



WELCOME

We are pleased to welcome you and/or your child to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.



PATIENT INFORMATION



Date _____ Occupation _____

SS/HIC/Patient ID # SS# Patient Employer/School _____

Patient Name _____ Employer/School Address _____

Address _____

City _____ Employer/School Phone (____) _____

State _____ Zip _____ Spouse's Name _____

E-mail _____ Birthdate _____ SS# _____

Sex M F Age _____ Birthdate _____

Married Widowed Single Minor

Separated Divorced Partnered for _____ years

Spouse's Employer _____

Whom may we thank for referring you? _____



DENTAL INSURANCE



Subscriber's Name _____ Is patient covered by secondary insurance? Yes No

Relationship to Patient _____ Subscriber's Name _____

Birthdate _____ SS# _____ Relationship to Patient _____

Insurance Co. _____ Birthdate _____ SS# _____

Group # _____ Phone (____) _____ Insurance Co. _____

Group # _____ Phone (____) _____



PHONE NUMBERS



Home (____) _____ Work (____) _____ Ext _____ Cell (____) _____

Spouse's Work (____) _____ Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____ Relationship _____

Home Phone (____) _____ Work Phone (____) _____ Ext _____ Cell Phone (____) _____



DENTAL HISTORY



Reason for today's visit _____

Former Dentist _____

City/State _____

Date of last dental visit _____

Date of last dental X-rays _____

How often do you floss? _____

How often do you brush? _____

Do you wear contact lenses? Yes No

Please check (✓) "yes" or "no" to indicate if you have had any of the following:

Bad breath	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw pain or tiredness	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding gums	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lip or cheek biting	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blisters on lips or mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Loose teeth or broken fillings	<input type="checkbox"/> Yes <input type="checkbox"/> No
Burning sensation on tongue	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth breathing	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chew on one side of mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth pain	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cigarette, pipe, or cigar smoking	<input type="checkbox"/> Yes <input type="checkbox"/> No	Orthodontic treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Clicking or popping jaw	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pain around ear	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dry mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Periodontal treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fingernail biting	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to cold	<input type="checkbox"/> Yes <input type="checkbox"/> No
Food collection between the teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to heat	<input type="checkbox"/> Yes <input type="checkbox"/> No
Foreign objects in mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to sweets	<input type="checkbox"/> Yes <input type="checkbox"/> No
Grinding teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity when biting	<input type="checkbox"/> Yes <input type="checkbox"/> No
Gums swollen or tender	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sores or growths in mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No



MEDICAL HISTORY



Physician's Name _____ Date of last visit _____

Phone (_____) _____ Pharmacy _____ Phone (_____) _____

Please check (✓) "yes" or "no" to indicate if you have had any of the following:

- | | | | | | |
|-----------------------------|----------------------------------------------------------|--------------------------|----------------------------------------------------------|--------------------------------------------------|----------------------------------------------------------|
| AIDS | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tonsillitis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | HIV Positive | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis, Rheumatism | <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaundice | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tumors or Growths | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaw Pain | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcer | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Back Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Venereal Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Chemical Dependency | <input type="checkbox"/> Yes <input type="checkbox"/> No | Low Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Have you ever had or been diagnosed with: | |
| Chemotherapy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Nervous Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Artificial Heart Valves | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Circulatory Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric Care | <input type="checkbox"/> Yes <input type="checkbox"/> No | Artificial Joints, Screws, Pins, etc. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cortisone Treatments | <input type="checkbox"/> Yes <input type="checkbox"/> No | Radiation Treatment | <input type="checkbox"/> Yes <input type="checkbox"/> No | Bleeding abnormally, with extractions or surgery | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cough, persistent or bloody | <input type="checkbox"/> Yes <input type="checkbox"/> No | Respiratory Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Blood Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Scarlet Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No | Congenital Heart Lesions | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Emphysema | <input type="checkbox"/> Yes <input type="checkbox"/> No | Shortness of Breath | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Murmur | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Epilepsy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sinus Trouble | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hernia Repair | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Fainting or dizziness | <input type="checkbox"/> Yes <input type="checkbox"/> No | Skin Rash | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mitral Valve Prolapse | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Glaucoma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Special Diet/Weight Loss | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pacemaker | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Headaches | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swollen Feet or Ankles | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Hepatitis Type _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swollen Neck Glands | <input type="checkbox"/> Yes <input type="checkbox"/> No | Are you allergic to: | |
| Herpes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Aspirin | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Have you ever had any complications following dental treatment? Yes No

If yes, please describe _____

Have you ever been hospitalized or do you have any other health concerns? Yes No

If yes, please describe _____

Women: Are you pregnant? Yes No

Due date _____

Are you nursing? Yes No

Taking birth control pills? Yes No

Have you ever taken any of these medications?

