Welcome

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us – we will be happy to help.

How Did You Hear About Us?

□ **Phone Book**	□ **Street Sign**	□ **Statesman Journal**
□ **Insurance:**	□ **Postcard**	□ **Valpak**
□ **Internet Site:**	□ **Is there someone we can thank for referring you?**	□ **Other:**

Responsible Party Who is responsible for the account?	
Name:	
Relationship to patient:	
Birthdate:	
Driver's License#:	
SS# or Subscriber Identification # (SIN):	
Address:	
City:	
State:	
Zip:	
Employer:	
Occupation:	**Best way to verify appt.:**
Work Phone:	□ Work
Home Phone:	□ Home
Cell Phone:	□ Cell
E-mail:	□ E-mail

Financial Arrangements	**Late Charges**
For your convenience, we offer the following methods of payment. Please check the option which you prefer:	If I do not pay the entire new balance within 25 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid and owed will be assessed each month (if allowed by law). I realize that failure to keep this account current may result in you being unable to provide additional dental services except for dental emergencies or where there is prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances. **Signature**_____ **Date**_____
□ **Cash**	
□ **Debit Card**	
□ **Credit Card**	
□ **Care Credit**	
*Personal checks are not accepted. Payment is expected at the time of service.	

Turn Page Over →

Primary Dental Insurance Information	Secondary Dental Insurance Information
Name of Insured:	Name of Insured:
Relationship to Patient:	Relationship to Patient:
Insured's Birthdate:	Insured's Birthdate:
SS#/SIN:	SS#/SIN:
Employer:	Employer:
Insurance Company:	Insurance Company:
Group #:	Group #:
Employee/Cert.#:	Employee/Cert.#:
Ins. Co. Address:	Ins. Co. Address:
Ins. Co. Phone:	Ins. Co. Phone:

Dental Insurance Agreement

We are happy to help you file your insurance claims to receive the dental benefits which your employer and you are paying premiums. Dental benefit plans can vary from company to company with different procedures covered or not covered. Insurance companies base the amounts that they will pay toward your dental treatment on restricted fee schedules related to premium payments and geographical location. Meaning your insurance plan will pay only what it allows for each service, regardless of what the actual fee is. Deductibles and co-payments are typically built in to most plans and their required payment is strictly regulated by state law. Your Employee Benefits Director can usually help you become familiar with your plan and any restrictions that may apply. Our office is happy to assist you in maximizing your benefits.

We agree to:
Complete your insurance claim forms and submit them to your carrier for you after treatment in our office.
Use current American Dental Association coding for correct reporting of procedures.
Accept direct payment from your carrier and keep track of balances.
If necessary, re-file your insurance a second time.
Your responsibilities as a patient:
To pay fees not covered by your plan at the time of treatment.
To provide our office with necessary information concerning your insurance coverage to allow correct filing of claims.
To understand that your plan is a contract between you and your employer and the insurance carrier. Our office will do all we can to facilitate claims payment, but we do not have the power to make your plan pay.
To pay any account balance not paid by insurance.

We thank you for choosing our office and will do all we can to help you maximize your benefits for the year. The information you have provided will help us serve your dental healthcare needs more effectively and efficiently. If you have any questions at anytime, please ask – we are always happy to help. We will keep one copy in your chart and will give you a copy for your records upon request.

I hereby authorize payment directly to the dental providers from my dental insurance company. I understand that I am ultimately responsible for all costs of dental treatment. I grant the right to this office to provide information to my insurance company regarding my dental treatment. I also authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to other health practitioners.

_____ _____

Patient or Insured Date

Health History Form

ADA American Dental Association®
America's leading advocate for oral health

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: *Mailing address*
City: State: Zip:

Occupation: Height: Weight: Date of Birth: Sex: M F

SS# or Patient ID: Emergency Contact: Relationship: Home Phone: *Include area code* ( ) Cell Phone: *Include area code* ( )

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 the question)*

	Yes	No	DK
Active Tuberculosis	☐	☐	☐
Persistent cough greater than a 3 week duration	☐	☐	☐
Cough that produces blood	☐	☐	☐
Been exposed to anyone with tuberculosis	☐	☐	☐

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

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

	Yes	No	DK
Do your gums bleed when you brush or floss?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Is your mouth dry?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Have you had any problems associated with previous dental treatment?	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐
Do you drink bottled or filtered water?	☐	☐	☐
If yes, how often? *Circle one:* DAILY / WEEKLY / OCCASIONALLY			
Are you currently experiencing dental pain or discomfort?	☐	☐	☐

	Yes	No	DK
Do you have earaches or neck pains?	☐	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐
Do you brux or grind your teeth?	☐	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐	☐
Do you wear dentures or partials?	☐	☐	☐
Do you participate in active recreational activities?	☐	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐	☐

Date of your last dental exam:
What was done at that time?

