WELCOME TO THE OFFICE OF JOSEPH L. KEEFER, DMD, MAGD

SCHEDULING: Time is a commodity in short supply these days. When you make an appointment with us, we recognize that this is your time in our office. We consider this a bond of trust that you will be here for treatment, and that we will here to serve you. We make every effort to seat our patients on time. We ask that you arrive 5-10 minutes before your scheduled appointment time to address any administrative needs. A 24 HOUR NOTICE IS REQUIRED FOR ANY CANCELLATION. This allows us to schedule another patient in that time. Failure to give a 24 HOUR notice may result in a $45.00 charge.

INSURANCE: Payment is expected at the time of service. As a courtesy and service to our patients, we will file your insurance for you. We expect you to pay the estimated portion that your insurance will not cover. Remember that insurance estimates are only estimates. Any charges not covered by insurance are the responsibility of the patient. Our office will allow the insurance company 30 days from the completion of the service to pay for the service provided. If the insurance company has not paid within 30 days, then the patient will be responsible to pay the account balance within 15 days. We make every effort to keep you abreast of insurance maximums, but this record keeping is ultimately the responsibility of the patient.

FEES: Fees are determined by the quality materials used to provide you dental services and by the time involved to provide your dental service. Fees are not determined by the amount that your insurance company is willing to pay. If the amount that the insurance is willing to pay is less than our fee, then the patient is responsible for payment of the difference. Our office does not reduce its fee to an amount set by the insurance company.

TREATMENT: We believe that all treatment begun should be completed. Incomplete treatment can lead to complications, problems, and misunderstandings. Incomplete treatment can lead to tooth loss and further disease. We ask that all agreed upon treatment, once started, be completed.

PRIVACY PRACTICES: We are required by applicable federal and state law to maintain the privacy of your health care information. A copy of our privacy practices is available below, on our website or at our physical office.

I HAVE READ AND UNDERSTAND THE ABOVE POLICIES:

NAME_____DATE_____

ASSIGNMENT OF INSURANCE BENEFITS

Dr. Keefer agrees to accept your assignment of benefits if you have dental insurance. This means that your insurance company will send the insurance payment to us and you will only have to pay your estimated portion at the time of service. After the insurance payment is received, if any portion of the bill remains, you will be billed for the balance. In order for us to accept assignment of benefits, you must sign below. If you would not like to assign Dr. Keefer benefits, you will be asked to pay all charges up front and the insurance will reimburse you. This assignment of benefits does not apply if you have a reimbursement plan or if your insurance company does not accept assignment of benefits.

I WOULD LIKE TO ASSIGN MY INSURANCE BENEFITS TO DR. KEEFER.

Signature_____Date_____

PATIENT REGISTRATION AND DENTAL HISTORY

PERSONAL INFORMATION (all information is kept strictly CONFIDENTIAL):

FULL NAME: _____ BIRTHDATE _____

ADDRESS: street_____

city_____ state _____ zip code _____

TEL. HOME _____ WORK _____CELL _____

EMAIL ADDRESS _____ Prefer vs. phone calls? Yes___ No___

EMPLOYER_____ SOCIAL SECURITY # of patient _____

INSURANCE CARRIER _____GROUP# _____

NAME OF INSURED _____ Relationship to patient _____ Date of Birth of insured_____

I.D. AND OR SS# OF INSURED _____

PARENT/GUARDIAN NAME (if minor) _____

NAME OF SPOUSE _____ BIRTHDATE _____

SECONDARY CARRIER _____ GROUP # _____

EMPLOYER _____ ID # _____

WHOM MAY WE CONTACT IN CASE OF EMERGENCY? (Name and number) _____
WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

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DENTAL HISTORY Date of your last dental visit _____

Are you having pain at this time?	**Y**	**N**
Have you noticed any loosening of your teeth?	**Y**	**N**
Does food tend to become caught between your teeth?	**Y**	**N**
Do you suffer from pain and/or swelling of your gums?	**Y**	**N**
Do your gums often bleed when you brush your teeth?	**Y**	**N**
Do you floss?	**Y**	**N**
Problems of the jaw. Have you experienced:		
Clicking of the jaw?	**Y**	**N**
Pain (joint, ear, side of face)?	**Y**	**N**
Difficulty in opening or closing?	**Y**	**N**
Difficulty in chewing?	**Y**	**N**
Habits. Do you:		
Clench or grind your teeth?	**Y**	**N**
Bite your lips or cheeks regularly?	**Y**	**N**
Mouth breathe?	**Y**	**N**
Is it important for you to keep your teeth?	**Y**	**N**
Are you satisfied with the appearance of your teeth?	**Y**	**N**

