



Health History Form

Email: _____ Today's Date: _____

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name: Last	First	Middle	Home Phone: Include area code ()	Business/Cell Phone: Include area code ()	
Address: <small>Mailing address</small>			City:	State: Zip:	
Occupation:		Height:	Weight:	Date of Birth: Sex: M F	
SS# or Patient ID:	Emergency Contact:	Relationship:	Home Phone: ()	Cell Phone: () <small>Include area codes</small>	
If you are completing this form for another person, what is your relationship to that person?					
Your name		Relationship			
Do you have any of the following diseases or problems:			(Check DK if you Don't Know the answer to the question)		
Active Tuberculosis			Yes	No	DK
Persistent cough greater than a 3 week duration			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cough that produces blood			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Been exposed to anyone with tuberculosis			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.					

Health History Form

For the following questions, please mark (X) your responses to the following questions.

	Yes	No	DK		Yes	No	DK
Do your gums bleed when you brush or floss?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have earaches or neck pains?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitive to cold, hot, sweets or pressure?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any clicking, popping or discomfort in the jaw?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does food or floss catch between your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you brux or grind your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your mouth dry?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have sores or ulcers in your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any periodontal (gum) treatments?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you wear dentures or partials?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had orthodontic (braces) treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you participate in active recreational activities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any problems associated with previous dental treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had a serious injury to your head or mouth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your home water supply fluoridated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Date of your last dental exam:			
Do you drink bottled or filtered water?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	What was done at that time?			
If yes, how often? Circle one: DAILY WEEKLY OCCASIONALLY				Date of last dental x-rays:			
Are you currently experiencing dental pain or discomfort?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
What is the reason for your dental visit today?							
How do you feel about your smile?							

Health History Form

Please mark (X) your responses to indicate if you have or have not had any of the following diseases or problems.

	Yes	No	DK		Yes	No	DK
Are you now under the care of a physician?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you had a serious illness, operation or been hospitalized in the past 5 years?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physician Name:	Phone: Include area code ()			If yes, what was the illness or problem?			
Address/City/State/Zip:				Are you taking or have you recently taken any prescription or over the counter medicine(s)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you in good health?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements:			
Has there been any change in your general health within the past year?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____			
If yes, what condition is being treated?				_____			
Date of last physical exam:				_____			

Health History Form

Please mark (X) your responses to indicate if you have or have not had any of the following diseases or problems.

