Glenn T. Clark D.D.S., M.S. / Ivan Lapidus, D.D.S., Inc./Daniel E. Lapidus D.D.S., Inc.
Orofacial Pain and Oral Medicine 1551 Bishop St – Suite 420; San Luis Obispo, Calif, 93401;
Tel: 805-543-7911; FAX: 805-543-5680

Title:___First Name:_____MI:___Last Name:_____Suffix: _____

Social Security Number:_____-____-_____Date of birth (mm/dd/yy):____/____/_____

Street Address:_____Male___Female____

_____Marital Status (Optional:_____)

City:_____: State:_____Zip:_____

Home Phone:( )_____Mobile:( )_____; E-mail:_____

Patient Employed By:_____Business Phone:( )_____

Patient's Occupation:_____

****

Spouse's Name:_____

Spouse Employed By:_____Business Phone:( )_____

****

Insurance Plan Name: (Medical)_____; (Dental)_____

Medical Plan #:_____; Dental Plan #_____

********** I

was referred by:_____

Patient's Physician:_____Phone( )_____City_____

[NOTE: I authorize my consultation report to be sent to my Physician (please initial):_____]

****

Patient's Dentist:_____Phone( )_____City:_____

[NOTE: I authorize my consultation report to be sent my Dentist (please initial):_____]

****

Other Specialist:_____Phone( )_____City:_____

Type of Specialist:_____;

[NOTE: I authorize a consultation report to be sent the above specialist (please initial):_____]

****

Other Specialist:_____Phone( )_____City:_____

Type of Specialist:_____;

[NOTE: I authorize a consultation report to be sent the above specialist (please initial):_____]

****

Patient's Signature:_____Date:_____

Patient's Guardian if required:_____Date: _____

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Medical History Questionnaire (2 pages)

Patient Name:_____SS#:_____Date of Birth: _____

State your reason for visiting clinic today: _____

Past/Current Medical Disease History: Do you have, or did you ever have, any of the following?

Cardiovascular:

YES	NO	
☐	☐	Angina (chest pain)
☐	☐	Atherosclerotic disease
☐	☐	Cardiac arrhythmia
☐	☐	Congestive heart failure
☐	☐	Hypertension or high blood pressure
☐	☐	Heart disease from childhood
☐	☐	Heart attack (myocardial infarction)
☐	☐	Heart murmur
☐	☐	Heart surgery
☐	☐	Heart valve defect or prolapse
☐	☐	Infection of heart (endocarditis)
☐	☐	Pacemaker
☐	☐	Rheumatic fever
☐	☐	Vascular graft

Endocrine/Hematologic:

☐	☐	Diabetes-Type I, II
☐	☐	Hypoglycemia
☐	☐	Hyperthyroid
☐	☐	Hypothyroid
☐	☐	Hemophilia
☐	☐	Hypercoagulability
☐	☐	Sickle cell disease
☐	☐	Anemia
☐	☐	Blood transfusion
☐	☐	Denied permission to give blood

Respiratory:

YES	NO	
☐	☐	Asthma
☐	☐	Emphysema
☐	☐	Tuberculosis
☐	☐	Bronchitis
☐	☐	Obstructive Pulmonary Disease
☐	☐	Obstructive Sleep Apnea
☐	☐	Severe Snoring

Musculo-Skeletal, Bone, Joint:

YES	NO	
☐	☐	Pinched or damaged cervical nerves
☐	☐	Artificial Joint replacement
☐	☐	Slipped Vertebral Disc
☐	☐	Spinal cord injury
☐	☐	Ankylosing Spondylitis
☐	☐	Artificial Joints
☐	☐	Carpal Tunnel Syndrome
☐	☐	Cervicogenic Pain/Headache
☐	☐	Chronic Fatigue Syndrome
☐	☐	Fibromyalgia
☐	☐	Myofascial Pain Disorder
☐	☐	Traumatic Local Arthritis
☐	☐	Osteoarthritis
☐	☐	Rheumatoid arthritis
☐	☐	Systemic Lupus Erythematosis
☐	☐	Gout
☐	☐	Psoriasis
☐	☐	Osteoporosis
☐	☐	Periodic Leg Movement Syndrome
☐	☐	Raynaud's Disease

Head, Ear, Eyes, Nose Throat

☐	☐	Glaucoma
☐	☐	Sinus Headache
☐	☐	TMJ Disease
☐	☐	Bell's Palsy
☐	☐	Burning Mouth Syndrome
☐	☐	Cataracts
☐	☐	Head Trauma
☐	☐	Laryngitis
☐	☐	Lymphadenopathy
☐	☐	Meniere's Disease
☐	☐	Macular Degeneration
☐	☐	Retinal Detachment
☐	☐	Sjogren's Syndrome
☐	☐	Xerostomia

