Jeff Griffin, DDS
13234 Perkins Road
Baton Rouge, LA 70810
225-767-8084

Patient Information

Patient Name: ____________________ Date: __________
Last First MI (Preferred Name)

Gender (M/F): ________ Marital Status: __________ Birth Date: ________ Social Security #: __________

Driver's License #: __________ E-Mail Address: ____________________

Address: ______________________________
Street Apartment #

____
City State Zip Code

Phone #'s: Home ________ Work __________ Pager/Cell Phone __________

Employer ____________________ Occupation ____________________

Person to contact for emergency: __________ Phone #: __________

Referral Information

Name of person, office or other source referring you to our practice:

____

Why did you select our office?

____

Is another member of your family or relative a patient in our practice?

____

Spouse or Responsible Party Information

Name: ____________________ Date: __________
Last First MI (Preferred Name)

Gender (M/F): ________ Marital Status: __________ Birth Date: __________ Social Security #: __________

Driver's License #: __________ E-Mail Address: ____________________

Address: ______________________________
Street Apartment #

____
City State Zip Code

Phone #'s: Home ________ Work __________ Pager/Cell Phone __________

Employer ____________________ Occupation ____________________

Insurance Information

Primary
Name of Insured: __________
Employer: __________
Insured's Birth Date: __________
ID#: __________
Group #: __________
Insurance Plan Name: __________
Address: __________
____
Phone #: __________

Secondary
Name of Insured: __________
Employer: __________
Insured's Birth Date: __________
ID#: __________
Group #: __________
Insurance Plan Name: __________
Address: __________
____
Phone #: __________

Medical History

1. Have you been under the care of a medical doctor during the past two years? ……………………… YES NO
   If yes, for what reason? ____________________
2. Please provide the name, address, and telephone number for your physician.
   ____
3. Have you been a patient in the hospital during the past two years? ……………………………………… YES NO
4. Have you taken any medicine or drugs during the past two years? ……………………………………… YES NO
5. Are you allergic to (i.e. itching, rash, swelling of hands, feet or eyes) or made sick by penicillin, aspirin, codeine, or any drugs or medications? ………………………………………………… YES NO
   If yes, please list: ____________________
6. Have you ever had excessive bleeding requiring special treatment? ……………………………………… YES NO
7. **Circle** any of the following which you have had or have at present:

Heart Failure	Shortness of Breath	HIV Positive (AIDS)
Heart Disease or Attack	Emphysema	Hepatitis A (Infectious)
Angina Pectoris (chest pain)	Hepatitis B (Serum)	High Blood Pressure
Tuberculosis (TB)	Liver Disease	Heart Murmur
Asthma	Yellow Jaundice	Bruise Easily
Rheumatic Fever	Hay Fever	Blood Transfusion
Congenital Heart Lesions	Allergies or Hives	Drug Addiction
Scarlet Fever	Diabetes	Hemophilia
Artificial Heart Valve	Thyroid Disease	Venereal Disease (Syphillis, Gonorrhea)
Heart Pacemaker	X-Ray or Cobalt Treatment	Cold Sores or Fever Blisters
Heart Surgery	Chemotherapy (Cancer, Leukemia)	Artificial Joint
Genital Herpes	Anemia	Arthritis
Epilepsy or Seizures	Stroke	Rheumatism
Fainting or Dizzy Spells	Kidney Trouble	Cortisone Medication
Nervousness	Ulcers	Glaucoma
Psychiatric Treatment	Pain in Jaw Joints	Sickle Cell Disease

8. List all medications you are taking at this time. ____________________
9. Are you a smoker? …………………………………………………………………………………………… YES NO
10. Do you use or have you ever used recreational drugs? …………………………………………………… YES NO
11. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, or shortness of breath, or because you are very tired? ……………………………………………………… YES NO
12. Do your ankles swell during the day? ……………………………………………………………………… YES NO
13. Have you lost or gained more than 10 pounds in the last year? …………………………………………… YES NO
14. Do you use more than 2 pillows to sleep? ………………………………………………………………… YES NO
15. Do you ever wake up from sleep short of breath? ………………………………………………………… YES NO
16. Are you on a special diet? ………………………………………………………………………………… YES NO
17. Has your medical doctor ever said you have cancer or a tumor? ………………………………………… YES NO
18. Do you have any disease, condition, or problem not listed? If so, please list. …………………………… YES NO
    ____
19. Women: Are you pregnant? YES NO If yes, what month are you due? ____________________
    Are you taking birth control pills? ………………………………………………………………………… YES NO

Dental History

1. Are you having dental problems at this time? YES NO
2. When was your last dental visit? ____________________
3. Do your gums bleed at any time? YES NO
4. When was the last time you had complete dental x-rays taken? ____________________
5. Do you feel very nervous about having dental treatment? YES NO
6. Have you ever had a bad experience in the dental office? YES NO
7. How do you feel about getting and maintaining a healthy mouth? ____________________
   ____
8. How do you feel about the appearance of your teeth? ____________________
   ____
9. If you could change anything about your smile, what would you change? ____________________
   ____
10. Have you ever had any teeth removed? YES NO How long have these teeth been missing? ____________________
    Have these been replaced? YES NO How? Bridge Partial Denture Implants

I hereby authorize the doctor to perform any and all forms of treatment, medication, and therapy, that may be indicated in connection with the dental care of the patient above and further authorize and consent that the doctor chooses and employs such assistance as he deems fit. I also understand that the prior to treatment, full explanation of the procedure(s) involved will be given by the doctor and /or his staff. I agree to pay for all services rendered by this office.