Date of last dental x-rays:

What is the reason for your dental visit today?

How do you feel about your smile?

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

	Yes	No	DK
Are you now under the care of a physician?	☐	☐	☐

Physician Name: Phone: *Include area code* ( )

Address/City/State/Zip:

Are you in good health?	☐	☐	☐
Has there been any change in your general health within the past year?	☐	☐	☐

If yes, what condition is being treated?

Date of last physical exam:

	Yes	No	DK
Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐	☐

If yes, what was the illness or problem?

Are you taking or have you recently taken any prescription or over the counter medicine(s)?	☐	☐	☐

If so, please list all, including vitamins, natural or herbal preparations and/or dietary supplements:

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

(Check DK if you Don't Know the answer to the question) **Yes No DK**

Do you wear contact lenses? ☐ ☐ ☐

Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? ☐ ☐ ☐

Date: _____ If yes, have you had any complications? _____

Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax®, Actonel®, Atelvia, Boniva®, Reclast, Prolia) for osteoporosis or Paget's disease? ☐ ☐ ☐

Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia®, Zometa®, XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? ☐ ☐ ☐

Date Treatment began: _____

Yes No DK

Do you use controlled substances (drugs)? ☐ ☐ ☐

Do you use tobacco (smoking, snuff, chew, bidis)? ☐ ☐ ☐
If so, how interested are you in stopping?
Circle one: VERY / SOMEWHAT / NOT INTERESTED

Do you drink alcoholic beverages? ☐ ☐ ☐

If yes, how much alcohol did you drink in the last 24 hours? _____

If yes, how much do you typically drink i n a week? _____

WOMEN ONLY Are you:

Pregnant? ☐ ☐ ☐
Number of weeks: _____
Taking birth control pills or hormonal replacement? ☐ ☐ ☐
Nursing? ☐ ☐ ☐

Allergies. Are you allergic to or have you had a reaction to:
To all **yes** responses, specify type of reaction.

Yes No DK

Local anesthetics _____ ☐ ☐ ☐
Aspirin _____ ☐ ☐ ☐
Penicillin or other antibiotics _____ ☐ ☐ ☐
Barbiturates, sedatives, or sleeping pills _____ ☐ ☐ ☐
Sulfa drugs _____ ☐ ☐ ☐
Codeine or other narcotics _____ ☐ ☐ ☐

Yes No DK

Metals _____ ☐ ☐ ☐
Latex (rubber) _____ ☐ ☐ ☐
Iodine _____ ☐ ☐ ☐
Hay fever/seasonal _____ ☐ ☐ ☐
Animals _____ ☐ ☐ ☐
Food _____ ☐ ☐ ☐
Other _____ ☐ ☐ ☐

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

Yes No DK

Artificial (prosthetic) heart valve ☐ ☐ ☐
Previous infective endocarditis ☐ ☐ ☐
Damaged valves in transplanted heart ☐ ☐ ☐
Congenital heart disease (CHD)
- Unrepaired, cyanotic CHD ☐ ☐ ☐
- Repaired (completely) in last 6 months ☐ ☐ ☐
- Repaired CHD with residual defects ☐ ☐ ☐

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

Yes No DK

Cardiovascular disease ☐ ☐ ☐
Angina ☐ ☐ ☐
Arteriosclerosis ☐ ☐ ☐
Congestive heart failure ☐ ☐ ☐
Damaged heart valves ☐ ☐ ☐
Heart attack ☐ ☐ ☐
Heart murmur ☐ ☐ ☐
Low blood pressure ☐ ☐ ☐
High blood pressure ☐ ☐ ☐
Other congenital heart defects ☐ ☐ ☐

