Timothy L. Gutierrez, DMD **Ryan T. Sterk, DDS**

Patient Medical History Patient Name: ______________________________

Do you now have, or have you ever had any of the following: CIRCLE YES or NO

Condition			Condition		
Heart Disease	Yes	No	Stroke	Yes	No
Heart Surgery	Yes	No	If yes, Date ________		
If yes, Date __________			Kidney Disease	Yes	No
Heart Murmur	Yes	No	Liver Disease	Yes	No
Rheumatic Fever	Yes	No	Jaundice	Yes	No
High Blood Pressure	Yes	No	Arthritis/Rheumatism	Yes	No
Emphysema/Chronic Bronchitis	Yes	No	Asthma	Yes	No
Seizures/Fainting	Yes	No	Hay fever/Allergies	Yes	No
Tuberculosis	Yes	No	Sinus Trouble	Yes	No
Diabetes	Yes	No	Venereal Disease	Yes	No
Hip __Knee __ Joint __ Surgery	Yes	No	HIV/AIDS	Yes	No
Any Joint Replacement	Yes	No	Hepatitis __A __B __C	Yes	No
If yes, Date ________			Dependency to Drugs	Yes	No
Do you smoke?	Yes	No	Dependency to Alcohol	Yes	No

Please Answer The Following Questions:

1. Have you had any serious problems associated with any previous dental work? (i.e. Abnormal bleeding) YES or NO.
   If yes, explain: ______________________________
2. Are you currently taking ANY medications? YES or NO. If yes, please list ALL medications. (Include aspirin, birth control, insulin, or blood thinners or IV medications or Narcotic Medications)
   ____
3. Do you have an allergy to, or adverse reaction to ANY medications or foods? YES or NO. If yes, please list and also note the reaction to the drug. ______________________________
4. Are you under a Physician's care for a particular problem? YES or NO. If yes, explain. ______________________________
   ____
5. Is there any clicking or popping in your jaw joints, pain near your ear, difficulty opening mouth, or do you grind or clench your teeth? ______________________________
6. WOMEN ONLY: Are you pregnant? ____________ If yes, Due date ______________________
   Doctor's Name: ______________________ Phone # ______________________
7. Are there any other conditions you would like Dr. Gutierrez or Dr. Sterk to know about? ______________
   ____
8. Reason for Today's visit? Please describe any symptoms, pain, swelling, etc.
   ____
9. Have you ever been treated for cancer? YES or NO If so what kind? (i.e: Chemotherapy or Radiation)
   ____
10. Have you ever been told you have osteopenia or osteoporosis? YES or NO.
    ____
11. Are you on Bisphosphonate therapy or have you ever been? (ie: Fosamax, Boniva, Actonel, Zometa, etc.) YES or NO.
    If Yes, when? ______________________________
12. Are you taking steroids or have you in the past? YES of NO.
    ____
13. Are you taking any herbal medicines? YES or NO. If so please list.
    ____

I swear the above statements are true and correct to the best of my knowledge:

______________________________ Date ____________________
Patient Signature (Parent if Patient is Minor)

______________________ Date __________ ______________________ Date __________
Witness Signature Doctor Signature

COVID-19 Pandemic Emergency Dental Treatment

Notice and Acknowledgement of Risk Form

Our goal is to provide a safe environment for our patients and staff, and to advance the safety of our local community. This document provides information we ask you to acknowledge and understand regarding the COVID-19 virus.

The COVID-19 virus is a serious and highly contagious disease. The World Health Organization has classified it as a pandemic. You could contract COVID-19 from a variety of sources. Our practice wants to ensure you are aware of the additional risks of contracting COVID-19 associated with dental care.

The COVID-19 virus has a long incubation period. You or your healthcare providers may have the virus and not show symptoms and yet still be highly contagious. Determining who is infected by COVID-19 is challenging and complicated due to limited availability for virus testing.

Due to the frequency and timing of visits by other dental patients, the characteristics of the virus, and the characteristics of dental procedures, there is an elevated risk of you contracting the virus simply by being in a dental office.

Dental procedures create water spray which is one way the disease is spread. The ultra-fine nature of the water spray can linger in the air for a long time, allowing for transmission of the COVID-19 virus to those nearby.

You cannot wear a protective mask over your mouth to prevent infection during treatment as your health care providers need access to your mouth to render care. This leaves you vulnerable to COVID-19 transmission while receiving dental treatment.

Pursuant to statements from the Center for Disease Control (CDC) and the American Dental Association (ADA), non-essential or elective treatment, based on the assessment of our staff, will be rescheduled. According to the ADA, dental emergencies are "potentially life threatening and require immediate treatment to stop ongoing tissue bleeding [or to] alleviate severe pain or infection." The ADA also recommends that urgent dental care which "focuses on the management of conditions that require immediate attention to relieve severe pain and/or risk of infection and to alleviate the burden on hospital emergency departments" be provided in as minimally invasive a manner as possible.

