



We are delighted to welcome you to our practice and that you have entrusted us to serve your dental needs. We are serious about providing superior dental care at a reasonable cost, and are proud of our dedication to our patients. Our goal is to help you feel and look your very best through excellent dental care.

Your initial appointment will take approximately 90 minutes. The following patient information and forms may take some time to fill out so we would appreciate it if you would fill them out prior to your arrival, this will give us more time to attend to your Dental needs.

If you have dental insurance that you will be utilizing at our office, we will gladly assist you in obtaining your benefits; we ask that you provide us with your insurance company information prior to your appointment.

We look forward to meeting you and serving your Dental needs. Thank you again for choosing our dental practice.

Mark E. Massaro DDS and Team

Patient Number \_\_\_\_\_

A B C

# HEALTH HISTORY & REGISTRATION

## PATIENT INFORMATION

PATIENT'S NAME Last \_\_\_\_\_ First \_\_\_\_\_ Middle Initial \_\_\_\_\_ SEX: M F BIRTHDATE \_\_\_\_\_ AGE \_\_\_\_\_  
 Soc. Sec. # \_\_\_\_\_ If Patient is a Minor, give Parent's or Guardian's Name \_\_\_\_\_ TODAY'S DATE \_\_\_\_\_  
 Who May We Thank for Referring You to our Office? \_\_\_\_\_ Reason for this Visit \_\_\_\_\_

## RESPONSIBLE PARTY INFORMATION

NAME Last \_\_\_\_\_ First \_\_\_\_\_ Middle Initial \_\_\_\_\_ MARITAL STATUS \_\_\_\_\_  
 RESIDENCE Street \_\_\_\_\_ Apt. # \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 MAILING ADDRESS Street \_\_\_\_\_ Apt. # \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 HOW LONG AT THIS ADDRESS \_\_\_\_\_ HOME PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_  
 WORK PHONE \_\_\_\_\_ E-MAIL \_\_\_\_\_  
 PREVIOUS ADDRESS (if less than 3 yrs.) Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ How Long \_\_\_\_\_  
 SOCIAL SECURITY # \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ DRIVER'S LICENSE # \_\_\_\_\_ RELATION TO PATIENT \_\_\_\_\_  
 EMPLOYER \_\_\_\_\_ OCCUPATION \_\_\_\_\_ NO. YEARS EMPLOYED \_\_\_\_\_

### RESPONSIBLE PARTY'S SPOUSE

NAME \_\_\_\_\_  
LAST FIRST MIDDLE  
 EMPLOYER \_\_\_\_\_ OCCUPATION \_\_\_\_\_ ( )  
NO. YEARS EMPLOYED  
 SOC. SEC. # \_\_\_\_\_ BIRTHDATE \_\_\_\_\_  
 HOME PH. \_\_\_\_\_ CELL PH. \_\_\_\_\_  
 WORK PH. \_\_\_\_\_ E-MAIL \_\_\_\_\_

### EMERGENCY INFORMATION: RELATIVE NOT LIVING WITH YOU.

NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_  
 ADDRESS \_\_\_\_\_ CITY, STATE \_\_\_\_\_  
 HOME PH. \_\_\_\_\_ CELL PH. \_\_\_\_\_  
 WORK PH. \_\_\_\_\_

### DENTAL INSURANCE INFORMATION (Primary Carrier)

Insured's Name \_\_\_\_\_  
 Insurance Co. \_\_\_\_\_ E-MAIL \_\_\_\_\_  
 Insurance Co. Address \_\_\_\_\_  
 Insured's Employer \_\_\_\_\_  
 Insured's Soc. Sec. # \_\_\_\_\_ Group # \_\_\_\_\_ Local # \_\_\_\_\_

### If you have double dental insurance coverage, complete this for the second coverage.

Insured's Name \_\_\_\_\_  
 Insurance Co. \_\_\_\_\_ E-MAIL \_\_\_\_\_  
 Insurance Co. Address \_\_\_\_\_  
 Insured's Employer \_\_\_\_\_  
 Insured's Soc. Sec. # \_\_\_\_\_ Group # \_\_\_\_\_ Local # \_\_\_\_\_