What concerns you most about your dental health?_____

If not, what would you change? _____

Health History Form

American Dental Association
www.ada.org

E-mail: Today's Date:

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name: (Last First Middle) | Home Phone: *Include area code* ( ) | Business/Cell Phone: *Include area code* ( )

Address: (Mailing address) | City: | State: | Zip:

Occupation: | Height: | Weight: | Date of birth: | Sex: M F

SS# or Patient ID: | Emergency Contact: | Relationship: | Home Phone: ( ) | Cell Phone: ( ) *Include area codes*

If you are completing this form for another person, what is your relationship to that person?

Your Name | Relationship

Do you have any of the following diseases or problems: *(Check DK if you Don't Know the answer to the question)*	**Yes**	**No**	**DK**
Active Tuberculosis	☐	☐	☐
Persistent cough greater than a 3 week duration	☐	☐	☐
Cough that produces blood	☐	☐	☐
Been exposed to anyone with tuberculosis	☐	☐	☐

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

Dental Information *For the following questions, please mark (X) your responses to the following questions.*

	Yes	**No**	**DK**
Do your gums bleed when you brush or floss?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Does food or floss catch between your teeth?	☐	☐	☐
Is your mouth dry?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Have you had any problems associated with previous dental treatment?	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐
Do you drink bottled or filtered water?	☐	☐	☐
If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY			
Are you currently experiencing dental pain or discomfort?	☐	☐	☐

	Yes	**No**	**DK**
Do you have earaches or neck pains?	☐	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐
Do you brux or grind your teeth?	☐	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐	☐
Do you wear dentures or partials?	☐	☐	☐
Do you participate in active recreational activities?	☐	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐	☐

Date of your last dental exam:
What was done at that time?

Date of last dental x-rays:

What is the reason for your dental visit today?

How do you feel about your smile?

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

	Yes	**No**	**DK**
Are you now under the care of a physician?	☐	☐	☐

Physician Name: Phone: *Include area code* ( )

Address/City/State/Zip:

Are you in good health?	☐	☐	☐
Has there been any change in your general health within the past year?	☐	☐	☐

If yes, what condition is being treated?

Date of last physical exam:

	Yes	**No**	**DK**
Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐	☐

If yes, what was the illness or problem?

Are you taking or have you recently taken any prescription or over the counter medicine(s)?	☐	☐	☐

If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements:

_____

_____

_____

_____

Medical Information

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

(Check DK if you Don't Know the answer to the question)	Yes	No	DK
Do you wear contact lenses?	☐	☐	☐
Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	☐	☐	☐
Date: _____ If yes, have you had any complications?_____			
Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease?	☐	☐	☐
Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?	☐	☐	☐
Date Treatment began: _____			

	Yes	No	DK
Do you use controlled substances (drugs)?	☐	☐	☐
Do you use tobacco (smoking, snuff, chew, bidis)?	☐	☐	☐
If so, how interested are you in stopping? (Circle one) VERY / SOMEWHAT / NOT INTERESTED			
Do you drink alcoholic beverages?	☐	☐	☐
If yes, how much alcohol did you drink in the last 24 hours? _____			
If yes, how much do you typically drink In a week? _____			
WOMEN ONLY Are you:			
Pregnant?	☐	☐	☐
Number of weeks: _____			
Taking birth control pills or hormonal replacement?	☐	☐	☐
Nursing?	☐	☐	☐

Allergies - Are you allergic to or have you had a reaction to:
To all **yes** responses, specify type of reaction.