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Oncologic/Immune/Infectious:

YES	NO	
☐	☐	HIV infection/AIDS
☐	☐	Hepatitis (A, B, C):_____
☐	☐	Organ transplant
☐	☐	Leukemia
☐	☐	Lymphoma
☐	☐	Radiation therapy
☐	☐	Chemotherapy
☐	☐	Cancer: _____
☐	☐	Idiopathic edema
☐	☐	Unusual immune suppression
☐	☐	Multiple Allergic Reactions
☐	☐	Herpes (Oral / Genital Herpes)
☐	☐	Lyme disease
☐	☐	Meningitis
☐	☐	Osteomyelitis
☐	☐	Pneumonia
☐	☐	Upper respiratory infection
☐	☐	Recurrent sinus infection

Neurologic/Degenerative/Developmental:

☐	☐	Stroke
☐	☐	Cerebral or other aneurysm
☐	☐	Seizures
☐	☐	Multiple Sclerosis
☐	☐	Cerebral palsy
☐	☐	Mental retardation
☐	☐	Dementia / Alzheimer's
☐	☐	Chronic Daily Headache
☐	☐	Cluster Headaches
☐	☐	Epilepsy
☐	☐	Migraines
☐	☐	Parkinson's Disease
☐	☐	Peripheral Neuropathy
☐	☐	Sciatica
☐	☐	Tension-Type Headache
☐	☐	Transient Ischemic Attacks (TIA)
☐	☐	Trigeminal Neuralgia

Psychological:

☐	☐	Anxiety/Nervousness
☐	☐	Depression
☐	☐	Mental health treatment
☐	☐	Phobias
☐	☐	Insomnia
☐	☐	Panic Disorder

Gastrointestinal:

YES	NO	
☐	☐	Crohn's Disease
☐	☐	Frequent esophagitis
☐	☐	Chronic gastritis
☐	☐	Gastro-esophageal reflux (GERD)
☐	☐	Hiatal Hernia
☐	☐	Irritable bowel syndrome
☐	☐	Malabsorption Syndrome
☐	☐	Ulcer

Genitourinary

☐	☐	Kidney dialysis
☐	☐	Sexually transmitted disease
☐	☐	Bladder or Urinary Infection

Medication Allergy or Intolerance:

☐	☐	Penicillin
☐	☐	Dental anesthetic ("Novocain")
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Latex products
☐	☐	Iodine

Other Allergy: _____

FEMALES ONLY:

☐	☐	Are you pregnant? How many months:___?
☐	☐	Do you take birth control pills?
☐	☐	Are you breast feeding now?

History of Hospitalization/Surgery (last 3 years):

_____

_____

Any medical problems not yet mentioned?

_____

_____

Signing below means all of the preceding answers are true. If I have any change in my health or in my medicines, I will inform my doctor at the next visit.

_____/_____
Patient signature (or parent or guardian)/Date

_____/_____
Drs. Signature (only after reviewing)

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Review of Systems, Psychosocial and Habit History (2 pages)

(Do you have, or have you recently (within 1 year) had any of the following?)

Constitutional

YES NO

- ☐ ☐ recent weight change
- ☐ ☐ appetite changes
- ☐ ☐ problems going to sleep
- ☐ ☐ problems staying asleep
- ☐ ☐ fever
- ☐ ☐ chills
- ☐ ☐ night sweats
- ☐ ☐ malaise (excessive tiredness)
- ☐ ☐ recent trauma or infections

Allergic/Immunologic

- ☐ ☐ multiple serious allergy problems
- ☐ ☐ HIV/AIDS
- ☐ ☐ unusual sneezing/rhinorrhea

Head/Eyes/Ears/Nose/Throat

- ☐ ☐ dizziness
- ☐ ☐ ear ringing
- ☐ ☐ hearing change or loss
- ☐ ☐ stuffy ears
- ☐ ☐ ear pain
- ☐ ☐ visual change or impairment
- ☐ ☐ eye pain
- ☐ ☐ nasal obstruction, sinusitis
- ☐ ☐ nasal or post-nasal discharge
- ☐ ☐ nose bleeding
- ☐ ☐ loss of smell
- ☐ ☐ swallowing abnormality
- ☐ ☐ swollen neck/throat
- ☐ ☐ tender or enlarged neck/throat glands

