BROADWAY DENTISTRY

PATIENT REGISTRATION

Welcome! So that we may provide you with the best possible care, please complete the following medical/dental history forms.

Date _____

Home Phone _____ Cell Phone _____ Email _____

Patient _____ Nickname: _____ Social Security # _____
(Last First Initial)

Address _____ How long at this address _____
(Street City State Zip)

Previous Address (if less than 3 years) _____
(Street City State Zip)

Sex ☐ M ☐ F Age _____ Birthdate _____ ☐ Single ☐ Married ☐ Other Maiden Name _____

Employed by _____ Occupation _____ No. Years Employed _____

Business Address _____ Business Phone _____

Spouse Name _____ Birth Date _____ Spouse's Social Security # _____

Spouse Employed by _____ Occupation _____ No. Years Employed _____

Who is responsible for this account? _____ Relationship to Patient _____

Dental Insurance Primary Carrier

Insured's Name _____

Insurance Co. _____

Insured's Employer _____

Insured's Soc. Sec# or ID# _____

Insured's Group # _____

Insured's Date of Birth _____

Dental Insurance Secondary Carrier

Insured's Name _____

Insurance Co. _____

Insured's Employer _____

Insured's Soc. Sec# or ID# _____

Insured's Group # _____

Insured's Date of Birth _____

How did you hear about our office? _____

If referred, whom may we thank? _____

Are there any immediate family members who have been seen in our office? (spouse or child) _____

Best phone number to call?
☐ Home ☐ Cell ☐ Work ☐ Other

How do you prefer to have your appointment confirmed?
☐ Email ☐ Text Message ☐ Phone Call/Message

This information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of these forms. If I ever have any changes in my health, or if my medicines change, I will inform the dentist at the next appointment without fail.

The patient or responsible party shall be responsible for any attorney fees, collection agency fees, cost of collection, court costs and other expenses or fees.

*Signature _____ Date _____

Patient Name

DENTAL HISTORY

PATIENT CONCERNS

Dental treatment desired

☐ Check up ☐ Cleaning ☐ Cavities Restored ☐ Missing Teeth Replaced
☐ Cosmetic Dentistry ☐ Teeth Extracted ☐ Complete Dentures ☐ Orthodontics
☐ Tooth Whitening ☐ Implants ☐ Other _____

Concerns with treatment

☐ Fear ☐ Time ☐ Health ☐ Pain
☐ Cosmetic ☐ Prevention ☐ Money ☐ Function
☐ Other _____

What is the reason for your visit today? _____

Date of Last Dental Visit _____ Last Dental Cleaning _____ Last Full Mouth X-rays _____

What was done at your last dental visit? _____

_____

Previous Dentist's Name _____ Reason for Leaving _____

_____

How often do you visit a dentist? _____ How often do you have your teeth cleaned? _____

How often do you brush your teeth? _____ How often do you floss? _____

What other dental aids do you use? (toothpick, etc.) _____

Do you have any dental problems now? ☐ Yes ☐ No If yes, please describe _____

_____

Are any of your teeth sensitive to:

Hot or cold? ☐ Yes ☐ No
Sweets? ☐ Yes ☐ No
Biting or chewing? ☐ Yes ☐ No

Have you ever had:

Orthodontic treatment? ☐ Yes ☐ No
Oral Surgery? ☐ Yes ☐ No
Periodontal treatment? ☐ Yes ☐ No
Your teeth ground or the bite adjusted? ☐ Yes ☐ No
A bite plate or mouth guard? ☐ Yes ☐ No
A serious injury to the mouth or head? ☐ Yes ☐ No
If so, please describe, including cause
_____
_____
_____
_____

Do you:

Clench or grind your teeth while awake or asleep? ☐ Yes ☐ No
Bite your lips or cheeks regularly? ☐ Yes ☐ No
Have tired jaws, especially in the morning? ☐ Yes ☐ No
Smoke/chew tobacco? ☐ Yes ☐ No

Have you experienced:

Clicking or popping of the jaw? ☐ Yes ☐ No
Pain? (joint, ear, side of face) ☐ Yes ☐ No
Difficulty in opening or closing the mouth? ☐ Yes ☐ No
Difficulty in chewing on either side of the mouth? ☐ Yes ☐ No
Headaches, neck aches or shoulder aches? ☐ Yes ☐ No
Sore muscles (neck, shoulders) ☐ Yes ☐ No