	Yes	No	DK
Local anesthetics	☐	☐	☐
Aspirin	☐	☐	☐
Penicillin or other antibiotics	☐	☐	☐
Barbiturates, sedatives, or sleeping pills	☐	☐	☐
Sulfa drugs	☐	☐	☐
Codeine or other narcotics	☐	☐	☐
Metals	☐	☐	☐
Latex (rubber)	☐	☐	☐
Iodine	☐	☐	☐
Hay fever/seasonal	☐	☐	☐
Animals	☐	☐	☐
Food	☐	☐	☐
Other	☐	☐	☐

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No	DK
Artificial (prosthetic) heart valve	☐	☐	☐
Previous infective endocarditis	☐	☐	☐
Damaged valves in transplanted heart	☐	☐	☐
Congenital heart disease (CHD)			
Unrepaired, cyanotic CHD	☐	☐	☐
Repaired (completely) in last 6 months	☐	☐	☐
Repaired CHD with residual defects	☐	☐	☐

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

	Yes	No	DK
Cardiovascular disease.	☐	☐	☐
Angina	☐	☐	☐
Arteriosclerosis	☐	☐	☐
Congestive heart failure	☐	☐	☐
Damaged heart valves	☐	☐	☐
Heart attack	☐	☐	☐
Heart murmur	☐	☐	☐
Low blood pressure	☐	☐	☐
High blood pressure	☐	☐	☐
Other congenital heart defects	☐	☐	☐
Mitral valve prolapse	☐	☐	☐
Pacemaker	☐	☐	☐
Rheumatic fever	☐	☐	☐
Rheumatic heart disease	☐	☐	☐
Abnormal bleeding	☐	☐	☐
Anemia	☐	☐	☐
Blood transfusion	☐	☐	☐
If yes, date:_____			
Hemophilia	☐	☐	☐
AIDS or HIV infection	☐	☐	☐
Arthritis	☐	☐	☐

	Yes	No	DK
Autoimmune disease	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Systemic lupus erythematosus	☐	☐	☐
Asthma	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Sinus trouble	☐	☐	☐
Tuberculosis	☐	☐	☐
Cancer/Chemotherapy/ Radiation Treatment	☐	☐	☐
Chest pain upon exertion	☐	☐	☐
Chronic pain	☐	☐	☐
Diabetes Type I or II	☐	☐	☐
Eating disorder	☐	☐	☐
Malnutrition	☐	☐	☐
Gastrointestinal disease	☐	☐	☐
G.E. Reflux/persistent heartburn	☐	☐	☐
Ulcers	☐	☐	☐
Thyroid problems	☐	☐	☐
Stroke	☐	☐	☐
Glaucoma	☐	☐	☐

	Yes	No	DK
Hepatitis, jaundice or liver disease	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells or seizures	☐	☐	☐
Neurological disorders	☐	☐	☐
If yes, specify:_____			
Sleep disorder	☐	☐	☐
Mental health disorders	☐	☐	☐
Specify:_____			
Recurrent Infections	☐	☐	☐
Type of infection:_____			
Kidney problems	☐	☐	☐
Night sweats	☐	☐	☐
Osteoporosis	☐	☐	☐
Persistent swollen glands in neck	☐	☐	☐
Severe headaches/ migraines	☐	☐	☐
Severe or rapid weight loss	☐	☐	☐
Sexually transmitted disease	☐	☐	☐
Excessive urination	☐	☐	☐

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ☐ ☐ ☐

Name of physician or dentist making recommendation: | Phone:

Do you have any disease, condition, or problem not listed above that you think I should know about? ☐ ☐ ☐
Please explain:

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: | Date:

FOR COMPLETION BY DENTIST

Comments:_____

Patient Privacy

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 healthcare information is important to us.

This notice describes how we will use and disclose your protected health information to provide treatment, obtain payment, and conduct health care operations. Other purposes permitted or required by law also apply to this notice. It also describes your rights concerning your protected health information. "Protected health information" is information about you, including demographic information that may identify you and related to your past, present, or future physical or mental health condition and related health care services.

We are required by law to follow the practices described in this notice. We may change the terms of this notice at any time. The new notice will be effective for all protected health information we maintain at the time including health information we created or received before we made the changes.

You may obtain a copy of our notice of privacy practices at any time by calling our office or requesting one at your next appointment.

Uses and Disclosures of Health Information

Treatment

We will use and disclose your health information to provide, coordinate, and manage health care related services for you. For example, we will disclose information to a specialist to whom you have been referred to ensure the provider has enough information to diagnose and/or treat you. We may also disclose information to a laboratory that, at our request, becomes involved in your treatment.