Mouth/Stomatognathic

- ☐ ☐ pain in mouth
- ☐ ☐ current oral sores/ulcers
- ☐ ☐ discoloration of oral tissues
- ☐ ☐ spontaneous mouth or gingival bleeding
- ☐ ☐ dry mouth
- ☐ ☐ unpleasant taste or bad breath
- ☐ ☐ burning lips, tongue or mouth
- ☐ ☐ limited opening or jaw locking
- ☐ ☐ jaw joint noises
- ☐ ☐ pain in TMJ/ear or temples on function
- ☐ ☐ uncomfortable bite

Gastrointestinal

YES NO

- ☐ ☐ frequent belching
- ☐ ☐ chronic diarrhea
- ☐ ☐ constipation
- ☐ ☐ abdominal pain
- ☐ ☐ frequent nausea or vomiting
- ☐ ☐ vomiting blood
- ☐ ☐ heartburn
- ☐ ☐ painful stomach
- ☐ ☐ bloody stools
- ☐ ☐ usually dark or pale stools.

Musculoskeletal

- ☐ ☐ substantial muscle weakness
- ☐ ☐ difficulty walking due to balance
- ☐ ☐ fatigue or leg pain with walking
- ☐ ☐ joint swelling
- ☐ ☐ dislocation of any joints
- ☐ ☐ pain and swelling in any joint
- ☐ ☐ joint flexibility or "double-jointedness
- ☐ ☐ stiff neck with loss of neck motion
- ☐ ☐ chronic pain problems

Dermatologic:

- ☐ ☐ skin rash
- ☐ ☐ dry/flaky/itchy skin
- ☐ ☐ spontaneous bruising
- ☐ ☐ bleeding under skin
- ☐ ☐ discoloration of skin
- ☐ ☐ blister or swelling on skin
- ☐ ☐ ulcer or growth on skin

Endocrine

- ☐ ☐ excessive hunger
- ☐ ☐ excessive thirst
- ☐ ☐ recent weight loss
- ☐ ☐ recent insomnia
- ☐ ☐ spontaneous palpitations

Hematologic/Lymphatic

- ☐ ☐ painful or discolored blood vessels
- ☐ ☐ painful or enlarged lymph glands
- ☐ ☐ excessive bleeding when cut
- ☐ ☐ spontaneous bleeding or anemia.

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Cardiovascular

YES	NO	
☐	☐	hypertension sensations
☐	☐	chest pain or angina
☐	☐	extra heart beats or palpitation

Respiratory

☐	☐	wet cough
☐	☐	labored or painful cough
☐	☐	frequent cough
☐	☐	difficult breathing
☐	☐	difficult breathing when laying flat
☐	☐	spitting up or coughing blood

Genitourinary

☐	☐	genital discharges or discolored urine
☐	☐	painful urination
☐	☐	difficulty or hesitancy with urinating
☐	☐	urinary or bladder infections

Alcohol/Tobacco/Other Issues:

☐ ☐ Do you use tobacco products?
If so, how much? _____
☐ ☐ Do you drink alcohol?
If every day, how much? _____
☐ ☐ Do you use recreational drugs?
☐ ☐ Do you clench or grind your teeth
☐ ☐ Do you hold facial/neck tension

Family: Did a parent, sibling or child of yours have any of the following?

☐	☐	Diabetes
☐	☐	High blood pressure
☐	☐	Heart disease
☐	☐	Bleeding tendency
☐	☐	Cancer

Neurological

YES	NO	
☐	☐	recent memory loss
☐	☐	unusual confusion
☐	☐	seizures
☐	☐	loss of consciousness or black-outs
☐	☐	feinting
☐	☐	reduced sensation or numbness
☐	☐	spontaneous muscle spasm
☐	☐	pain to light touch
☐	☐	spinning sensations

Psychiatric

☐	☐	"Stressed out"
☐	☐	Phobias
☐	☐	Depression
☐	☐	Anxiety
☐	☐	Insomnia
☐	☐	Unusual anger
☐	☐	Suicidal thoughts

Medications:

☐ ☐ Are you taking any prescriptions, over-the-counter or herbal medicines now? If so, please list them and the doses you use:

_____
_____
_____
_____
_____
_____
_____

Signing below means all of the preceding answers are true. If I have any change in my health status, or any change in my medicines, I will inform my dental health care provider at my next appointment.