Have you noticed any mouth odors or bad tastes? ☐ Yes ☐ No
Do you frequently get cold sores, blisters or any other oral lesions? ☐ Yes ☐ No
Do your gums bleed or hurt? ☐ Yes ☐ No
Have your parents experienced gum disease or tooth loss? ☐ Yes ☐ No
Have you noticed any loose teeth or change in your bite? ☐ Yes ☐ No
Does food tend to become caught in between your teeth? ☐ Yes ☐ No
If yes, where? _____
Do you gag easily? ☐ Yes ☐ No

Do you feel nervous about having dental treatment? ☐ Yes ☐ No If so, what is your biggest concern? _____

_____

Have you ever had an upsetting dental experience? ☐ Yes ☐ No If yes, please describe _____

_____

How do you feel about the appearance of your teeth? _____

Is there anything else about having dental treatment that you would like us to now? ☐ Yes ☐ No

If yes, please describe _____ _____

Patient Name

MEDICAL HISTORY

Today's Date _____ Date of Birth: _____

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

Preferred Pharmacy _____ Phone: _____

In case of emergency, who should be notified? _____ Phone: _____

Have you ever had any of the following? (Check all that apply)

☐ Anemia or Hemophilia	☐ Chemical Dependency	☐ Headaches	☐ Liver Disease	☐ Swelling of Ankles
☐ Arthritis/Rheumatism	☐ Chest Pain (Angina)	☐ Hearing Impaired	☐ Low Blood Pressure	☐ Thyroid Disease
☐ Artificial Heart Valve	☐ Circulatory Problems	☐ Heart Condition	☐ Lung Disease	☐ Tobacco/Vapor Use
☐ Artificial Joints	☐ Cortisone Medication	☐ Heart Disease/Attack	☐ Mitral Valve Prolapse	☐ Transplant
☐ Asthma	☐ Diabetes	☐ Heart Murmur	☐ Osteoporosis	☐ Tuberculosis (TB)
☐ Back Problems	☐ Emphysema	☐ Heart Surgery	☐ Pacemaker/Defibrillator	☐ Vision Impaired
☐ Blood Disorders	☐ Epilepsy/Seizures	☐ Hepatitis A (Infectious)	☐ Psychiatric Care	☐ Yellow Jaundice
☐ Blood Thinners	☐ Excessive Bleeding	☐ Hepatitis B (Serum)	☐ Rheumatic Fever	
☐ Blood Transfusion	☐ Fainting or Dizzy Spells	☐ High Blood Pressure	☐ Sinus Problems/Hay Fever	
☐ Bruise Easily	☐ General Allergies	☐ HIV Positive/AIDS	☐ Shortness of Breath	
☐ Cancer	☐ Glaucoma	☐ Kidney Trouble	☐ Stroke	

Do you have any diseases, conditions or problems not listed above? ☐ Yes ☐ No If yes, please explain: _____

Do you have any drug allergies or have you ever had an adverse reaction to any medication? ☐ Yes ☐ No
If yes, please list: _____

Do you have any general allergies? (metals, etc.) ☐ Yes ☐ No If yes, please explain: _____

Have you ever had complications or illness following dental treatment? ☐ Yes ☐ No If yes, please explain: _____

Have you ever had a reaction to local anesthetic? ☐ Yes ☐ No If yes, please explain: _____

Are you taking any medications, dietary supplements or herbal supplements at this time? ☐ Yes ☐ No If yes, please list: _____

Do you regularly take any of the following?
☐ Diet or Energy Supplements ☐ Echinacea ☐ Garlic ☐ Ginkgo ☐ CBD Oil ☐ Kava ☐ John's Wort ☐ Valerian ☐ Vitamin E >400 I.U.
☐ Fish Oil >3 grams/day

Have you ever been hospitalized or had surgery? ☐ Yes ☐ No If yes, please explain: _____

Do you have any artificial joints? (i.e.: knee replacement)? ☐ Yes ☐ No If yes, please explain: _____

Are you under the care of a physician? ☐ Yes ☐ No If yes, for what conditions: _____

(Women) Do you suspect that you may be pregnant? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No

Is there anything else we should know about your medical history? _____

OFFICE USE ONLY

Date	Description	Date	Description

BROADWAY DENTISTRY

CONTACT INFORMATION
FOR PROTECTED HEALTH INFORMATION

3611 Broadway, Fort Wayne, IN 46807

I, _____, Date of Birth _____,
(Patient Name)

request that the following be followed for the disclosure of my Protected Health Information (PHI). Protected Health Information would include your name, Diagnosis (es), test results, date of services.

