

[Insert Name of Practice]

# NOTICE OF PRIVACY PRACTICES

**THIS NOTICE DESCRIBES HOW HEALTH 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 HEALTH INFORMATION IS IMPORTANT TO US.**

## OUR LEGAL DUTY

Federal and state law requires us to maintain the privacy of your health information. That law also requires us to give you this notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices we describe in this notice while it is in effect. This notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such applicable law permits the changes. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

## USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and health care operations. For example:

**Treatment:** We may use your health information for treatment or disclose it to a dentist, physician or other health care provider providing treatment to you.

**Payment:** We may use and disclose your health information to obtain payment for services we provide to you. We may also disclose your health information to another health care provider or entity that is subject to the federal Privacy Rules for its payment activities.

**Health Care Operations:** We may use and disclose your health information for our health care operations. Health care operations include quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities. We may disclose your health information to another health care provider or organization that is subject to the federal privacy rules and that has a relationship with you to support some of their health care operations. We may disclose your information to help these organizations conduct quality assessment and improvement activities, review the competence or qualifications of health care professionals, or detect or prevent health care fraud and abuse.

**On Your Authorization:** You may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any uses or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

**To Your Family and Friends:** We may disclose your health information to a family member, friend or other person to the extent necessary to help with your health care or with payment for your health care. Before we disclose your health information to these people, we will provide you with an opportunity to object to our use or disclosure. If you are not present, or in the event of your incapacity or an emergency, we will disclose your medical information based on our professional judgment of whether the disclosure would be in your best interest. We may use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information. We may use or disclose information about you to notify or assist in notifying a person involved in your care, of your location and general condition.

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

**Disaster Relief:** We may use or disclose your health information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

**Public Benefit:** We may use or disclose your medical information as authorized by law for the following purposes deemed to be in the public interest or benefit:

- as required by law;
- for public health activities, including disease and vital statistic reporting, child abuse reporting, FDA oversight, and to employers regarding work-related illness or injury;
- to report adult abuse, neglect, or domestic violence;

- to health oversight agencies;
- in response to court and administrative orders and other lawful processes;
- to law enforcement officials pursuant to subpoenas and other lawful processes, concerning crime victims, suspicious deaths, crimes on our premises, reporting crimes in emergencies, and for purposes of identifying or locating a suspect or other person;
- to coroners, medical examiners, and funeral directors;
- to an organ procurement organizations;
- to avert a serious threat to health or safety;
- in connection with certain research activities;
- to the military and to federal officials for lawful intelligence, counterintelligence, and national security activities;
- to correctional institutions regarding inmates; and
- as authorized by state worker's compensation laws.

## PATIENT RIGHTS

**Access:** You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge you a reasonable cost-based fee that may include labor, copying costs, and postage. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we may—but are not required to—prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this notice for more information about fees.

**Disclosure Accounting:** You have the right to receive a list of instances in which we or our business associates disclosed your health information over the last 6 years (but not before April 14, 2003). That list will not include disclosures for treatment, payment, health care operations, as authorized by you, and for certain other activities. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. Contact us using the information listed at the end of this notice for more information about fees.

**Restriction:** You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. Your request is not binding unless our agreement is in writing.

**Alternative Communication:** You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing. You must specify in your request the alternative means or location, and provide satisfactory explanation how you will handle payment under the alternative means or location you request.

**Amendment:** You have the right to request that we amend your health information. Your request must be in writing, and it must explain why we should amend the information. We may deny your request under certain circumstances.

## QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us using the information listed at the end of this notice.

If you believe that:

- we may have violated your privacy rights,
- we made a decision about access to your health information incorrectly,
- our response to a request you made to amend or restrict the use or disclosure of your health information was incorrect, or
- we should communicate with you by alternative means or at alternative locations,

you may contact us using the information listed below. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health 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.

Provider Contact Office: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

E-Mail: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_  
*[Insert Name of Practice]*

**SECTION A: The Patient.**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ E-mail: \_\_\_\_\_

Patient Number: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

**SECTION B: Acknowledgement of Receipt of Privacy Practices Notice.**

I, \_\_\_\_\_, acknowledge that I have received a Notice of Privacy Practices from the above-named practice.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If a personal representative signs this authorization on behalf of the individual, complete the following:

Personal Representative's Name: \_\_\_\_\_

Relationship to Individual: \_\_\_\_\_

**SECTION C: Good Faith Effort to Obtain Acknowledgement of Receipt.**

Describe your good faith effort to obtain the individual's signature on this form: \_\_\_\_\_

\_\_\_\_\_

Describe the reason why the individual would not sign this form: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**SIGNATURE.**

I attest that the above information is correct.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print name: \_\_\_\_\_ Title: \_\_\_\_\_

*Include this acknowledgement of receipt in the individual's records.*

**ACKNOWLEDGEMENT OF RECEIPT OF  
PRIVACY PRACTICES NOTICE**



PATIENT NUMBER

Age \_\_\_\_\_ Date \_\_\_\_\_

Patient's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  Male  Female  
Last First Initial

