Laura Heisch, D.D.S.
David Gartz, D.D.S. Reed Cannon, D.M.D.

106-A Longview Drive 555 Oppenheimer Drive
Los Alamos, NM 87544
672-3869 672-1336 662-4252

PATIENT

Patient Name:

Last_____ First_____MI_____ Social Security # _____

Street Address:_____City_____State_____Zip_____

P. O. Box:_____City_____State_____Zip_____

Home #:_____Work #:_____Alternate #:_____

Sex: Male_____ Female_____ Marital Status: S____M____D____W____

Date of Birth:_____/_____/_____ Employer:_____

RESPONSIBLE PARTY

Responsible Party:

Relationship to Patient (If self you may skip this portion.):_____

Last_____ First_____MI_____ Social Security # _____

Street Address:_____City_____State_____Zip_____

P. O. Box:_____City_____State_____Zip_____

Home #:_____Work #:_____Alternate #:_____

Sex: Male_____ Female_____ Marital Status: S____M____D____W____

Date of Birth:_____/_____/_____ Employer:_____

DENTAL INSURANCE

Primary Insurance:_____ Group #:_____

Address:_____City_____State_____Zip_____

Phone Number:_____ Identification #_____

Primary Policy Holder's Name: Last_____First_____MI_____

SSN:_____ Date of Birth:_____/_____/_____ Relationship to Patient:_____

Employer:_____ Work Phone:_____

Address of Employment:_____

Secondary Insurance:_____ Group #:_____

Address:_____City_____State_____Zip_____

Phone Number:_____ Identification #_____

Secondary Policy Holder's Name: Last_____First_____MI_____

SSN:_____ Date of Birth:_____/_____/_____ Relationship to Patient:_____

Employer:_____ Work Phone:_____

Address of Employment:_____

I ACKNOWLEDGE THAT HIGH MESA DENTAL ARTS IS ONLY A DELTA PROVIDER. IF I HAVE ANOTHER INSURANCE COMPANY MY BENEFITS MAY BE DECREASED, IF I HAVE QUESTIONS REGARDING MY COVERAGE I NEED TO CHECK WITH MY INSURANCE COMPANY.

Initials:_____Date:_____/_____/_____

EMERGENCY CONTACT

Please print the name of a friend or relative that you **do not** live with.

Name:_____ Relationship to you:_____

Phone:_____ Address:_____

HEALTH HISTORY INFORMATION

Patient Name_____ **Patient D.O.B**:_____

Date of last physical examination:_____ Physician's Name:_____

Dates of: Last dental examination_____ Dental cleaning_____

X-rays_____ Dentist's Name:_____

What is the purpose of this dental visit?_____

Are you having pain or discomfort at this time? YES NO

Do you feel nervous about having dental treatment? YES NO

Is there anything that you dislike about your smile? YES NO

Have you been a patient in the hospital during the past two years? YES NO

Have you been under the care of a physician during the past two years? If so, for what? YES NO

Are you currently taking any of the following medicines or drugs? If yes, please note dosage.

Digitalis, Nitroglycerin or similar heart medications	YES	NO	Dosage_____
Birth Control Pills or other Hormones	YES	NO	Dosage_____
Anticoagulants (blood thinners)	YES	NO	Dosage_____
Cortisone or other Steroids	YES	NO	Dosage_____
Blood Pressure Medication	YES	NO	Dosage_____
Vitamins or Supplements	YES	NO	Dosage_____
Antibiotics or Sulfa Drugs	YES	NO	Dosage_____
Asthma Inhalers or other	YES	NO	Dosage_____
Tranquilizers	YES	NO	Dosage_____
Dilantin	YES	NO	Dosage_____

List any other medications you are currently taking:_____

Are you allergic or have you had any adverse reaction (i.e. itching, rash swelling of hands, feet or eyes) to penicillin, aspirin, codeine, any medications, metals, local anesthetics, food or latex? YES NO

