financial data.

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider of agency, who may release such information to you. I will notify the doctor of change in my health and medication.

_____ _____ _____

Patient (Print Name) Patient Signature Date

_____ _____ _____

Doctor Doctor Signature Date

Thank you for your time!

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

Federal and state law requires us to maintain the privacy of your health information. That law requires us 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 we describe in this notice while it is in effect. This notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right change our privacy practices and the terms of this notice at any time, provided such applicable law permits the changes. 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 rime. 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 health care operations. For example:
Treatment: we may use your health information for treatment of 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 practitioners 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 help these organizations conduct quality assessment and improvement activates, review the competence or qualifications of health care professionals or detect of prevent health care fraud and abuse.

On 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 of 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 our 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 you 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 of 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;
- In response to court and administrative orders and other lawful processes;

- To law enforcement officials pursuant to subpoenas and other lawful processes, concerning victims, suspicious death, 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 your 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 of 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 April 14, 2003). 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. 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 your 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 rights 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.

Provider Contact Office: **Peter L. Thompson, DDS**

Telephone: **575-359-1011** Fax: **575-356-2947**

Email: **peterdds@yucca.net**

Address: **123 W Second St. Portales, MN 88130**

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY POLICIES

You May Refuse to Sign This Acknowledgment

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

_____

Please Print Name)

_____

(Signature)

_____

(Date)

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- ❑ Individual refused to sign
- ❑ Communications barriers prohibited obtaining the acknowledgment
- ❑ An emergency situation prevent us from obtaining acknowledgment
- ❑ Other (Please Specify)_____