- Sensitive Protected Health Information
- You may disclose information to my family members and/or non-family members

Please list the name, phone number, and relationship

NAME	PHONE NUMBER	RELATIONSHIP

- You may leave Protected Health Information on my answering machine/voicemail:
  Phone Number _____
- You may leave me a text message: Text Phone Number _____
- You may email me (unencrypted) for dental appointments:
  Email Address _____
- You may fax me for dental information: Fax Number _____
- Other _____

*I would like to receive a copy of this office's Notice of Privacy Practices. ☐ Yes ☐ No

Print Name: _____

Signature: _____
(Patient's Signature (or Guardian, if Minor)

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
- Communication barriers prohibited obtaining the acknowledgment
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please specify)

_____	_____
Staff Initials	Date

BROADWAY DENTISTRY
CONFIDENTIAL PATIENT INFORMATION

3611 Broadway, Fort Wayne, IN 46807 | Phone: (260) 456-3406

NOTICE OF PRIVACY PRACTICES

Effective Date 2/14/2026

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

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

We are required by law to protect the privacy of your protected health information ("medical information"). We are also required to send you this notice about our privacy practices, our legal duties and your rights concerning your medical information.

We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect on the date set forth at the top of this page and will remain in effect unless we replace it. We reserve the right at any time 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 any change in our privacy practices and the new terms of our notice applicable to all medical information we maintain, including medical information we created or received before we made the change in practices.

We may amend the terms of this notice at any time. If we make a material change to our policy practices, we will provide to you, the revised notice. Any revised notice will be effective for all health information we maintain. The effective date of a revised notice will be noted. A copy of the current notice in effect will be available in our facility and on our website. You may request a copy of the current notice at any time. We collect and maintain oral, written and electronic information to administer our business and to provide products, services and information of importance to our patients. We maintain physical, electronic and procedural safeguards in the handling and maintenance of our patients' medical information, in accordance with applicable state and federal standards, to protect against risks such as loss, destruction and misuse.

Treatment: We may disclose your medical information, without your prior approval, to another dentist or healthcare provider working in our facility or otherwise providing you treatment for the purpose of evaluating your health, diagnosing medical conditions and providing treatment. For example, your health information may be disclosed to an oral surgeon to determine whether surgical intervention is needed.

Payment: We provide dental services. Your medical information may be used to seek payment from your insurance plan or from you. For example, your insurance plan may request and receive information on dates that you received services at our facility in order to allow your employer to verify and process your insurance claim.

Healthcare Operations: We may use and disclose your medical information, without your prior approval, for health care operations. Health care operations include:

- healthcare quality assessment and improvement activities;
- reviewing and evaluating dental care provider performance, qualifications and competence, health care training programs, provider accreditation, certification, licensing and credentialing activities;
- conducting or arranging for medical reviews, audits and legal services, including fraud and abuse detection and prevention; and
- business planning, development, management and general administration including customer service, complaint resolutions and billing, de-identifying medical information, and creating limited data sets for health care operations, public health activities and research.

We may disclose your medical information to another dental or medical provider or to your health plan subject to federal privacy protection laws, as long as the provider or plan has had a relationship with you and the medical information is for that provider's or health plan's care quality assessment and improvement activities, competence and qualification evaluation and review activities, or fraud and abuse detection and prevention.

Your Authorization: You (or your legal personal representative) may give us written authorization to use your medical information or to disclose it to anyone for any purpose. Once you give us authorization to release your medical information, we cannot guarantee that the person to whom the information is provided will not disclose that information. You may take back or "revoke" your written authorization at any time, except if we have already acted based on your authorization. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give us written authorization, we will not use or disclose your medical information for any purpose other than those described in this notice. We will obtain your authorization prior to using your medical information for marketing, fundraising purposes or for commercial use. Once authorized, you may opt out of these communications at any time.

Business Associates: We may disclose your medical information, without your prior notice, to our business associates, such as billing services or healthcare professionals providing services as independent contractors, for the purpose of performing specified functions on our behalf and/or providing us with services. Medical information will only be used or disclosed if the information is necessary for such functions or services. Our business associates are required, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Your Family, Friends, and Others involved in your care or payment for care: We may disclose your medical information to a family member, friend or any other person you involve in your care or payment for your health care. We will disclose on the medical information that is relevant to the person's involvement.

We may use or disclose your name, location and general condition to notify, or to assist an appropriate public or private agency to locate and notify, a person responsible for your care in appropriate situations, such as a medical emergency or during disaster relief efforts.

We will provide you with an opportunity to object to these disclosures, unless you are not present or are incapacitated or it is an emergency or disaster relief situation. In those situations, we will use our professional judgment to determine whether disclosing your medical information is in your best interest under the circumstances.

Health-Related Products and Services: We may use your medical information to communicate with you about health-related products, benefits, services, payment for those products and services and treatment alternatives.