If so, please specify_____

Have you ever had any excessive bleeding requiring special treatment? YES NO

Are there now any growths or sores in or around your mouth? YES NO

Do you have any trouble chewing? YES NO

Does food catch between your teeth? YES NO

Do you have pain in or near your ears? YES NO

Do you habitually clench or grind your teeth during the day or at night? YES NO

Have you ever been told that you have gum problems, gingivitis or periodontal disease? YES NO

Do you now have bleeding gums or any other gum condition? YES NO

WOMEN: Are you pregnant now? YES NO

Is there anything related to your medical or dental history that you have not indicated above? YES NO

If yes, explain_____

_____

Circle any of the following which you have had, or have at the present time:

Heart Failure	Anemia	Glaucoma	Dental Implant
Heart Disease or Attack	Emphysema	Ulcers	Pain in Jaw Joints
Angina Pectoris	Cough	HIV Positive/AIDS	Periodontal Surgery
High Blood Pressure	Tuberculosis (TB)	Liver Disease	Sickle Cell Disease
*Endocarditis	Asthma	Hepatitis A (Infectious)	Bruise Easily
Rheumatic Fever	Hay Fever	Hepatitis B (Serum)	*Artificial Hip, Knee or Joint
*Congenital Heart Lesions	Sinus Trouble	Hepatitis C (Serum)	Thyroid Disease
*Artificial Heart Valve	Allergies	Jaundice	Immune System Problems
Mitral Valve Prolapse	Diabetes	Blood Transfusion	Use of Tobacco Products
Heart Pacemaker	Radiation Therapy	Kidney Trouble	Sexually Transmitted Disease
Psychiatric Treatment	Cold Sores (Herpes)	Chemotherapy	Arthritis (Rheumatoid, etc.)
Organ Transplant	Mental Handicap	Substance Abuse	Fainting or Dizzy Spells
Stroke	Alcoholism	Hemophilia	Epilepsy or Seizure Disorder
Cancer (Type_____)		Heart Surgery (Specify_____)	

Antibiotic pre-medication may be required prior to your appointment.

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form. I acknowledge that I am responsible for informing the doctor about any changes in my health history prior to treatment. I understand that my health history information will be used as necessary for diagnosis or treatment by doctors Gartz, Roberts, Heisch, and Cannon. If in the event my account becomes past due and is sent to collections, I may be held responsible for any fees or charges associated with the collections proceedings.

PRINTED NAME:_____

SIGNATURE:_____

DATE:_____

COMPLETE FOR SUBSEQUENT VISITS ONLY: I have read my answers to the questions above and there are no changes or I have made changes.

Initials/Date_____ Initials/Date_____ Initials/Date_____

Initials/Date_____ Initials/Date_____ Initials/Date_____

HEISCH, GARTZ, D.D.S., & CANNON, D.M.D.
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****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}

For Office Use Only

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)

_____

_____

_____

HEISCH, GARTZ, D.D.S.

AND CANNON, D.M.D.

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 04/18/2007, 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. Everyone on our staff is required to sign a confidentiality statement.

Payment: We may use and disclose your health information to obtain payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.

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 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 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.

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).

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 this Notice. If you request copies, we will charge you $0.05 for each page, $15 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. 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).

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.

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: Marna Riedel

Telephone: 505-672-1336 Fax: 505-672-0840

Email: highmesadental@gmail.com

Address: 106 A Longview Drive, Los Alamos, NM, 87544

LAURA HEISCH, D.D.S.,
DAVID GARTZ, D.D.S., REED CANNON, D.M.D.
106 A LONGVIEW DRIVE
LOS ALAMOS, NM 87544
(505) 672-3869 672-1336 662-4252

Date:_____

I authorize the release of all dental records and x-rays for the following patients:

Name_____ **Date of birth**_____

Name_____ **Date of birth**_____

Name_____ **Date of birth**_____

Name_____ **Date of birth**_____

Name_____ **Date of birth**_____

Please send to: **Drs. Heisch, Gartz and Cannon**
Medical Records
106 A Longview Dr.
Los Alamos, NM 87544

Previous Dentist:_____

_____

_____

Signature_____