_____/_____
Signature of patient (or Parent or Guardian as needed) Date

_____/_____
Drs. Signature Signature (only after reviewing) Date

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Oral Medicine / Orofacial Pain and Headache
Temporomandibular Disorders
Snoring and Apnea

1551 BISHOP STREET
SUITE 420
SAN LUIS OBISPO, CALIFORNIA 93401

TELEPHONE (805) 543-7911
FAX (805)543-5680

Due to recent developments, we are asking all patients to answer the following:

Yes / No Are you allergic to Latex?

Yes / No Have you ever taken prescription medication for weight reduction (DIET PILLS)?
If "YES", did you take any of the Drugs listed below?

_____Fen-Phen (fenfluramine-phentemine)
_____Pondimin (fenfluramine)
_____Redux (dexfenfluramine)

Yes / No If you have ever taken any of the above Drugs, have you had a medical exam to insure that your heart valves were not affected?

Patient's Signature _____

Date _____

Please print name _____

Thank you for your time in completing the much needed information.

Sincerely,

Glenn T. Clark, D.D.S., M.S.
Ivan Lapidus D.D.S.
Daniel Lapidus D.D.S., M.S.

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to sign This Acknowledge*

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 acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Other (Please Specify)

_____

_____

_____

This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002)

Your Information. Your Rights. Our Responsibilities.

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.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you. You can get an electronic or paper copy of your medical record:

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information. We may charge a reasonable, cost-based fee.

ASK US TO CORRECT YOUR MEDICAL RECORD

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days

REQUEST CONFIDENTIAL COMMUNICATIONS

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

ASK US TO LIMIT WHAT WE USE OR SHARE

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

GET A LIST OF THOSE WITH WHOM WE'VE SHARED INFORMATION

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

GET A COPY OF THIS PRIVACY NOTICE

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

CHOOSE SOMEONE TO ACT FOR YOU

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

FILE A COMPLAINT IF YOU FEEL YOUR RIGHTS ARE VIOLATED

- You can complain if you feel we have violated your rights by contacting us at 805-543-7993.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.
In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

HOW DO WE TYPICALLY USE OR SHARE YOUR HEALTH INFORMATION?

We typically use or share your health information in the following ways:

TREAT YOU

We can use your health information and share it with other professionals who are treating you.
Example: A doctor treating you for an injury asks another doctor about your overall health condition.

RUN OUR ORGANIZATION

We can use and share your health information to run our practice, improve your care, and contact you when necessary.
Example: We use health information about you to manage your treatment and services.

BILL FOR YOUR SERVICES

We can use and share your health information to bill and get payment from health plans or other entities.
Example: We give information about you to your health insurance plan so it will pay for your services.

HOW ELSE CAN WE USE OR SHARE YOUR HEALTH INFORMATION?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

HELP WITH PUBLIC HEALTH AND SAFETY ISSUES

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

DO RESEARCH

We can use or share your information for health research.

COMPLY WITH THE LAW

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

RESPOND TO ORGAN AND TISSUE DONATION REQUESTS

We can share health information about you with organ procurement organizations.

WORK WITH A MEDICAL EXAMINER OR FUNERAL DIRECTOR

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

ADDRESS WORKERS' COMPENSATION, LAW ENFORCEMENT, AND OTHER GOVERNMENT REQUESTS

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

RESPOND TO LAWSUITS AND LEGAL ACTIONS

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

FOR MORE INFORMATION SEE:

www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

CHANGES TO THE TERMS OF THIS NOTICE

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.

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Dr. Glenn Clark, Dr. Ivan Lapidus, Dr. Daniel Lapidus

Medicare Non-Participating Provider Agreement for
Patient (please print): _____

Please read each statement and initial it.

___1. I understand that by signing this agreement, I give up all Medicare payment options for services furnished by the above named doctor.

___2. I understand and agree not to bill Medicare or ask the physician to bill Medicare for these services.

___3. I understand that I am liable for all of the agreed to service charges (without any Medicare balance billing limits being in place).

___4. I understand and acknowledge that Medigap or any other supplemental insurance will not pay toward these services.

___5. I understand and acknowledges that I have right to receive services from another physician or dentist for whom Medicare coverage and payment would be available.

_____
Patient's Signature Date

_____
Doctor's Signature Date

_____
Witness's Signature Date

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Financial Responsibility

- This practice is fee for service and does not bill any medical or dental insurance.
- Payment is due at time of service unless other arrangements have been made.
- We make **no guarantee** of any reimbursement from any insurance carrier that you may have.
- You will be provided with a super bill containing the doctor's tax ID number, procedure and diagnosis codes if you would like to attempt billing your own insurance.

_____

Patient or Guardian Signature Date