Yes No DK

Mitral valve prolapse ☐ ☐ ☐
Pacemaker ☐ ☐ ☐
Rheumatic fever ☐ ☐ ☐
Rheumatic heart disease ☐ ☐ ☐
Abnormal bleeding ☐ ☐ ☐
Anemia ☐ ☐ ☐
Blood transfusion ☐ ☐ ☐
If yes, date: _____
Hemophilia ☐ ☐ ☐
AIDS or HIV infection ☐ ☐ ☐
Arthritis ☐ ☐ ☐

Yes No DK

Autoimmune disease ☐ ☐ ☐
Rheumatoid arthritis ☐ ☐ ☐
Systemic lupus erythematosus ☐ ☐ ☐
Asthma ☐ ☐ ☐
Bronchitis ☐ ☐ ☐
Emphysema ☐ ☐ ☐
Sinus trouble ☐ ☐ ☐
Tuberculosis ☐ ☐ ☐
Cancer/Chemotherapy/ Radiation Treatment ☐ ☐ ☐
Chest pain upon exertion ☐ ☐ ☐
Chronic pain ☐ ☐ ☐
Diabetes Type I or II ☐ ☐ ☐
Eating disorder ☐ ☐ ☐
Malnutrition ☐ ☐ ☐
Gastrointestinal disease ☐ ☐ ☐
G.E. Reflux/persistent heartburn ☐ ☐ ☐
Ulcers ☐ ☐ ☐
Thyroid problems ☐ ☐ ☐
Stroke ☐ ☐ ☐

Yes No DK

Glaucoma ☐ ☐ ☐
Hepatitis, jaundice or liver disease ☐ ☐ ☐
Epilepsy ☐ ☐ ☐
Fainting spells or seizures ☐ ☐ ☐
Neurological disorders ☐ ☐ ☐
If yes, specify: _____
Sleep disorder ☐ ☐ ☐
Do you snore? ☐ ☐ ☐
Mental health disorders ☐ ☐ ☐
Specify: _____
Recurrent Infections ☐ ☐ ☐
Type of infection: _____
Kidney problems ☐ ☐ ☐
Night sweats ☐ ☐ ☐
Osteoporosis ☐ ☐ ☐
Persistent swollen glands in neck ☐ ☐ ☐
Severe headaches/ migraines ☐ ☐ ☐
Severe or rapid weight loss ☐ ☐ ☐
Sexually transmitted disease ☐ ☐ ☐
Excessive urination ☐ ☐ ☐

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ☐ ☐ ☐

Name of physician or dentist making recommendation:

Phone: *Include area code*
( )

Do you have any disease, condition, or problem not listed above that you think I should know about? ☐ ☐ ☐
Please explain:

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:

Signature of Dentist: Date:

FOR COMPLETION BY DENTIST

Comments:

COCHELL FAMILY DENTISTRY

PRIVACY NOTICE

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.

Our organization is committed to providing you with medical care that meets your needs. An important aspect of our service commitment to you is the protection and security of the protected health information that we obtain about you. We have always safeguarded your health information and our written privacy policy gives us an opportunity to share with you our policies that protect your health information.

We are required by law to provide you with this notice. It will describe to you what protected health information we collect about you and how that information might be used.

The Type Of Protected Health Information That We May Obtain About You:

Demographic Information: including your name, address, date of birth, phone number(s), name of your employer, your spouse or other family members, and emergency contact.

Insurance Information: including your insurance carrier, the name of the insured person, insurance identification numbers, and benefits and eligibility information.

Health Information: including your health history, past illnesses or injuries, family medical history, your social activities including use of tobacco, alcohol, or drugs, family life and living situation, your current and/or ongoing health problems, including medications, allergies, advised treatment and outcomes of that treatment.

Payment Information: including your insurance carrier, your record of charges, adjustments, and payments to our organization.

How We May Use and Disclose Protected Health Information About You:

Section 1:
We are not obligated to have your consent when using or disclosing protected health information for the following purposes:

A. **For Treatment:** We may use and disclose your health information to provide, coordinate or manage your health care and any related services. We may disclose information about you to doctors, dentists, nurses, technicians, office staff or other personnel who are involved in taking care of you and your health.