Reminders: We may use or disclose medical information to send you reminders about your dental care, such as appointment reminders via US Mail, email, telephone and texting. By providing your email address to us, you agree that you may receive reminders and breach notifications via email as a possible alternative to US Mail. It is the policy of our office to leave a message on any voicemail or answering machine that may be attached to a number that you provide (home, cell or work). You may opt out of this service.

Plan Sponsors: If your dental insurance coverage is through an employer's sponsored group dental plan, we may share summary health information with the plan sponsor.

Public Health and Benefit Activities: We may use and disclose your medical information, without your permission, when required by law and when authorized by law for the following kinds of public health and public benefit activities;

- for public health, including to report disease and vital statistics, child abuse, adult abuse, neglect or domestic violence;
- to avert a serious an imminent threat to health or safety;
- for health care oversight, such as activities of state insurance commissioners, licensing and peer review authorities and fraud prevention agencies;
- for research;
- in response to court and administrative orders and other lawful process;
- to law enforcement officials with regard to crime victims and criminal activities;
- to coroners, medical examiners, funeral directors and organ procurement organizations;
- to the military, to federal officials for lawful intelligence, counterintelligence, and national security activities, and to
- correctional institutions and law enforcement regarding persons in lawful custody; and
- as authorized by state worker's compensation laws.

Special protections for SUD records: Substance Use Disorder (SUD) Treatment records have enhanced protections. They cannot be used in legal proceedings without your consent or court order.

If a use or disclosure of health information described above in this notice is prohibited or materially limited by other laws that apply to us, it is our intent to meet the requirements of the more stringent law.

Abuse or Neglect: We may disclose your medical records to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence, or the victim of other crimes. We may disclose your medical information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: Under certain circumstances, we may disclose medical records to military authorities as required for lawful intelligence, counterintelligence, and other national security activities.

Under certain circumstances, we may disclose medical information to a correctional institution or law enforcement official with whom you are in lawful custody.

Fundraising: We may contact you in relation to fundraising activities, however you have the right to opt out of receiving such communications.

Data Breach Notification Purposes: We may use or disclose your contact information to provide legally required notices of unauthorized acquisition, access or disclosure of your health information.

Additional Restrictions on use and disclosure: Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including highly confidential information about you. "Highly Confidential Information" may include confidential information under Federal laws governing reproductive

rights, alcohol and drug abuse information and genetic information as well as state laws that often protect the following types of information:

1) HIV/AIDS;
2) Mental Health;
3) Genetic Tests (in accordance with GINA 2009);
4) Alcohol and drug abuse;
5) Sexually transmitted diseases and reproductive health information; and
6) Child or adult abuse or neglect, including sexual assault.

YOUR RIGHTS:

1) You have a right to see and get a copy of your health records.
2) You have a right to amend your health information.
3) You have a right to ask to get an Accounting of Disclosures of when and why your health information was shared for certain purposes.
4) You are entitled to receive a Notice of Privacy Practices that tells you how your health information may be used and shared.
5) You may decide if you want to give your Authorization before your health information may be used or shared for certain purposes, such as marketing. It is the policy of our office NOT to sell or disclose your information to any outside firms or business partners. Your information may be used, only within our office, for the purposes of presenting to you certain products or services which our dentist(s) or staff feel may present a benefit for you, your oral health or happiness with your smile. You have the right to opt out of this level or service.
6) You have the right to receive your information in a confidential manner and restrict certain communication methods.
7) You have a right to restrict who receives your information, unless they are a legal guardian.
8) You have a right to request amendment to be made to your health records by submitting the request in writing to our privacy officer. Your request does not guarantee the amendment, but does guarantee that it will be reviewed and considered.
9) If you believe your rights are being denied or your health information is not being protected, you can:
   a. File a complaint with your provider or health insurer
   b. File a complaint with the U.S. Government
10) Right to opt out of fundraising activities. If you would like to opt out of any fundraising programs that our office may participate in, such as cancer walks, or other fundraising programs.

COMPLAINTS

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your medical information, about amending your medical information, about restricting our use or disclosure of your medical information, or about how we communicate with you about your medical information (including a breach notice communication), you may contact our Privacy Officer to register either a verbal or written complaint.

You may also submit a written complaint to the Office for Civil Rights of the United States Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, Washington, DC, 20201. You may contact the Office for Civil Rights' hotline at 1-800-368-1019. We support your right to privacy of your medical information. We will not retaliate in any way if you choose to file a complaint with us or with the US Department of Health and Human Services.

Contact Officer: Dr. Denise Acosta
Address: Broadway Dentistry, 3611 Broadway, Fort Wayne, IN 46807
Telephone: (260) 456-3406
Email: info@broadwaydentistryllc.com