Dirk P. DeKoch, DDS John M. DeKoch, DDS Susie R. DeKoch, DDS Fraser H. Graham, DDS

PATIENT INFORMATION:

NAME ______________________________ DATE OF BIRTH ____________ AGE ______ SEX: M___ F___ SS # ________________

ADDRESS ______________________________ CITY ______________________ STATE ________ ZIP__________

EMAIL ______________________________ HOME # ________________ CELL # ________________

CHECK APPROPRIATE BOX: MINOR____ S____ M____ W____ D____ WHOM MAY WE THANK FOR REFERRING YOU? ________________

GUARDIAN'S NAME (IF MINOR) ______________________________ PATIENT/GUARDIAN'S OCCUPATION ________________

PATIENT/GUARDIAN'S EMPLOYER ______________________________ WORK # ________________

EMERGENCY CONTACT ______________________ RELATIONSHIP ____________ PHONE # ________________

PERSON RESPONSIBLE FOR THIS ACCOUNT ______________________________ RELATIONSHIP ________________

INSURANCE INFORMATION:

NAME OF INSURED ______________________________ RELATIONSHIP TO PATIENT ________________

DATE OF BIRTH ________________ SS #/MEMBER ID #____________________

NAME OF EMPLOYER ______________________________ WORK #________________

INSURANCE COMPANY ______________________________ GROUP # ________________

INSURANCE ADDRESS ______________________ CITY ______________________ STATE ________ ZIP__________

I HEREBY AUTHORIZE PAYMENT OF THE DENTAL BENEFITS DIRECTLY TO ALAMO HEIGHTS DENTAL (INITIAL PLEASE): Y__________ N__________

PATIENT MEDICAL HISTORY:

PHYSICIAN ____ OFFICE # ____________________________ DATE OF LAST EXAM _____________________

CURRENT MEDICATIONS ____

PHARMACY NAME & PHONE NUMBER ____

KNOWN ALLERGIES: NONE _______ PENICILLIN _______ ASPIRIN _______ LOCAL ANESTHETICS _______ DENTISTS! _______ LATEX _______

OTHER __________________________

DO YOU HAVE OR HAVE YOU EVER HAD:

HEART PROBLEMS	Y____ N____	DIABETES	Y____ N____	KIDNEY PROBLEMS	Y____ N____
HEART MURMUR	Y____ N____	CANCER	Y____ N____	HEADACHES	Y____ N____
CARDIAC PACEMAKER	Y____ N____	CHEMO/RADIATION	Y____ N____	FAINTING SPELLS	Y____ N____
BACTERIAL ENDOCARDITIS	Y____ N____	RESPIRATORY PROBLEMS	Y____ N____	SEIZURES	Y____ N____
HIGH BLOOD PRESSURE	Y____ N____	ASTHMA	Y____ N____	TMJ/JOINT PROBLEMS	Y____ N____
BLEEDING PROBLEMS	Y____ N____	HEPATITIS	Y____ N____	ULCERS	Y____ N____
STROKE	Y____ N____	HIV/AIDS	Y____ N____	THYROID DISEASE	Y____ N____
RHEUMATIC FEVER	Y____ N____	HERPES	Y____ N____	OTHER: ___________________________________	

ARE YOU USING OR HAVE YOU EVER USED:

ALCOHOL Y____ N____ If so, please specify amount and # of years: ____

TOBACCO PRODUCTS Y____ N____ If so, please specify type, amount, and # of years: ____

ILLICIT DRUGS Y____ N____ If so, please specify type, amount, and # of years: ____

HAVE YOU TAKEN STEROIDS IN THE PAST 6 MONTHS? Y___ N___

PLEASE LIST PRIOR SURGERIES ALONG WITH DATES:

____

HAVE YOU EXPERIENCED ANY COMPLICATIONS WITH DENTAL TREATMENT? IF SO, PLEASE ELABORATE:

____

IS THERE ANYTHING ABOUT YOUR SMILE THAT CONCERNS YOU? IF SO, PLEASE ELABORATE:

____

ARE YOU PREGNANT? Y____ N____ MAYBE____ NURSING Y____ N____

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION. THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION COULD BE DETRIMENTAL TO MY HEALTH.

SIGNATURE ____ PRINTED NAME___________________________________ DATE ______________________

NOTICE OF PRIVACY PRACTICES

<u>THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU MAY GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY!</u>

I. *Our Legal Responsibilities*

This Privacy Notice is being provided to you as a requirement of a federal law known as the Health Insurance Portability and Accountability Act ("HIPAA"). The Privacy Notice describes how we may use and disclose your protected health information to carry out treatment, payment, or healthcare operations and for other purposes that are permitted or required by law. It also describes your rights to access and control protected health information in some cases. Your "protected health information" means any written and oral health information about you, including demographic data that can be used to identify you.

We are required to follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect on April 14, 2003 and will remain in effect until we replace it.