____

SIGNATURE OF RESPONSIBLE PARTY RELATIONSHIP DATE

Jeff Griffin, DDS
13234 Perkins Road, Suite A
Baton Rouge, LA 70810
225-767-8084

CONSENT TO PERFORM DENTISTRY

I hereby authorize and direct Dr. Jeff Griffin and/or dental auxiliaries of his choice, to perform the following dental treatment or oral surgery procedure(s), including the use of any necessary or advisable local anesthesia, radiographs (x-rays), or diagnostic aids.

A. Preventive hygiene treatment (prophylaxis) and the application of topical fluoride.
B. Application of plastic "sealants" to the grooves of teeth.
C. Treatment of diseased or injured teeth with dental restorations (fillings and crowns).
D. Replacement of missing teeth with dental prostheses (bridges, partial dentures, full dentures)
E. Removal (extraction) of one or more teeth.
F. Treatment of diseased or injured oral tissues (hard and/or soft).
G. Use of sedative drugs to control apprehension and/or disruptive behavior.
H. Treatment of malposed (crooked) teeth and/or oral development or growth abnormalities.
I. Use of general anesthesia to accomplish the necessary treatment.

I understand that there are risks involved in this treatment and hereby acknowledge that these risks will be explained to me, that I will have an opportunity to ask questions regarding the treatment and the risks, and that I fully understand the same.

I agree to the use of local anesthesia and the use of nitrous oxide/oxygen analgesia depending on the judgement of the doctor. Nitrous oxide/oxygen may occasionally produce nausea and vomiting. I am also aware that the nosepiece leaves an indentation or ring around the nose, which disappears shortly after the procedure. I understand and have been informed of the above risks and complications.

I recognize that during the course of treatment unforeseen circumstances may necessitate additional or different procedures from those discussed. I therefore authorize and request the performance of any additional procedures deemed necessary or desirable to oral health and well being in the professional judgement of the dentist.

There are possible risks and complications associated with the administration of local anesthesia, sedation, and drugs. The most common of these are swelling, bleeding, pain, nausea, vomiting, bruising, tingling, and numbness of the lips, gums, face and tongue, allergic reactions, hematoma (swelling or bleeding at or near the injection site), fainting, lip and cheek biting resulting in ulceration and infection of the mucosa. I also understand that there are rare potential risks seen as unfavorable reactions to medications in respiratory and cardiovascular collapse (stopping of breathing and heart function) and lack of oxygen to the brain that could result in coma or death. I understand and have been informed of the above risks and complications.

I also authorize the doctor to use photographs, radiographs, other diagnostic materials and treatment records for the purpose of teaching, research and scientific publications.

I will be advised that the success of dental treatment to be provided will require that the patient and the parents follow the post operative and post-care instructions of the dentist. I agree that the success of the treatment requires that all post-operative and post-care instructions be followed and that regular office visits as scheduled by my dentist and his auxiliaries must be maintained.

I hereby state that I have read and understand this consent, and that all questions about the procedures will be answered in a satisfactory manner; and I understand that I have the right to be provided answers to questions which may arise during and after the course of my treatment.

I further understand that this consent will remain in effect until such time that I choose to terminate it.

Date: ______________________________

Patient's Name: ______________________________

Signature: Patient or Parent/Guardian: ______________________________

Witness: ______________________________

HIPAA Notice of Privacy Practices

Jeff Griffin DDS
13234 Perkins Road, Suite A
Baton Rouge, La 70810
225-767-8084

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. “Protected health information” is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician’s practice, and any other use required by law .

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician’s practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers’ Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician’s practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. **You have the right to obtain a paper copy of this notice from us**, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with 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.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name:___________________________ Signature_______________________Date________________________

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FINANCIAL INFORMATION

Welcome and Special! It is our goal to help you feel this way every time you call or come to our practice. Your health, comfort, and individual needs are foremost in our minds. We are committed to excellence and to service in all areas of dental care, including the financial aspect of your dental care. We want to make your dental care financially comfortable so you will have the treatment you need and deserve. Below is our financial policy we have adopted to help meet the needs of our patient family. Please read and sign below that you have read and understand our financial policy.

1.) Insurance on Assignment. After 60 days if insurance has not paid, the balance is due and payable by you, the patient.

2.) Payment by the Appointment

3.) Visa/MasterCard/Discover

4.) Short and Long Term or Extended Payments through a Health Care Financing Program

5.) A 25.00 Fee will Accompany NSF Checks

All accounts with a past due balance of 60 days and greater will be charged a service fee of 1.75% per month.

Signature: ____Date: _____________