



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.

(Initial) I ACKNOWLEDGE THAT I HAVE REVIEWED AND UNDERSTAND THE NOTICE OF PRIVACY PRACTICES FOR ALAMO HEIGHTS DENTAL.

SIGNATURE _____ **PRINTED NAME** _____ **DATE** _____

NOTICE OF PRIVACY PRACTICES

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!

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. Treatment: 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. Payment: 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. Healthcare Operations: 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. Uses of Information: 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. Your Authorization: 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. To Your Family and Friends: 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. Persons Involved in Care: 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. Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.
- I. Required by Law: We may use or disclose your health information when we are required to do so by law.
- J. Abuse and Neglect: 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. National Security: 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.

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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 Heights 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: _____

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 _____

Printed Name _____ Relationship _____

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 indefinitely unless you notify Alamo Heights Dental in writing.

OR

I **DO NOT give** my consent for Alamo Heights Dental to disclose and release my health, dental, and/or financial information to anybody as needed for completion of my dental treatment.

Signature of Patient or Individual Granting Authorization

Printed Name

Relationship to Patient

Date