RICHARD NEWHART, D.D.S.
Practice Limited to Periodontics and Implant Dentistry

1308 Market Street
Parkersburg, WV 26101
(304) 422-4867

HEALTH QUESTIONNAIRE

Date: _____ SS#: _____
Full Name: _____ D.O.B.: _____ Age: _____
Address: _____ Marital Status: M/S/D Male/Female
City _____ State _____ Zip _____ Occupation _____
Home Phone # _____ Work Phone # _____
E-mail _____ Cell Phone # _____
Spouse: _____ Closest Relative: _____ Phone #: _____
If you are completing this form for another person, what is your relationship? _____
Person to contact in case of emergency: _____ Phone #: _____
Referred by: _____ Dental Insurance: **Yes** **No**

Please answer the following questions. Your answers are for our records only. Confidential.

1. Has there been any change in your general health in the last year? ..... YES NO
2. My last physical was on _____
3. Are you now under the care of a physician? ..... YES NO
   If so, what is the condition being treated? _____
4. Primary Care Physician's Name _____
5. Have you had any serious illnesses or operations in the past 5 years? ..... YES NO
6. Have you had abnormal bleeding associated with previous extractions or trauma? ..... YES NO
7. Do you bruise easily? ..... YES NO
8. Do you have any artificial limbs, hip, knee or joint replacement, or pins? ..... YES NO
9. Have you had surgery or x-ray treatments for a tumor, growth, or other conditions of your mouth or lips? ..... YES NO
10. Have you ever had spontaneous bleeding from the nose, mouth, ears, joints, intestine, stomach, vagina, or urinary tract? If so explain: _____ YES NO
11. Do you have chest pain upon exertion? ..... YES NO
12. Does your mouth frequently become dry? ..... YES NO
13. Do any members of your family have diabetes? ..... YES NO
14. Do you smoke or use smokeless tobacco? How much _____ How often? _____ ..... YES NO
15. Do you consume alcohol? If so how much? _____ YES NO
16. Have you ever taken any bisphosphonates for osteoporosis?.....YES NO.....If so, how long? _____ please circle all that apply: Aredia, Zometa, Prolia, Boniva, Actonel, Fosamax, Reclast, Evista, Forteo, Other _____
17. Have you ever had Chemotherapy or Radiation Therapy? ..... YES NO
18. Do you have/had any of the following diseases? Circle the ones you have/have had:

Rheumatic Fever	Arteriosclerosis	Stroke	Asthma	Painful/Swollen Joints
Rheumatic Heart Disease	Sinus Trouble	Hives or Rash	Hay fever	Emphysema
Congenital Heart Lesion	Heart Trouble	Heart Attack	Anemia	Artificial Heart Valves
High Blood Pressure	Liver Disease	Kidney Trouble	Diabetes	Heart Pacemaker
Low Blood Pressure	Stomach Ulcers	Fainting Spells	Seizures	Heart Surgery
Coronary Insufficiency	Venerial Disease	Persistent Cough	Hepatitis	Sinus Surgery
Coronary Occlusion	Tuberculosis	Jaundice	Allergies	Cold Sores
Mouth Ulcers	Pain in the Jaw Joint	Alcohol/ Drug Abuse	Arthritis	Epilepsy/Seizures
Hemophilia	Radiation Therapy	Heart Murmur	Tumors	Depression/Anxiety
HIV	Other _____			

19. We **NEED** to know **ALL DRUGS** (prescription, recreational, supplements and herbs) that you are taking in case of interaction with any prescribed in our treatment. **Failure to do so could result in severe consequences or death.**
    Please list:

    _____ _____
    _____ _____
    _____ _____
    _____ _____
    _____ _____

20. Are you allergic to or have acted adversely to? Circle all that apply and give specific allergy details.

Local Anesthetics	Penicillin	Clindamycin	Aspirin	Latex	Metals	Silk
Sleeping Pills	Amoxicillin	Tetracycline	Iodine	Food color	Sedatives	
Sulfa Drugs	Doxycycline	Metronidazole	Barbiturates	Codeine	Flavorings	

    Please list all allergies: _____
21. Do you require antibiotics before dental procedures? If yes, what? _____ ..... YES NO

ANSWERS TO THE FOLLOWING QUESTIONS WILL BE HELD STRICTLY CONFIDENTIAL AND WILL NOT BE RELEASED TO ANY OTHER AGENCY WITHOUT YOUR WRITTEN CONSENT.