I confirm that I have read the Notice above and understand and accept that there is an increased risk of contracting the COVID-19 virus in the dental office or with dental treatment. I further confirm I am seeking treatment for a condition that meets the emergent or urgent criteria noted above. I understand and accept the additional risk of contracting COVID-19 from contact at this office. I also acknowledge that I could contract the COVID-19 virus from outside this office and unrelated to my visit here.

I have read and understand the information stated above:

______________________________ ______________________________

Signature Date

____

Witness

COVID-19 Pandemic - Patient Disclosures

This patient disclosure form seeks information from you that we must consider before making treatment decisions in the circumstance of the COVID-19 virus.

A weak or compromised immune system (including, but not limited to, conditions like diabetes, asthma, COPD, cancer treatment, radiation, chemotherapy, and any prior or current disease or medical condition), can put you at greater risk for contracting COVID-19. Please disclose to us any condition that compromises your immune system and understand that we may ask you to consider rescheduling treatment after discussing any such conditions with us.

It is also important that you disclose to this office any indication of having been exposed to COVID-19, or whether you have experienced any signs or symptoms associated with the COVID-19 virus.

	Yes	No
Do you have a fever or above normal temperature?	☐	☐
Have you experienced shortness of breath or had trouble breathing?	☐	☐
Do you have a dry cough?	☐	☐
Do you have a runny nose?	☐	☐
Have you recently lost or had a reduction in your sense of smell?	☐	☐
Do you have a sore throat?	☐	☐
Have you been in contact with someone who has tested positive for COVID-19?	☐	☐
Have you tested positive for COVID-19?	☐	☐
Have you been tested for COVID-19 and are awaiting results?	☐	☐
Have you traveled outside the United States by air or cruise ship in the past 14 days?	☐	☐
Have you traveled within the United States by air, bus or train within the past 14 days?	☐	☐

I fully understand and acknowledge the above information, risks and cautions regarding a compromised immune system and have disclosed to my provider any conditions in my health history which may result in a compromised immune system.

By signing this document, I acknowledge that the answers I have provided above are true and accurate.

______________________________ ______________________________

Signature Date

____

Witness

Ryan Sterk, Inc.

Timothy L. Gutierrez, DMD **Ryan T. Sterk, DDS**

Notice of Privacy Practices for Protected Health Information

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!

With your consent, the practice is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services.

Example of uses of your health information for treatment purposes: A nurse obtains treatment information about you and records it in a health record. During the course of your treatment, the doctor determines a need to consult with another specialist in the area. The doctor will share the information with such specialist and obtain input.

Example of use of your health information for payment purposes: We submit a request for payment to your health insurance company. The health insurance company requests information from us regarding medical care given. We will provide information to them about you and the care given.

Example of Use of Your Information for Health Care Operations: We obtain services from our insurers or other business associates such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guidelines development, training programs, credentialing, medical review, legal services, and insurance. We will share information about you with such insurers or other business associates as necessary to obtain these services.

Your Health Information Rights

The health record we maintain and billing records are the physical property of the practice. The information in it, however, belongs to you. You have a right to:

- Request a restriction on certain uses and disclosures of your health information by delivering the request in writing to our office. We are not required to grant the request but we will comply with any request granted;
- Request that you be allowed to inspect and copy your health record and billing record—you may exercise this right by delivering the request in writing to our office;
- Appeal a denial of access to your protected health information except in certain circumstances;
- Request that your health care record be amended to correct incomplete or incorrect information by delivering a written request to our office;
- File a statement of disagreement if your amendment is denied, and require that the request for amendment and any denial be attached in all future disclosures of your protected health information;
- Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a written request to our office. An accounting will not include internal uses of information for treatment, payment, or operations, disclosures made to you or made at your request, or disclosures made to family members or friends in the course of providing care;
- Request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office; and,
- Revoke authorizations that you made previously to use or disclose information except to the extent information or action has already been taken by delivering a written revocation to our office.

If you want to exercise any of the above rights, please contact **Privacy Officer 1513 Carlisle Blvd NE, Albuquerque, NM 87110, (505) 881-7373,** in person or in writing, during normal hours. **She** will provide you with assistance on the steps to take to exercise your rights.

Our Responsibilities

The practice is required to:

- Maintain the privacy of your health information as required by law;
- Provide you with a notice of our duties and privacy practices as to the information we collect and maintain about you;
- Abide by the terms of this Notice;
- Notify you if we cannot accommodate a requested restriction or request; and
- Accommodate your reasonable requests regarding methods to communicate health information with you.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our "Notice" or by visiting our office and picking up a copy.

To Request Information or File a Complaint

If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact **Dr. Timothy L. Gutierrez or Privacy Officer 1513 Carlisle Blvd NE, Albuquerque, NM 87110, (505) 881-7373 or fax (505) 881-5096.**

Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office by delivering the written complaint to **Dr. Timothy L. Gutierrez or Privacy Officer.** You ma also file a complaint by mailing it or e-mailing it to the Secretary of Health and Human Services. We will provide you with the address to file the complaint upon request.