Payment

We may use and disclose your information to obtain payment for services we provided to you. For example, we will send the necessary information to your health insurance company to obtain payment for the treatment provided and we will send family billing statements to the designated party.

Healthcare Operations

We will use and disclose your health information to conduct the business activities of this office. These activities include, but are not limited to, quality assessment and improvement activities, review of the performance and qualifications of employees, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities. Other business activities may include; appointment confirmation by phone and postcards and leaving messages with other persons regarding appointments, etc. We may also leave messages on an automated answering device.

We may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when we are ready to begin your treatment.

We will share your protected health information with business associated that perform specific functions for our practice such as billing. When a business arrangement of this type requires the use of your information, we will have a written contract with a third party to protect the privacy of your protected health information.

Others Involved in Your Healthcare

We must disclose your health information to use as described in the Patient Rights section of this notice. We may disclose your health information to a family member or other person to the extent necessary to help with your health care or with payment for your health care, but only if you agree. If we determine it is in your best interest based on our professional judgment or experience with common practices, we may allow another person to pick up filled prescriptions, medical supplies, x-rays, or other forms of health information.

We may use or disclose protected health information to notify or assist in notifying a family member, a personal representative, or other person responsible for your care of your location, general condition, or death. If you are present prior to the use or disclosure of your protected health information, we will provide you with the opportunity to object to such uses or disclosures. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family members or others involved in your health care.

Emergencies

In the event of your incapacity or in emergency circumstances, we may use or disclose your protected health information to treat you.

Uses and Disclosures of Protected Health Information Based Upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that an action has already been taken in reliance on the authorization.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object

We may use or disclose your protected health information in the following situations without your consent or authorization. These situations include;

Required by Law

We may use or disclose your protected health information to the extent that law requires the use or disclosure. The use or disclosure in compliance with the lad will be limited to the relevant requirements of the law.

We must make disclosures to you and, when required, to the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of the Privacy Rule, Section 164.500et.seq.

Public Health

We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury, or disability. Additionally, we may disclose your protected health information if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

We may disclose protected health information to a health oversight agency for activities authorized by law such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regularity programs, and civil rights laws.

Abuse or Neglect

We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect, or domestic violence to the government entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Legal Proceedings

We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery or other lawful purpose.

Law Enforcement

We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1)Legal processes and otherwise required by law, (2)Limited information request for identification and location purposes, (3)Pertaining to victims of a crime, (4)Suspicion that death has occurred as a result of criminal conduct, (5)In the event that a crime occurs on the premises of the practice, and (6)Medical Emergency (not on the practice's premises) and it is likely a crime occurred.

Military Activity and National Security

When the appropriate conditions apply, we may disclose, to military authorities, protected health information of individuals who are Armed Forces personnel. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activity including for the provision of protective services to the President or others legally authorized.

Workers' Compensation

We may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally established programs.

Inmates

We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

Your Rights

Your rights with respect to your protected health information and how you may exercise those rights are outlined below.

You have the right to obtain a copy and/or inspect your health information. Health information includes treatment records, billing records, and any other records used by us to make decisions about your treatment. You may obtain a form from our office to request access. A reasonable cost-based fee will be charged for expenses such as staff time, copies, and postage. Contact us as indicated in the "contact us" section of our website if you have question about access or applicable fees.

You have a right to request a restriction on use and disclosure of your protected health information. You may ask us not to use or disclose some part of your protected health information for the purposes of treatment, payment, or operations. You may also request that we do not disclose some part of your information to family and others who may be involved in your care or for notification purposes as otherwise described in this Notice. We are not required to agree to the restrictions but if we do, we are obligated to abide by the agreement except in cases of emergency. You may request a restriction by sending your request in writing to our office.

You have a right to request to receive confidential communications by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to your office. You may have the right to request an amendment to your protected health information. You may also request that we amend protected health information about you. Your request must be submitted in writing to your office and must contain an explanation as to why the information should be amended. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement or disagreement with us. We may prepare a rebuttal to your statement and will provide you a copy of any such rebuttal. You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures made by our Business Associates or us. It excludes disclosures for treatment, payment, or health care operations as described in this Notice.