A. Have you been diagnosed with AIDS? ..... YES NO
B. Have you been diagnosed as carrying the AIDS virus? ..... YES NO
C. Are you in a high risk category for AIDS? ..... YES NO
D. Do you feel you may have been exposed to the AIDS virus? ..... YES NO

WOMEN

Are you pregnant or breast feeding? ..... YES NO
Are you taking any birth control pills? ..... YES NO
Are you trying to get pregnant? ..... YES NO

OB/GYN Name_____ Phone #_____

****

PAST DENTAL HISTORY

1. Present Dentist_____ How Long? _____
2. Previous Dentist_____ How Long? _____
3. When was your last dental visit? _____
4. When were your teeth cleaned last? _____
5. How often are they cleaned? _____
6. Do you have any dental phobia?_____
7. Have you had any of the following treatments?
   Periodontal* (Gum Work) YES/NO Dental Implants? YES/NO
   Root Canals YES/NO Orthodontics (braces) YES/NO
   Partial Dentures YES/NO Age_____ Bridgework YES/NO Age_____
   Wisdom teeth removed or other oral surgery? YES/NO

   *Please tell us about your prior periodontal work. (Surgery? When? Where? Who does your cleanings now?)
   _____
   _____
8. Does anyone in your family have any periodontal (gum) problems? _____
9. Do you have any of the following mouth habits?
   Grinding teeth at night? YES/NO Clenching teeth excessively? YES/NO
   Bleeding Gums? YES/NO Bad Breath? YES/NO
   Sensitive teeth? YES/NO.....What area?_____
10. Are you in pain at the present time? YES/NO If so, where?_____
11. How long have you been aware of this problem? _____
12. What can we do for you today? _____

ORAL HYGIENE QUESTIONS

1. How often do you brush your teeth? ____ times per Day/Week/Month
2. What type of toothbrush do you use? Manual/Electric Brand:_____
3. Do you use dental floss? YES/NO How often? _____ times per Day/Week/Month
4. Do you feel your teeth are clean after brushing? _____
5. What else do you use to clean your teeth? _____
6. How do you feel about your teeth? _____
7. Can you chew your food comfortably? _____
8. Are you satisfied with how they look? _____
9. How would you change them? _____

BP _____/_____ Base Pulse _____ bpm

Comments: _____
_____
_____
_____
_____
_____

_____ _____
Patient Signature **Dentist Signature**

Revised Sept 2015 mlb

1308 MARKET STREET
PARKERSBURG, WV 26101
(304) 422-4867

RICHARD NEWHART, DDS
PRACTICE LIMITED TO PERIODONTICS AND IMPLANT DENTISTRY

Insurance Information

Patient Full Name:_____
Date of Birth:____/____/_____.

PRIMARY DENTAL:

Subscriber's Name:_____ Date of Birth:_____
Relationship to patient:_____
Subscriber's Employer:_____
Employer's Address:_____ Phone #_____
Insurance Company:_____
Insurance Co. Address:_____
City:_____ State:_____ Zip Code:_____
Insurance Co. Phone #:_____
Policy #:_____ Group #:_____ ID #:_____
Subscriber's SSN: _____

SECONDARY DENTAL:

Subscriber's Name:_____ Date of Birth:_____
Relationship to patient:_____
Subscriber's Employer:_____
Employer's Address:_____ Phone #_____
Insurance Company:_____
Insurance Co. Address:_____
City:_____ State:_____ Zip Code:_____
Insurance Co. Phone #:_____
Policy #:_____ Group #:_____ ID #:_____
Subscriber's SSN: _____

We do NOT submit to your MEDICAL insurance company. We ONLY submit to DENTAL. If you would like to submit the claim to your medical insurance carrier we will provide you with any documentation we can.

©2013 Wisconsin Dental Association
(800) 243-4675

NOTICE OF PRIVACY PRACTICES

Effective Date: _____

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 PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

CONTACT INFORMATION

For more information about our privacy practices, to discuss questions or concerns, or to get additional copies of this notice, please contact our Privacy Officer.

Title: Privacy Officer Dr. Richard Newhart Telephone: (304) 422 - 4867 Fax: (304) 422 - 0002

Email: drnewhart@thegumdr.com Address: 1308 Market Street, Parkersburg, WV 26101

OUR LEGAL DUTY

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 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.