*It is important that I know about your Medical and Dental History. These facts have a direct bearing on your Dental Health. This information is strictly confidential and will not be released to anyone. Thank you for taking the time to completely fill out this questionnaire.*

*DENTAL HISTORY*		YES	NO	*MEDICAL HISTORY*				YES	NO			
HOW LONG SINCE you have seen a dentist?				Do you have any CURRENT HEALTH PROBLEMS?				<input type="checkbox"/>	<input type="checkbox"/>			
Last COMPLETE Dental Exam, Date:				Are you under a PHYSICIAN'S CARE now?				<input type="checkbox"/>	<input type="checkbox"/>			
Last FULL MOUTH X-RAYS, DATE:(16 Small Films or Panoramic)				For what?								
Are you having PROBLEMS now?		<input type="checkbox"/>	<input type="checkbox"/>	What MEDICATIONS are you currently taking?								
WHAT?												
Is your present dental health POOR?		<input type="checkbox"/>	<input type="checkbox"/>	Have you ever taken Fen-Phen/Redux?				<input type="checkbox"/>	<input type="checkbox"/>			
Do you wear DENTURES? (Partials or Full)		<input type="checkbox"/>	<input type="checkbox"/>	Are you PREGNANT?				<input type="checkbox"/>	<input type="checkbox"/>			
Are you UNHAPPY with your dentures?		<input type="checkbox"/>	<input type="checkbox"/>	Do you use cigars/cigarettes, pipe or chewing tobacco? (circle)				<input type="checkbox"/>	<input type="checkbox"/>			
Would you like to know more about PERMANENT REPLACEMENTS?		<input type="checkbox"/>	<input type="checkbox"/>	<b>PLEASE ✓ YES OR NO OF THE FOLLOWING WHICH YOU HAVE HAD, OR PRESENTLY HAVE:</b>								
Are you APPREHENSIVE about dental treatment?		<input type="checkbox"/>	<input type="checkbox"/>	YES NO		YES NO		YES NO				
Have you had any PERIODONTAL (GUM) treatments?		<input type="checkbox"/>	<input type="checkbox"/>	AIDS/HIV Pos.	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric care	<input type="checkbox"/>	<input type="checkbox"/>
Do your gums BLEED, or feel TENDER or IRRITATED?		<input type="checkbox"/>	<input type="checkbox"/>	Anaphylaxis	<input type="checkbox"/>	<input type="checkbox"/>	Food allergies	<input type="checkbox"/>	<input type="checkbox"/>	Rapid weight gain/loss	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth SENSITIVE to hot, cold, sweets, pressure? (circle)		<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Radiation treatment	<input type="checkbox"/>	<input type="checkbox"/>
Are you UNHAPPY with the APPEARANCE of your teeth?		<input type="checkbox"/>	<input type="checkbox"/>	Arthritis (Rheumatism)	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory disease	<input type="checkbox"/>	<input type="checkbox"/>
Are you aware of GRINDING or CLENCHING your teeth?		<input type="checkbox"/>	<input type="checkbox"/>	Artificial heart valves	<input type="checkbox"/>	<input type="checkbox"/>	Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic/scarlet fever	<input type="checkbox"/>	<input type="checkbox"/>
Do you have HEADACHES, EARACHES, or NECK PAINS?		<input type="checkbox"/>	<input type="checkbox"/>	Artificial joints	<input type="checkbox"/>	<input type="checkbox"/>	Heart problems (please describe)	<input type="checkbox"/>	<input type="checkbox"/>	Shingles	<input type="checkbox"/>	<input type="checkbox"/>
Have you worn BRACES on your teeth (ORTHODONTICS)		<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
Do you have DISCOLORED teeth that bother you?		<input type="checkbox"/>	<input type="checkbox"/>	Atopic (Allergy Prone)	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia (Abnormal bleeding)	<input type="checkbox"/>	<input type="checkbox"/>	Skin rash	<input type="checkbox"/>	<input type="checkbox"/>
Would you like your smile to LOOK BETTER or DIFFERENT?		<input type="checkbox"/>	<input type="checkbox"/>	Back problems	<input type="checkbox"/>	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	<input type="checkbox"/>	Spina Bifida	<input type="checkbox"/>	<input type="checkbox"/>
Do you REGULARLY use DENTAL FLOSS?		<input type="checkbox"/>	<input type="checkbox"/>	Blood disease	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Name of Previous Dentist:				Cancer	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Surgical implant	<input type="checkbox"/>	<input type="checkbox"/>
City: _____ State: _____				Chemical dependency	<input type="checkbox"/>	<input type="checkbox"/>	Jaw pain	<input type="checkbox"/>	<input type="checkbox"/>	Swelling of feet or ankles	<input type="checkbox"/>	<input type="checkbox"/>
How do you feel about your teeth?				Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease or malfunction	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease or malfunction	<input type="checkbox"/>	<input type="checkbox"/>
Please RANK the following in the order in which they would KEEP YOU FROM having dental treatment.				Circulatory problems	<input type="checkbox"/>	<input type="checkbox"/>	Liver disease	<input type="checkbox"/>	<input type="checkbox"/>	Tobacco habit	<input type="checkbox"/>	<input type="checkbox"/>
FEAR of pain # _____ LACK of concern # _____				Cortisone treatments	<input type="checkbox"/>	<input type="checkbox"/>	Material allergies	<input type="checkbox"/>	<input type="checkbox"/>	Tonsillitis	<input type="checkbox"/>	<input type="checkbox"/>
COST of treatment # _____ MISSING work time # _____				Cough (persistent)	<input type="checkbox"/>	<input type="checkbox"/>	(latex, wool, metal, chemicals)	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
				Cough up blood	<input type="checkbox"/>	<input type="checkbox"/>	Mitral valve prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer/Colitis	<input type="checkbox"/>	<input type="checkbox"/>
				Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Nervous problems	<input type="checkbox"/>	<input type="checkbox"/>	Venereal disease	<input type="checkbox"/>	<input type="checkbox"/>
				Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker/heart surgery	<input type="checkbox"/>	<input type="checkbox"/>			
				<b>ARE YOU ALLERGIC TO OR HAVE YOU REACTED ADVERSELY TO ANY OF THE FOLLOWING MEDICATIONS?</b>								
				Aspirin	Local Anesthetic	Erythromycin	Latex (balloons, gloves, etc.)					
				Nitrous Oxide	Codeine	Penicillin						
				Are you aware of being allergic to any other medications or substances?								
				If yes, please list:								
				Is there any other Medical or Dental information that you feel I should know about?								
				FAMILY PHYSICIAN _____ PHONE _____ E-MAIL _____								