If Child: Parent's Name \_\_\_\_\_

How do you wish to be addressed \_\_\_\_\_  
Single  Married  Separated  Divorced  Widowed  Minor

Residence - Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Business Address \_\_\_\_\_

Telephone: Res. \_\_\_\_\_ Bus. \_\_\_\_\_

Fax \_\_\_\_\_ Cell Phone # \_\_\_\_\_

eMail \_\_\_\_\_

Patient/Parent Employed By \_\_\_\_\_

Present Position \_\_\_\_\_

How Long Held \_\_\_\_\_

Spouse/Parent Name \_\_\_\_\_

Spouse Employed By \_\_\_\_\_

Present Position \_\_\_\_\_

How Long Held \_\_\_\_\_

Who is Responsible for this account \_\_\_\_\_

Drivers License No. \_\_\_\_\_

Method of Payment: Insurance  Cash  Credit Card

Purpose of Call \_\_\_\_\_

Other Family Members in this Practice \_\_\_\_\_

Whom may we thank for this referral \_\_\_\_\_

Patient/parent Social Security No. \_\_\_\_\_

Spouse/Parent Social Security No. \_\_\_\_\_

Someone to notify in case of emergency not living with you \_\_\_\_\_

**DENTAL INSURANCE  
1ST COVERAGE**

Employee Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Relationship to patient \_\_\_\_\_

Employer Name \_\_\_\_\_ Yrs. \_\_\_\_\_

Name of Insurance Co. \_\_\_\_\_

Address \_\_\_\_\_

Telephone \_\_\_\_\_

Program or policy # \_\_\_\_\_

Social Security No. \_\_\_\_\_

Union Local or Group \_\_\_\_\_

**DENTAL INSURANCE  
2ND COVERAGE**

Employee Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Relationship to patient \_\_\_\_\_

Employer Name \_\_\_\_\_ Yrs. \_\_\_\_\_

Name of Insurance Co. \_\_\_\_\_

Address \_\_\_\_\_

Telephone \_\_\_\_\_

Program or policy # \_\_\_\_\_

Social Security No. \_\_\_\_\_

Union Local or Group \_\_\_\_\_

**CONSENT:**

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

I consent to the dentist's use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment.

I consent to the disclosure of my records (or my child's records) to the following persons who are involved in my care (or my child's care) or payment for that care.

My consent to disclosure of records shall be effective until I revoke it in writing.

I authorize payment directly to the dentist or dental group of insurance benefits otherwise payable to me. I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, by my dental care payor.

I attest to the accuracy of the information on this page.

PATIENT'S OR GUARDIAN'S SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_

**REGISTRATION**

PATIENT NUMBER



Patient's Name \_\_\_\_\_ Last \_\_\_\_\_ First \_\_\_\_\_ Initial \_\_\_\_\_ Date of Birth \_\_\_\_\_

1. Purpose of initial visit \_\_\_\_\_
  2. Are you aware of a problem? \_\_\_\_\_
  3. How long since your last dental visit? \_\_\_\_\_
  4. What was done at that time? \_\_\_\_\_
  5. Previous dentist's name \_\_\_\_\_  
Address: \_\_\_\_\_ Tel. \_\_\_\_\_
  6. When was the last time your teeth were cleaned? \_\_\_\_\_
- CIRCLE THE APPROPRIATE ANSWER. IF YOU DON'T KNOW THE CORRECT ANSWER, PLEASE WRITE "DON'T KNOW" ON THE LINE AFTER THE QUESTION.
7. Have you made regular visits? .....YES NO  
How often: \_\_\_\_\_
  8. Were dental x-rays taken? .....YES NO
  9. Have you lost any teeth or have any teeth been removed? .....YES NO  
Why? \_\_\_\_\_
  10. Have they been replaced? .....YES NO
  11. How have they been replaced?
    - a. Fixed bridge \_\_\_\_\_ Age \_\_\_\_\_
    - b. Removable bridge \_\_\_\_\_ Age \_\_\_\_\_
    - c. Denture \_\_\_\_\_ Age \_\_\_\_\_
    - d. Implant \_\_\_\_\_ Age \_\_\_\_\_
  12. Are you unhappy with the replacement? .....YES NO  
If yes, explain \_\_\_\_\_
  13. Would you like to know about permanent replacements? .....YES NO
  14. Have you ever had any problems or complications with previous dental treatment? ...YES NO  
If yes, explain: \_\_\_\_\_
  15. Do you clench or grind your teeth? .....YES NO
  16. Does your jaw click or pop? .....YES NO
  17. Have you experienced any pain or soreness in the muscles or your face or around your ear? .....YES NO
  18. Do you have frequent headaches, neckaches or shoulder aches? .....YES NO
  19. Does food get caught in your teeth? .....YES NO
  20. Are any of your teeth sensitive to:    Hot?    Cold?    Sweets?    Pressure?
  21. Do your gums bleed or hurt? .....YES NO  
When? \_\_\_\_\_
  22. Do you experience dry mouth? .....YES NO
  23. How often do you brush your teeth? \_\_\_\_\_ When? \_\_\_\_\_
  24. Do you use dental floss? .....YES NO  
How often? \_\_\_\_\_
  25. Are any of your teeth loose, tipped, shifted or chipped? .....YES NO
  26. Are you unhappy with the appearance of your teeth? .....YES NO
  27. How do you feel about your teeth in general? \_\_\_\_\_
  28. Do you feel your breath is offensive at times? .....YES NO
  29. Have you ever had gum treatment or surgery? .....YES NO  
What? \_\_\_\_\_  
Where? \_\_\_\_\_  
When? \_\_\_\_\_
  30. Have you had any orthodontic work? \_\_\_\_\_
  31. Have you had any unpleasant dental experiences or is there anything about dentistry that you strongly dislike? \_\_\_\_\_
  32. Do you have any questions or concerns? .....YES NO

COMMENTS

Large empty box for patient or dentist comments.