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 that 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 if applicable. 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 security 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 or misuse.

USES AND DISCLOSURES OF YOUR MEDICAL INFORMATION

Treatment: We may disclose your medical information, without your prior approval, to another dentist, a physician or other health care 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. 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.

Health Care 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 or had a relationship with you and the medical information is for that provider's or plan's health 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 the information. You may take back or "revoke" your written authorization at any time in writing, 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 a 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 any of these communications.

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 only 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.

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.

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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, and adult abuse, neglect or domestic violence;
- to avert a serious and 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.

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.

Business Associates: We may disclose your medical information to our business associates that perform functions on our behalf or provide us with services 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.

Data Breach Notification Purposes: We may use 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 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;
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

Access: You have the right to examine and to receive a copy of your medical information, with limited exceptions. We will use the format you request unless we cannot practicably do so. You should submit your request in writing to our Privacy Officer.

We may charge you reasonable, cost-based fees for a copy of your medical information, for mailing the copy to you, and for preparing any summary or explanation of your medical information you request. Contact our Privacy Officer for information about our fees.

Disclosure Accounting: You have the right to a list of instances in which we disclose your medical information for purposes other than treatment, payment, health care operations, as authorized by you, and for certain other activities.

You should submit your request to our Privacy Officer. We will provide you with information about each accountable disclosure that we made during the period for which you request the accounting, except we are not obligated to account for a disclosure that occurred more than 6 years before the date of your request.

Amendment: You have the right to request that we amend your medical information. You should submit your request in writing to our Privacy Officer.

We may deny your request only for certain reasons. If we deny your request, we will provide you a written explanation. If we deny your request, you may have a statement of your disagreement added to your medical information. If we accept your request, we will make your amendment part of your medical information and use reasonable efforts to inform others of the amendment who we know may have and rely on the unamended information to your detriment, as well as persons you want to receive the amendment.

Restriction: You have the right to request that we restrict our use or disclosure of your medical information for treatment, payment or health care operations, or with family, friends or others you identify. Except in limited circumstances, we are not required to agree to your request. But if we do agree, we will abide by our agreement, except in a medical emergency or as required or authorized by law. You should submit your request to our Privacy Officer. Except as otherwise required by law, we must agree to a restriction request if:

1. except as otherwise required by law, the disclosure is to a health plan for purposes of carrying out payment or health care operations (and not for purposes of carrying out treatment); and

2. the medical information pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full by the patient.

Confidential Communication: You have the right to request that we communicate with you about your medical information in confidence by means or to locations that you specify. You should submit your request in writing to our Privacy Officer.

Breach Notification: You have the right to receive notice of a breach of your unsecured medical information. Breach may be delayed or not provided if so required by a law enforcement official. You may request that notice be provided by electronic mail. If you are deceased and there is a breach of your medical information, the notice will be provided to your next of kin or personal representatives if we know the identity and address of such individual(s).

Electronic Notice: If you receive this notice on our web site or by electronic mail (e-mail), you are entitled to receive this notice in written form. Please contact our Privacy Officer to obtain this notice in written form.

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 to our Privacy Officer.

You also may 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, D.C. 20201. You may contact the Office for Civil Rights' Hotline at 1-800-368-1019.

We support your right to the privacy of your medical 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.

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1308 MARKET STREET
PARKERSBURG, WV 26101
(304) 422-4867

RICHARD NEWHART, DDS
PRACTICE LIMIITED TO PERIODONTICS AND IMPLANT DENTISTRY

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 Notices 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)

_____

_____

_____

1308 MARKET STREET
PARKERSBURG, WV 26101
RICHARD NEWHART, DDS (304) 422-4867
PRACTICE LIMITED TO PERIODONTICS AND IMPLANT DENTISTRY

Patient name _____
Last First MI

Authorization for Release of Information

I hereby authorize Richard Newhart, D.D.S., to release information requested by my insurance company. I also authorize Richard Newhart, D.D.S., to release information to any Dentist or Physician I may be referred to by this office.

Signature _____ Date _____

Relationship to patient _____

Assignment of Benefits

I hereby authorize assignment and payment directly to Richard Newhart, D.D.S. dental benefits due to me.