As permitted by law, we reserve the right to change our privacy practices and the terms of this Notice at any time. We reserve the right to make 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 to you at your next visit to our Practice. You may request a copy of our Notice at any time.

II. *Examples of Uses and Disclosures of Protected Health Information*

Our Practice may use your protected health information for purposes of providing treatment, obtaining payment for treatment, and conducting health care operations.

A. <u>Treatment</u>: We may use or disclose your health information to a physician or other healthcare practitioner providing treatment to you. For example, a doctor to whom we refer you to for ongoing or further care may need your medical record. We also may disclose medical information about you to people who may be involved in your medical care, which may include your family member or other personal representatives.

B. <u>Payment</u>: We may use and disclose your health information to obtain payment for services we provide to you. For example, we may need to give your healthcare information regarding the treatment you received from us to obtain payment or reimbursement for the care.

C. <u>Healthcare Operations</u>: We may use and disclose your health information in connection with healthcare operations. Healthcare operations include such activities as: quality assessment and improvement activities, training programs, medical reviews, and employee review activities, licensing, and credentialing programs.

D. <u>Uses of Information</u>: We may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting area when your dentist is ready to see you or to contact you to remind you of your appointment.

E. <u>Your Authorization</u>: In addition to our use of your health information for treatment, payment, or healthcare operations, 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 use 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.

F. <u>To Your Family and Friends</u>: We must disclose your health information to you, as described in the Patient Rights Section Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

G. <u>Persons Involved in Care</u>: 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, your general condition, or your death. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment, disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also 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.

H. <u>Marketing Health-Related Services</u>: We will not use your health information for marketing communications without your written authorization.

I. <u>Required by Law</u>: We may use or disclose your health information when we are required to do so by law.

J. <u>Abuse and Neglect</u>: We may disclose your health information to public authorities as allowed by law to report abuse or neglect. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

K. <u>National Security</u>: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances.

<u>CONTINUE AND SIGN ON PAGE 2</u>

III. Your Health Information Rights

You have the following rights regarding medical information we maintain about you:

A. Right to Inspect and Copy: You have the right to inspect and copy your protected health information, with limited exceptions. (The request to review your records must be made in writing to the Privacy Officer. You may obtain a form to request access by using the contact information at the bottom of this Notice.) We may deny your request under certain circumstances. If you request a copy of your information, we may charge you a fee for the costs incurred by us in complying with your request. If you prefer, we may prepare a summary or an explanation of your health information for a fee.

B. Right to an Accounting Disclosure: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, healthcare operations, and certain other activities for the last 7 years, but not before April 14, 2003. 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.

C. Right to Request Restrictions: You have the right to request that we place additional restrictions on our use and disclosures of your protected health information. We are not required to agree with these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

D. Right to Request Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or alternative location. You must make your request in writing. Your request must specify the alternative means or location and provide satisfactory explanation how payments will be handled under the alternative means or locations you request.

E. Right to Request an Amendment: You have a right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances. If we deny your request for amendment, you have the right to file a statement of disagreement, and we may prepare a rebuttal to your statement and will provide you with a copy of such rebuttal.

F. Right to a Paper Copy of this Notice: You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to this notice electronically, you are still entitled to a paper copy of this notice.

IV. Questions and Complaints

If you have any questions, would like additional information, or want to report a problem regarding the handling of your information, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us by addressing a written complaint to Alamo Height Dental. You may also submit a written complaint to the Secretary of the United States Department of Health and Human Services. We will provide you with the address to file your complaint with the United States Department of Health and Human Services upon request.

We support the right to the privacy of your protected health information. We will not retaliate in any way if you choose to file a complaint with us or with the United States Department of Health and Human Services.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received the Notice of Privacy Practices.

____ ____

Printed Name of Patient/Legal Representative Date

____ ____

Signature of Patient/Legal Representative Relationship

CONSENT TO DISCLOSE PROTECTED INFORMATION

Patient: ___________________________________ Date of Birth:__________ Phone: ______________

Address: ____

I, ______________________________, give my consent for Alamo Heights Dental to disclose and release my health, dental, and/or financial information as needed for completion of my dental treatment to:

____

Printed Name   Relationship

____

Address   Phone Number

____

Printed Name   Relationship

____

Address   Phone Number

Health/Dental Information to be Disclosed (Please check one or both):

_____ Scheduling Information (Including treatment, appointment times, and possible follow-up appointments)

_____ Complete Health and Dental Record (Including, but not limited to, medical history, diagnoses, prognosis, treatment, and billing)

This authorization is effective until (Please check one): ____ All past, present, and future periods, OR

____ Date or Event: ________________________

(Note: You may revoke this authorization at any time by notifying Alamo Heights Dental in writing.)

______________________________________   ______________________________________

Signature of Patient or Individual Granting Authorization   Printed Name

______________________________________   ______________________________________

Relationship to Patient   Date