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE  
PATIENT'S / GUARDIAN'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_  
DENTIST'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

ANEST.

MED. ALERT

DENTAL HISTORY

PATIENT NUMBER

welcome

Patient's Name \_\_\_\_\_ Last \_\_\_\_\_ First \_\_\_\_\_ Initial \_\_\_\_\_ Date of Birth \_\_\_\_\_

CIRCLE THE APPROPRIATE ANSWER, IF YOU DON'T KNOW THE CORRECT ANSWER PLEASE WRITE "DON'T KNOW" ON THE LINE AFTER THE QUESTION

COMMENTS

- 1. Physician's Name \_\_\_\_\_ Address \_\_\_\_\_ Tel: (\_\_\_\_) \_\_\_\_\_
2. Are you under a physician's care? . . . . . YES NO
Since when \_\_\_\_\_ Why \_\_\_\_\_
3. When was your last complete physical exam? \_\_\_\_\_
4. Are you taking any medication or substances? . . . . . YES NO
(If yes, please list medications in comments section or on the back of this form.)
5. Do you routinely take health related substances? (Vitamins, herbal supplements, natural products) . . YES NO
6. Are you allergic to any medications or substances? (please list) . . . . . YES NO
7. Do you have any other allergies or hives? . . . . . YES NO
8. Do you have any problems with penicillin, antibiotics, anesthetics
or other medications? . . . . . YES NO
9. Are you sensitive to any metals or latex? . . . . . YES NO
10. Are you pregnant or suspect you may be? . . . . . YES NO
11. Do you use any birth control medications? . . . . . YES NO
12. Have you ever been treated for or been told you might have heart disease? . . . . . YES NO
13. Do you have a pacemaker, an artificial heart valve implant, or
been diagnosed with mitral valve prolapse? . . . . . YES NO
14. Have you ever had rheumatic fever? . . . . . YES NO
15. Are you aware of any heart murmurs? . . . . . YES NO
16. Do you have high or low blood pressure? (please circle) . . . . . YES NO
17. Have you ever had a serious illness or major surgery? . . . . . YES NO
If so, explain \_\_\_\_\_
18. Have you ever had radiation treatment, chemo treatment for tumor,
growth or other condition? . . . . . YES NO
19. Have you ever taken Fosamax, Zometa, Aredia or any other oral or intravenous treatment
(bisphosphonates) for bone tumors, excessive calcium in your blood, or osteoporosis? . YES NO
20. Do you have inflammatory diseases, such as arthritis or rheumatism? . . . . . YES NO
21. Do you have any artificial joints/prosthesis? . . . . . YES NO
22. Do you have any blood disorders, such as anemia, leukemia, etc? . . . . . YES NO
23. Have you ever bled excessively after being cut or injured? . . . . . YES NO
24. Do you have any stomach problems? . . . . . YES NO
25. Do you have any kidney problems? . . . . . YES NO
26. Do you have any liver problems? . . . . . YES NO
27. Are you diabetic? . . . . . YES NO
28. Do you have fainting or dizzy spells? . . . . . YES NO
29. Do you have asthma? . . . . . YES NO
30. Do you have epilepsy or seizure disorders? . . . . . YES NO
31. Do you or have you had venereal or any sexually transmitted disease? . . . . . YES NO
32. Have you tested HIV positive? . . . . . YES NO
33. Do you have AIDS? . . . . . YES NO
34. Have you had or do you test positive for hepatitis? . . . . . YES NO
35. Do you or have you had T.B.? . . . . . YES NO
36. Do you smoke, chew, use snuff or any other forms of tobacco? . . . . . YES NO
37. Do you regularly consume more than one or two alcoholic beverages a day? . . . . . YES NO
38. Do you habitually use controlled substances? . . . . . YES NO
39. Have you had psychiatric treatment? . . . . . YES NO
40. Have you taken any prescription drugs fenfluramine, fenfluramine combined with
phentermine (fen-phen), dexfenfluramine (redux), or other weight loss products? . . . . . YES NO
41. Do you have any disease condition, or problem not listed? If so, explain \_\_\_\_\_
42. Is there anything else we should know about your health that we have not covered in this form? \_\_\_\_\_
43. Would you like to speak to the Doctor privately about any problem? . . . . . YES NO

Large empty box for patient or dentist comments.

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S / GUARDIAN'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

DENTIST'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

ANEST.

MED. ALERT

MEDICAL HISTORY