- | | |
|------------------|----------------------------------------------------------|
| Blood Thinners | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Coumadin | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Warfarin | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diet Medications | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Dexfenfluramine | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Fen-phen | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Pondimin | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Redux | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Levoxyl | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Synthroid | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Please PRINT all medications now taking: _____

SIGNATURES

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

Insurance Assignment: I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Authorization to Release Protected Health Information: I understand that there may be a need to consult with other health care providers. I voluntarily authorize

Dr. _____ to use and/or disclose my Protected Health Information (PHI) related to _____

_____ Describe in detail the Protected Health Information you are authorizing to be used and/or disclosed. The information will be used and/or disclosed for the purpose of _____ Describe each purpose for which you are authorizing

_____ I authorize Dr. _____ to receive and use the information. your Protected Health Information to be used and/or disclosed. _____ Name of Doctor Receiving PHI

This authorization will end when my current treatment plan is completed or one year from the date signed below. I understand that once the information is released it may be re-disclosed by the recipient and may no longer be protected by federal privacy regulations. I understand that I may revoke this authorization at any time by notifying, in writing, the above-named doctor disclosing the PHI. However, if I do revoke this authorization, it will not have any effect on any actions taken by the above-named doctor disclosing the PHI prior to their receipt of the revocation. I understand that my treatment cannot be conditioned on whether I sign this authorization. I understand I may refuse to sign this authorization.

X _____ Signature of Patient, Parent, Guardian or Personal Representative _____ Date

Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

DOCTOR'S COMMENTS & UPDATE

(to be completed by the dentist)

Medical Clearance Letter Sent to _____ Date _____

Results _____

Signature _____ Date _____

Meda Dental PC

2801 Ogden Ave Ste 4 | LISLE IL, 60532 | (630) 416-8080

Written Financial Policy

Thank you for choosing Meda Dental PC. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

- Cash, Credit Card (Visa , Mastercard ,and Discover Card)

- Convenient Monthly Payment Plans¹ from CareCredit
 - o Allow you to pay over time
 - o No annual fees or pre-payment penalties

Please note:

Meda Dental PC requires payment prior to the completion of your treatment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.

For plans requiring multiple appointments, you may pay per visit for treatment provided.


For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.²

Please note you are responsible for any checks paid to you to by the insurance to return it to us.

A fee of \$50 is charged for patients who miss or cancel without 48-hour notice. If you are more than 15 minutes late for your it is considered as a no show and treated accordingly.

Please note that reply to text doesn't count as cancellation due to third party involvement.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.



Patient, Parent or Guardian Signature

Date

Patient Name (Please Print)

¹Subject to credit approval

²However, if we do not receive payment from your insurance carrier within 60 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.

DENTAL TREATMENT CONSENT FORM

Patient Name _____

Birthdate _____

Please read and initial the items checked below. Then read and sign the section at the bottom of form.

1. WORK TO BE DONE

I understand that I am having the following work done: Fillings _____ Bridges _____ Crowns _____ Extractions _____
Impacted teeth removed _____ General Anesthesia _____ Root Canals _____ Other _____

(Initials X)

2. DRUGS AND MEDICATIONS

I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction).

(Initials X)

3. CHANGES IN TREATMENT PLAN

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary.

(Initials X)

4. REMOVAL OF TEETH

Alternatives to removal have been explained to me (root canal therapy, crowns, and periodontal surgery, etc.) and I authorize the Dentist to remove the following teeth _____ and any others necessary for reasons in paragraph #3. I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue (Paresthesia) that can last for an indefinite period of time (days or months) or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility.

(Initials _____)

5. CROWN, BRIDGES AND CAPS

I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown, bridge, or cap (including shape, fit, size, and color) will be before cementation.

(Initials _____)

6. DENTURES, COMPLETE OR PARTIAL

I realize that full or partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The problems of wearing these appliances have been explained to me, including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new dentures (including shape, fit, size, placement, and color) will be the "teeth in wax" try-in visit. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not included in the initial denture fee.

(Initials _____)

7. ENDODONTIC TREATMENT (ROOT CANAL)

I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment, and that occasionally metal objects are cemented in the tooth or extend through the root, which does not necessarily affect the success of the treatment, I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy).

(Initials _____)

8. PERIODONTAL LOSS (TISSUE & BONE)

I understand that I have a serious condition, causing gum and bone infection or loss and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including gum surgery, replacements and/or extractions. I understand that undertaking any dental procedures may have a future adverse effect on my periodontal condition.