- We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from the practice.
- We cannot, and will not, retaliate against you for filing a complaint with the Secretary.

Other Disclosures and Uses

Notification: Unless you object, we may use or disclose your protected health information to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care, about your location, and about your general condition, or your death.

Communication with Family: Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency.

Food and Drug Administration (FDA): We may disclose to the FDA your protected health information relating to adverse events with respect to products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacements.

Workers Compensation: If you are seeking compensation through Workers Compensation, we may disclose your protected health information to the extent necessary to comply with laws relating to Workers Compensation.

Public Health: As required by law, we may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Abuse & Neglect: We may disclose your protected health information to public authorities as allowed by law to report abuse or neglect.

Correctional Institutions: If you are an inmate of a correctional institution, we may disclose to the institution, or its agents, your protected health information necessary for your health and the health and safety of other individuals.

Law Enforcement: We may disclose your protected health information for law enforcement purposes as required by law, such as when required by a court order, or in cases involving felony prosecutions, or to the extent an individual is in the custody of law enforcement.

Health Oversight: Federal law allows us to release your protected health information to appropriate health oversight agencies or for health oversight activities.

Judicial/Administrative Proceedings: We may disclose your protected health information in the course of any judicial or administrative proceeding as allowed or required by law, with your consent, or as directed by a proper court order.

Other Uses: Other uses and disclosures besides those identified in this Notice will be made only as otherwise authorized by law or with your written authorization and you may revoke the authorization as previously provided.

Website: If we maintain a website that provides information about our entity, this Notice will be on the website.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail, messages, postcards or letters).

Effective Date: April 14, 2003

Ryan Sterk, Inc.

Timothy L. Gutierrez, DMD **Ryan T. Sterk, DDS**

Notice of Privacy Practices for Protected Health Information

I, ___________________________, hereby acknowledge that I have received a copy of this practice's Notice of Privacy Practices. I have been given the opportunity to ask any questions I may have regarding this Notice.

______________________________________ ________________________________

Patient Signature (Parent if patient is minor) **Date**

______________________________________ ________________________________

Witness **Date**

Ryan Sterk, Inc.

Timothy L. Gutierrez, DMD **Ryan T. Sterk, DDS**

Insurance Information

Name of Patient: ______________________________

Name of **Primary** Dental Insurance: ______________________________
Phone # of Dental Insurance: ______________________________
Name of Dental Card Holder: ______________________________
Dental Card Holder's SS #: ______________________ D.O.B __________
Dental Card Holder's Employer: ______________________________
Relationship to Patient: ______________________________

Name of **Secondary** Dental Insurance: ______________________________
Phone # of Dental Insurance: ______________________________
Name of Dental Card Holder: ______________________________
Dental Card Holder's SS #: ______________________ D.O.B __________
Dental Card Holder's Employer: ______________________________
Relationship to Patient: ______________________________

Name of **Primary** Medical Insurance: ______________________________
Phone # of Medical Insurance: ______________________________
Name of Medical Card Holder: ______________________________
Medical Card Holder's SS #: ______________________ D.O.B __________
Medical Card Holder's Employer: ______________________________
Relationship to Patient: ______________________________

Assignment of Benefits:

I authorize release of any information relating to Dental/Medical claims and I understand I am responsible for all costs of treatment. I hereby authorize payment directly to Ryan Sterk, Inc. the group insurance benefits otherwise payable to me.

Ryan Sterk, Inc.

Timothy L. Gutierrez, DMD **Ryan T. Sterk, DDS**

Patient Information (Please Print Legibly)

Circle One

Name: ______________________ Prefix: ________ Nickname: ____________ Male Fem

Date of Birth: ________________ Age: ________ Social Security # ________________

Address: ______________________ Apt #: ____________ PO Box ____________

City: ______________________ State: ____________ Zip ________

Employer: ____

Home Phone # ______________ Work Phone #: ____________ Cell Phone # ____________

Marital Status M S D W Name of School (if applicable) ______________________

Responsible Party Information (If Patient is Minor)

Circle One

Name: ______________________ Prefix: ________ Nickname: ____________ Male Fema

Date of Birth: ________________ Age: ________ Social Security # ________________

Address: ______________________ Apt #: ____________ PO Box ____________

City: ______________________ State: ____________ Zip ________

Employer: ____

Home Phone # ______________ Work Phone #: ____________ Cell Phone # ____________

Marital Status M S D W Name of School (if applicable) ______________________

Pharmacy: ____

Patient's Primary Physician: ______________________________ Phone #: ____________

Patient's Primary Dentist: ______________________________ Phone #: ____________

Who Referred You to Our Office? ____

Did You Bring X-rays? Yes No Were X-rays Mailed Yes No

Did You Bring a Referral or extraction order from your doctor? Yes No

If yes who are X-rays or Referral from? ______________________________________

Emergency Contact Information

Person to contact in case of an emergency: ______________________________________

Relationship to patient: ____

Home Phone # ______________ Work Phone #: ____________ Cell Phone#: ____________