D. Greg Seal
PROSTHODONTICS
D. GREG SEAL, DDS, PC
6010 SHERRY LANE
DALLAS, TEXAS 75225
214.361.0883 PHONE
214.361.2706 FAX
WWW.DRSEAL.COM

PLEASE COMPLETE BOTH SIDES OF THIS FORM

CONFIDENTIAL PATIENT INFORMATION

Name: ☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms.

_____
Last First MI

Preferred Name: _____

Date: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other

Social Security #: _____

Birth Date: _____

Home Phone: (_____) _____

Work Phone: (_____) _____

Cell Phone/Other: (_____) _____

Please circle preferred contact # ☐ HOME ☐ WORK ☐ CELL

E-mail address: _____

Address:

_____
Street Apt/Unit Number

_____
City State Zip

Occupation: _____

Employer Name: _____

Address:

_____
Street Apt/Unit Number

_____
City State Zip

In Case of Emergency please contact:

_____
Name

(_____) _____
Phone

Referred by: _____

Have you ever had any of the following? Please check all that apply.

☐ Allergies (to) _____
_____
☐ Anemia
☐ Anxiety
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Diabetes
☐ Dizziness
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Hay Fever
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis
☐ High Blood Pressure
☐ HIV Positive
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disease
☐ Metal Allergies
☐ Mitral Valve Prolapse
☐ Pacemaker
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Seizures
☐ Sexually Transmitted Disease
☐ Sinus Problems
☐ Smoker/Tobacco Use
☐ Stomach Problems
☐ Stroke
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Other (Please list)
_____
_____

Personal Physician: _____

Phone: (_____) _____

City: _____

Do you need a referral to a physician or other medical specialist? (i.e.: Internist, ENT, Dermatologist, Plastic Surgeon) ☐ Yes ☐ No

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

Reason: _____

Are you currently being treated by a physician? ☐ Yes ☐ No

Reason: _____

Have you had a joint replacement surgery? ☐ Yes ☐ No

Have you taken an oral or I.V. bisphosphonate drug? (i.e. Fosamax, Actonel, Boniva, Reclast, etc.) ☐ Yes ☐ No

Are you currently taking any medications or drugs? ☐ Yes ☐ No

For what disease? _____

Please list: _____

_____

Are you allergic to any medications? ☐ Yes ☐ No

Please list: _____

Are you Pregnant? ☐ Yes ☐ No Due Date: _____

If the patient is a minor or another party is responsible for the patient, please provide the following:

Name: _____

Social Security #: _____

Birth Date: _____

Preferred Contact Phone: (____) _____

DENTAL HISTORY

Reason for today's visit: _____

_____

_____

_____

_____

_____

Date of last dental visit: _____

When did you last have dental x-rays taken? _____

Where? _____

Have you had orthodontic treatment? ☐ Yes ☐ No

Have you had periodontal (gum) treatment? ☐ Yes ☐ No

Have you had any dental implants placed? ☐ Yes ☐ No

Please check all of the statements that apply:

I am concerned about:

☐ the appearance of my teeth or smile.
☐ the color of my teeth.
☐ the position or angle of one or more of my teeth.
☐ the shape of one or more of my teeth.

I sometimes have:

☐ sensitivity to cold foods or beverages.
☐ sensitivity to hot foods or beverages.
☐ clicking or pain in my jaw.
☐ sore spots in my mouth.
☐ bleeding in my gums.
☐ bad breath.
☐ pain when biting or chewing.
☐ headaches or neck and shoulder pain.

Do you wear dentures? ☐ Yes ☐ No

How many? _____

How long have you worn dentures? _____

How long have you worn your present dentures? _____

If you are currently having a denture problem, is it related to:

☐ Pain ☐ Discomfort ☐ Appearance ☐ Function

Do you now, or have you ever, had pain in your jaw joint or the sides of your face (in or around the ears)?
☐ Yes ☐ No

Do you have a clicking jaw joint or have you ever experienced an inability to move your jaw or open your mouth widely?
☐ Yes ☐ No

Have you had any trouble associated with any previous dental treatment? ☐ Yes ☐ No

To the best of my knowledge, all preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctor at the next appointment without fail.

_____
Signature of patient, parent or guardian

_____
Date

PLEASE COMPLETE BOTH SIDES OF THIS FORM

D. Greg Seal
PROSTHODONTICS
D. GREG SEAL, DDS, PC
6010 SHERRY LANE
DALLAS, TEXAS 75225
214.361.0883 PHONE
214.361.2706 FAX
WWW.DRSEAL.COM

NOTICE OF PRIVACY PRACTICES

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.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

If you sign a Consent Form, we may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

We may, without prior consent, use or disclose protected health information to carry out treatment, payment, or health care operations in the following circumstances:

- In emergency treatment situations, if we attempt to obtain such consent as soon as reasonable practicable after the delivery of such treatment;
- If we are required by law to provide and we attempt to obtain such consent but are unable to obtain such consent; or
- If we attempt to obtain consent but are unable to do so due to substantial barriers to communicate with you, and we determine that, in our professional judgment, your consent to receive treatment is clearly inferred from the circumstances.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of benefit to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to our office.

- The right to reasonable request to receive confidential communications of protected health information from us by alternative means.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of May 23, 2007 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. You may request a written copy of a revised Notice of Privacy practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office.

Please contact us for more information:

D. Greg Seal, DDS, P.C.
6010 Sherry Lane
Dallas, TX 75225

Attn:

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services (202) 619-0257
Toll free: (877) 969-6755
Office of Civil Rights
200 Independence Avenue, S. W.
Washington, D.C. 20201

D. Greg Seal, D.D.S., P.C.
6010 Sherry Lane
Dallas, TX 75225
214-361-0883

Notice of Privacy Practices
Acknowledgment of Receipt Form

Your signature below indicates that you have been offered a copy of our Notice of Privacy Practices. If you have any questions about the Notice of Privacy Practices, please call our office at 214-361-0883.

I have been offered the Notice of Privacy Practices.

_____ _____
Patient Signature Date

_____ _____
Print Patient Signature Date

_____ _____
Legal Guardian or Patient Representative Signature Date

_____ _____
Print Legal Guardian or Representative Name Date

If there is an individual or individuals that you would like to grant access to your account, please complete the section below

_____ _____
Print Name Date

_____ _____
Print Name Date

_____ _____
Print Name Date

_____

FOR OFFICE USE ONLY:
D. Greg Seal, D.D.S., P. C. will make a good faith effort to obtain a written acknowledgement of receipt of the Notice provided to the individual. If the patient is unwilling and or unable to sign this acknowledgment, Dr. Seal must document its good faith efforts to obtain such acknowledgement and record the reason why the acknowledgement was not obtained.

Reason: _____

Notice mailed to patient Date: _____ Staff Signature: _____

Click here to submit this form