(Initials _____)

I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot guarantee results. I acknowledge that no guarantee or assurance has been made to me by anyone regarding the dental treatment that I have requested and authorized for my self or my minor child. I have had full opportunity to discuss and ask questions regarding the dental treatment, and all questions have been answered to my satisfaction.

X

Signature of Patient, Parent, Guardian or Personal Representative

Date

Please print name of Patient, Parent, Guardian or Personal Representative

Relationship to Patient

INDIVIDUAL PATIENT'S AUTHORIZATION

THIS FORM IS TO CONFIRM YOUR AUTHORIZATION TO USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION FOR A SPECIAL PURPOSE.

1. INDIVIDUAL PATIENT (OR PERSONAL REPRESENTATIVE) CONFIRMING THE AUTHORIZATION

I give my authorization to use or disclose my protected dental information as described in Section 2 below. I give this authorization voluntarily.

Your Name _____

Your Street Address _____

Your City _____ State _____ Zip _____

Your Telephone Number _____

Your E-Mail Address _____

Your Patient Account Number _____

2. THE USE AND/OR DISCLOSURE AUTHORIZED

Describe in detail the protected dental information you are authorizing to be used and/or disclosed.

Name the people and/or organizations (or the kinds of people and/or organizations) that you are authorizing to use and/or to disclose the protected dental information described above.

Name the people and/or organizations (or the kinds of people and/or organizations) that you are authorizing to receive and use your protected dental information.

Describe each purpose for which you are authorizing your protected health information to be used and/or disclosed.

3. ENDING THIS AUTHORIZATION

Select one of the following two choices.

- This authorization will end on the following date: _____
- This authorization will end when the following event happens. The event must relate to the individual or the purpose of the authorized use and/or disclosure. Describe the event below:

4. CHANGING YOUR MIND ABOUT THIS AUTHORIZATION

I understand that I may revoke this authorization at any time by giving written notice to the Privacy Officer at your office. However, I understand that I may not revoke this authorization for any actions taken before receipt of my written notice to revoke this authorization. In addition, I understand that if I am giving this authorization as a condition of obtaining insurance coverage, and I revoke this authorization, the insurance company has a right to contest my claims under the insurance policy.

5. SIGNING THIS AUTHORIZATION IS NOT A CONDITION OF TREATMENT

I understand that under most circumstances a dental care provider may not condition treatment, payment, enrollment, or eligibility for benefits on my signing this authorization. However, I understand that signing an authorization that permits the use and/or disclosure of my protected health information for research purposes may be a condition of my treatment if I am undergoing research-related treatment. Also, I may be required to sign an authorization if my treatment is provided solely for the purpose of creating protected health information for disclosure to a third party. And under some circumstances, a health plan may condition my enrollment in a health plan or my eligibility for benefits on my providing an authorization permitting the health plan to make enrollment and eligibility determinations.

6. POSSIBILITY OF REDISCLOSURE

I understand that information disclosed under this authorization may be redisclosed by the recipient. Federal privacy rules may not protect the privacy of my health information once the recipient rediscloses my health information.

7. INDIVIDUAL PATIENT'S SIGNATURE

I have had the chance to read and think about the content of this authorization form and I agree with all statements made in this authorization. I understand that, by signing this form, I am confirming my authorization for use and/or disclosure of the protected health information described in this form with the people and/or organizations named in this form.

Signature: _____ Date: _____

If this authorization form is signed by a personal representative for the individual patient:

Personal Representative's Name: _____
Print name

Signature

Relationship to Individual Patient: _____

YOU HAVE A RIGHT TO HAVE A COPY OF THIS FORM AFTER YOU SIGN IT.

Submit the authorization to the Privacy Official and include a copy in the individual patient's dental record.

NOTICE OF PRIVACY PRACTICES

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.

This notice takes effect on _____ and remains in effect until we replace it.

1. OUR PLEDGE REGARDING DENTAL INFORMATION

The privacy of your dental information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our dental office. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share dental information about you. We also describe your rights and certain duties we have regarding the use and disclosure of dental information. Throughout this notice we refer to your medical information as dental information.

2. OUR LEGAL DUTY

Law Requires Us to:

1. Keep your dental information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your dental information.
3. Follow the terms of the current notice.

We Have the Right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all dental information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices:

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

3. USE AND DISCLOSURE OF YOUR DENTAL INFORMATION

The following section describes different ways that we use and disclose dental information. For each kind of use or disclosure, we will explain what we mean and give an example. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose dental information. We will not use or disclose your dental information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us at the address provided at the end of this notice.