I HEREBY AGREE TO PAY ANY AND ALL CHARGES THAT EXCEED OR ARE NOT COVERED BY MY INSURANCE. I UNDERSTAND THAT FEES FOR OFFICE SERVICES AND VISITS ARE DUE AND PAYABLE AT THE TIME SERVICE IS RENDERED.

Signature _____ Date _____

Relationship to patient _____

1308 MARKET STREET
PARKERSBURG, WV 26101
(304) 422-4867

RICHARD NEWHART, DDS

PRACTICE LIMITED TO PERIODONTICS AND IMPLANT DENTISTRY

MEDICARE PRIVATE CONTRACT

This contractual agreement is between Dr. Richard Craig Newhart, D.D.S. whose principal place of business is at 1308 Market Street, Parkersburg, West Virginia, 26101 and _____ (Patient), a Medicare Part B beneficiary. As a Dentist that has opted out of the Medicare program on April 15, 2015 for a period of at least two years, Dr. Newhart has informed Patient that treatment he provides to any Medicare beneficiary is not subject to Medicare limits. Pursuant to Dr. Newhart's "Opt-Out" agreement with Medicare, Patient has also been informed that Dr. Newhart is prohibited from billing Medicare for services provided to Patient.

As required by law, this agreement clearly states that Dr. Richard Craig Newhart is a provider in good standing with the Medicare program under Section 1128, 1156 or 1892 of the Social Security Act.

By signing this contract, the beneficiary or the beneficiary's legal representative, agrees to pay Dr. Newhart according to Dr. Newhart's fee schedule. Patient also agrees, understands, and expressly acknowledges the following: (please initial)

_____ Patient is not currently in an emergency health care situation.

_____ Patient agrees not to submit a claim (or to request Dr. Newhart to submit a claim) to the Medicare program even if services may be covered by Medicare Part B.

_____ Patient acknowledges that neither Medicare's fee limitations nor any other Medicare reimbursement regulations apply to services provided by Dr. Newhart.

_____ Patient understands that Medicare payment will not be made for any items or services furnished by Dr. Newhart that would have otherwise been covered by Medicare if there were no private contract and a proper Medicare claim were submitted.

_____ Patient acknowledges that Medigap plans will not provide payment for services rendered because payment will not be made under the Medicare program. Other supplemental plans may also deny payment.

_____ Patient acknowledges that he/she has a right, as a Medicare beneficiary, to obtain Medicare covered items and services from dentists who have not opted out of Medicare and that Patient is not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other dentists who have not opted out.

_____ Patient agrees to be responsible, whether through insurance or otherwise, to make payment in full for services provided by Dr. Newhart and acknowledges that Dr. Newhart will not submit a claim for Medicare reimbursement.

_____ Patient acknowledges that a copy of this agreement has been made available to him/her.

This contractual agreement shall remain in force from the date it is signed by Patient until the end of the term of Dr. Newhart's current opt-out period. The expected expiration date of Dr. Newhart's opt-out period is March 15, 2017.

Agreement Accepted by: Dr. Richard Craig Newhart, D.D.S.

_____
Patient Signature

Date:_____

Richard Newhart, DDS
thegumdr
West Virginia's First LANAP Periodontist
1308 Market Street * Parkersburg, WV 26101 * 304-422-4867

General Consent Form

I hereby voluntarily consent to dental examinations, treatments, and/or procedures including x-rays, which are deemed necessary on the opinion of my periodontist. I understand that procedures may be performed by Dr. Newhart, his hygienists, and dental assistants.

I understand that no guarantees or warranties have been made to me concerning the results of the examinations, treatments or procedures. I understand that successful treatment often depends upon my cooperation in following my doctor's instructions. I agree to fully follow my doctor's instructions and to fully cooperate in my care, including keeping necessary additional appointments with my doctor, hygienist, or assistant, to enhance the possibility of successful treatment outcomes.

Permission to Photograph

I authorize Dr. Newhart and his staff to take photographs and/or videos of my face, jaws, and teeth. I understand that the photographs and/or videos will be used as a record of my care, and may be used for educational purposes in lectures, demonstrations, professional publications, and our web page. I further understand that if the photographs and/or videos are used in any publication or as part of a demonstrations, all reasonable attempts will be made to conceal my identity.

Patient's signature:_____ Date:_____

Patient's Printed Name:_____

Authorization to consent for minor child:

Signature of person authorized to consent:_____

Printed name of person authorized to consent:_____

Relationship to child:_____ Date:_____