Do you wear contact lenses? Yes No DK <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you use controlled substances (drugs)? Yes No DK <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? Yes No DK <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Date: _____ If yes, have you had any complications? _____	Do you use tobacco (smoking, snuff, chew, bidis)? Yes No DK <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> If so, how interested are you in stopping? (Circle one) VERY / SOMEWHAT / NOT INTERESTED
Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax) or risedronate (Actonel) for osteoporosis or Paget's disease? Yes No DK <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you drink alcoholic beverages? Yes No DK <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> If yes, how much alcohol did you drink in the last 24 hours? _____ If yes, how much do you typically drink in a week? _____
Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia or Zometa) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? Yes No DK <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Date Treatment began: _____	WOMEN ONLY Are you: Pregnant? Yes No DK <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Number of weeks: _____ Taking birth control pills or hormonal replacement? Yes No DK <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Nursing? Yes No DK <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Allergies – Are you allergic to or have you had a reaction to: Yes No DK To all yes responses, specify type of reaction.	Yes No DK
Local anesthetics <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Aspirin <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Penicillin or other antibiotics <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Barbiturates, sedatives, or sleeping pills <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sulfa drugs <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Codeine or other narcotics <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Metals <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Latex (rubber) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Iodine <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hay fever/seasonal <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Animals <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Food <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Other <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.	
Artificial (prosthetic) heart valve <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Previous infective endocarditis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Damaged valves in transplanted heart <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Congenital heart disease (CHD) Unrepaired, cyanotic (CHD) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Repaired (completely) in last 6 months <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Repaired CHD with residual defects <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Yes No DK
Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.	Autoimmune disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Rheumatoid arthritis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Systemic lupus erythematosus <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Asthma <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bronchitis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Emphysema <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sinus trouble <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Tuberculosis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Cancer/Chemotherapy/ Radiation Treatment <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Chest pain upon exertion <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Chronic pain <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Diabetes Type I or II <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Eating disorder <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Malnutrition <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Gastrointestinal disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> G.E. Reflux/ persistent heartburn <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Ulcers <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Thyroid problems <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Stroke <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Yes No DK	Yes No DK
Cardiovascular disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Angina <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Arteriosclerosis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Congestive heart failure <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Damaged heart valves <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Heart attack <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Heart murmur <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Low blood pressure <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> High blood pressure <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Other congenital heart defects <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Mitral valve prolapse <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Pacemaker <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Rheumatic fever <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Rheumatic heart disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Abnormal bleeding <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Anemia <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Blood transfusion <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> If yes, date: _____ Hemophilia <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> AIDS or HIV infection <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Arthritis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Glaucoma <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hepatitis, jaundice <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> or liver disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Epilepsy <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Fainting spells or seizures <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Neurological disorders <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> If yes, specify: _____ Sleep disorder <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Mental health disorders <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Specify: _____ Recurrent Infections <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Type of infection: _____ Kidney problems <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Night sweats <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Osteoporosis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Persistent swollen glands in neck <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Severe headaches/migraines <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Severe or rapid weight loss <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sexually transmitted disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Excessive urination <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Glaucoma <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hepatitis, jaundice <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> or liver disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Epilepsy <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Fainting spells or seizures <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Neurological disorders <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> If yes, specify: _____ Sleep disorder <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Mental health disorders <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Specify: _____ Recurrent Infections <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Type of infection: _____ Kidney problems <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Night sweats <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Osteoporosis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Persistent swollen glands in neck <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Severe headaches/migraines <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Severe or rapid weight loss <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sexually transmitted disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Excessive urination <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? Yes No DK <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Name of physician or dentist making recommendation: _____	Phone: _____
Do you have any disease, condition, or problem not listed above that you think I should know about? Yes No DK Please explain: _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: _____

Date: _____

FOR COMPLETION BY DENTIST

Comments: _____

HIPAA Notice

288 Redfern Village - St. Simons Island, GA 31522 | OFFICE: 912.638.9090 | FAX: 912-638-0990

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.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; examining your teeth; prescribing medications and faxing them to be filled; referring you to another doctor or clinic for other health care or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or dental care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we usually will not ask you for special written permission.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- When a state or federal law mandates that certain health information be reported for a specific purpose;
- For public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
- Disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- Uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
- Disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- Disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
- Disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- Uses or disclosures for health related research;
- Uses and disclosures to prevent a serious threat to health or safety;
- Uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
- Disclosures of de-identified information;
- Disclosures relating to worker's compensation programs;
- Disclosures of a "limited data set" for research, public health, or health care operations;
- Incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- Disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information;

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your dental care.

APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this Notice.

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YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

- Ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address, fax or E Mail shown at the beginning of this Notice.
- Ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E Mail to your personal E Mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax, or E Mail shown at the beginning of this Notice.
- Ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30 day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address, fax or E Mail shown at the beginning of this Notice.
- Ask us to amend your health information if you think it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax or E Mail shown at the beginning of this Notice.
- Get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address, fax or E Mail shown at the beginning of this Notice.
- Get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address, fax or E Mail shown at the beginning of this Notice.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our Web site.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or E Mail shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this Notice.

Zachary J. Powell D.M.D.

HIPAA Notice

For the following questions, please mark (X) your responses to the following questions.

Home Phone: ()

Cell: ()

Email:

Have you had a heart valve or joint replacement? **Yes** **No**

If yes, does it require antibiotics before dental work? _____

Have you had any changes in your health since last visit?

Do you have a pacemaker?

Please list your current daily medications:

Vitamins not required

Do you have any dental complaints or concerns? _____

If yes, explain: _____

Have you or do you currently use tobacco products?



Acknowledgment of Receipt

Please print your name: _____

I acknowledge that I have received a copy of the HIPAA Notice of Privacy Practices for Dr. Zachary J. Powell's office

Patient Signature: _____

Date: / /