PATIENT Signature (Parent of Child) \_\_\_\_\_

Date: \_\_\_\_\_

DENTIST Signature \_\_\_\_\_



**NOTICE OF PRIVACY PRACTICES**

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**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED  
HOW YOU CAN GET ACCESS TO THIS INFORMATION**

**PLEASE REVIEW IT CAREFULLY.  
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.**

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**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 04/14/03, 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 at the end of this Notice.

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**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 your, 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 your 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 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:** Our dental office does not use patient information for any marketing purposes.

**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 to 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 authorized 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).

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## 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 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. You may also request access by sending us a letter to the address at the end of the Notice. 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, but not before April 14, 2003. 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 health 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.

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## QUESTIONS AND COMPLAINTS

If you want more information about our privacy practice 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: Patient Care Coordinator  
Privacy Officer: Mark E. Massaro, D.D.S., Owner  
Telephone: 918.743.9924  
Address: 3150 E. 41<sup>st</sup>, Suite 141, Tulsa, OK 74105

Mark E. Massaro, D.D.S.  
3150 E. 41<sup>st</sup>, Suite 141  
Tulsa, Ok. 74105  
(918) 743-9924

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**ACKNOWLEDGEMENT OF RECEIPT OF  
NOTICE OF PRIVACY PRACTICES**

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\* You May Refuse to Sign This Acknowledgement \*

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

\_\_\_\_\_  
Please Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

If there are any immediate family members/guardians that you wish to restrict from  
having access to your health information, please indicate below:

\_\_\_\_\_  
\_\_\_\_\_

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**For Office Use Only**

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

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (please specify)

\_\_\_\_\_  
\_\_\_\_\_