FOR TREATMENT: We may use dental information about you to provide you with dental treatment or services. We may disclose dental information about you to doctors, nurses, technicians, or other people who are taking care of you. We may also share dental information about you to your other health care providers to assist them in treating you.

FOR PAYMENT: We may use and disclose your dental information for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your dental information.

FOR DATA BREACH NOTIFICATION PURPOSES: We may use your medical information to provide legally required notices of unauthorized acquisition, access, or disclosure of your health information due to a breach.

FOR HEALTH CARE OPERATIONS: We may use and disclose your dental information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

ADDITIONAL USES AND DISCLOSURES: In addition to using and disclosing your dental information for treatment, payment, and health care operations, we may use and disclose dental information for the following purposes.

Notification: We may use and disclose dental information to notify or help notify: a family member, your personal representative or another person responsible for your care. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, dental supplies, x-ray or other dental information for you.

Research in Limited Circumstances: We may use medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of dental information.

Funeral Director, Coroner, Medical Examiner: To help them carry out their duties, we may share the dental information of a person who has died with a coroner, medical examiner, funeral director, or an organ procurement organization.

Specialized Government Functions: Subject to certain requirements, we may disclose or use dental information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

Court Orders and Judicial and Administrative Proceedings: We may disclose dental information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may share your dental information with law enforcement officials. We may share limited information with a law enforcement official concerning the dental information of a suspect, fugitive, material witness, crime victim or missing person. We may share the dental information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

Public Health Activities: As required by law, we may disclose your dental information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your dental information to persons subject to jurisdiction of the Food and Drug Administration for purposes of reporting adverse events associated with product defects or problems, to enable product recalls, repairs or replacements, to track products, or to conduct activities required by the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

Victims of Abuse, Neglect, or Domestic Violence: We may use and disclose dental information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may share your dental information if it is necessary to prevent a serious threat to your health or safety or the health or safety of others. We may share dental information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.

Workers Compensation: We may disclose dental information when authorized or necessary to comply with laws relating to workers compensation or other similar programs.

Health Oversight Activities: We may disclose dental information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations or proceedings, inspections, licensure or disciplinary actions, or other authorized activities.

Law Enforcement: Under certain circumstances, we may disclose dental information to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding suspected victims of crimes at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.

Appointment Reminders: We may use and disclose dental information for purposes of sending you appointment postcards or otherwise reminding you of your appointments.

Alternative and Additional Dental Services: We may use and disclose dental information to furnish you with information about health-related benefits and services that may be of interest to you, and to describe or recommend treatment alternatives.

4. YOUR INDIVIDUAL RIGHTS

You Have a Right to:

1. Look at or get copies of certain parts of your dental information. You may request that we provide copies in a format other than photocopies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. You may get the form to request access by using the contact information listed at the end of this notice. You may also request access by sending a letter to the contact person listed at the end of this notice. If you request copies, we will charge you \$_____ for each page, and postage if you want the copies mailed to you. Additionally, if we maintain an electronic health record containing your health information, you have the right to request that we send a copy of your health information in an electronic format to you or to a third party that you identify. We may charge a reasonable fee for sending the electronic copy of your health information. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.
2. Receive a list of all the times we or our business associates shared your dental information for purposes other than treatment, payment, and health care operations and other specified exceptions.
3. Request that we place additional restrictions on our use or disclosure of your dental information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).
4. Request that we communicate with you about your dental information by different means or to different locations. Your request that we communicate your dental information to you by different means or at different locations must be made in writing to the contact person listed at the end of this notice.
5. Request that we change certain parts of your dental information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.
6. If you have received this notice electronically, and wish to receive a paper copy, you have the right to obtain a paper copy by making a request in writing to the contact person listed at the end of this notice.
7. You have the right to restrict information given to your third party payer (e.g., health insurance plan) if you fully paid for your health care services out of your own pocket. If you paid in full for services out of your own pocket, you can request that the information regarding the services not be disclosed to your third party payer since no claim is being made against the third party payer.
8. You have the right to be notified in the event that we (or one of our Business Associates) discover a breach of your unsecured protected health information. Notice of any such breach will be made in accordance with federal requirements.

QUESTIONS AND COMPLAINTS

If you have any questions about this notice or if you think that we may have violated your privacy rights, please contact us. You may contact us to submit a complaint or submit requests involving any of your rights in Section 4 of this notice by writing to the following address:

You may also 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. We will not retaliate in any way if you choose to file a complaint.

PRIVACY PRACTICES ACKNOWLEDGEMENT

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name _____ Birthdate _____

Signature  _____

Date _____