For example:
- ◊ *If we schedule a test, therapy or surgery for you, we must provide information about you in order to complete the scheduling. This includes your name, demographic and insurance information and the reason for the test.*
- ◊ *Your doctor may share your medical information with another doctor who is also involved in your care so that both may have all the information to make the best treatment decisions for you.*
- ◊ *We may share information with a pharmacy so that they can fill or refill a prescription for you.*
- ◊ *We may share information about you with another provider who is on call in the absence of your provider.*

B. **For Payment:** We may use and disclose your information to obtain payment for services you receive. If you pay in full for service out of pocket you have the right to restrict your information being given to any health plan.

For example:
- ◊ *We may use or disclose your information to determine eligibility for insurance or benefits.*
- ◊ *We may use the name of your insurance carrier and your identification numbers in order to file a claim for you.*
- ◊ *We may disclose your information about your conditions or reasons for seeking care and the care that is provided to your insurance carrier so that they may process and pay your claim.*
- ◊ *We may disclose information about your conditions to your insurance carrier to seek approval as necessary for recommended tests and treatment.*
- ◊ *We may provide information about your services to a health care clearinghouse so that they may distribute a claim to your insurance carrier on our behalf.*

◊ *If we refer you to another facility or provider we may provide them with your insurance information to expedite your registration and assure that they are participants in your insurance plan.*

C. **For Health Care Operations:** We may use or disclose protected health information about you in order to evaluate our care for you or to meet a business need of the organization. These activities include quality assessment activities, employee review activities, training students, compliance audits by your insurance carrier, and conducting or arranging for other business activities.

For example:
◊ *We may use information about you to evaluate the performance of our staff in caring for you.*
◊ *We may use your information to evaluate our efficiency.*
◊ *We may use your information to evaluate and respond to a patient complaint.*
◊ *We may share your health information with students or residents who are learning to care for patients.*

We may also use or disclose protected health information to our Business Associates in the performance of health care operations. A Business Associate is an entity or person engaged by this organization to perform a business activity on behalf of the organization. Our Business Associates are obligated by contract to protect health information they receive or generate about you.

For example:
◊ *We may provide information to our transcription service so that they can produce a written copy of your encounter in our office.*
◊ *We may provide information to our accountant in order to prepare our organization's financial reports.*
◊ *We may share information with qualified consultants in order for them to provide business management advice.*

D. **Other Contact Situations:**
◊ We may use your information to call and remind you of an appointment in our office.
◊ We may tell you about or recommend possible treatment options or alternatives that may be of interest to you.
◊ We may tell you about health-related products or services that may be of interest to you.
◊ We may use your information for marketing, and fund raising you do have the right to opt out of the marketing and fund raising information.

E. **Special Situations:**
Emergencies: We may use or disclose protected health information in the case of a medical emergency.

Required by Law: We may use or disclose your protected health information if the disclosure is required by law.

Public Health: We may disclose protected health information about you for public health activities. These activities generally include the following:
◊ To prevent or control disease, injury or disability
◊ To report births or deaths
◊ To report child abuse or neglect
◊ To report reactions to medications or problems with products
◊ To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition
◊ To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight: We may disclose protected health information to health oversight agencies that oversee our activities. These activities may include audits, investigations and inspections and are necessary for the government to monitor the health care system, government programs and compliance with civil rights laws.

Lawsuits or Disputes: If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. Subject to legal requirements, we may also disclose medical information about you in response to a subpoena.

Law Enforcement: We may disclose protected health information, so long as all applicable legal requirements are met, for law enforcement purposes.

Coroners, Medical Directors and Funeral Directors: We may disclose protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release information about patients to funeral directors as necessary to carry out their duties.

Workers Compensation: We may disclose medical information about you for programs that provide benefits for work-related injuries or illness.

Military Activities, National Security and Intelligence Activities: If you are a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to disclose protected health information about you. We may also disclose information about foreign military personnel to the appropriate foreign military authority.

Organ and Tissue Donation: If you are an organ or tissue donor, we may disclose protected health information to organizations that handle organ or tissue procurement when necessary to facilitate organ or tissue donation or transplantation.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. The release would be necessary 1) for the institution to provide you with health care; 2) to protect your health and safety or the health and safety of others; or 3) for the safety and security of the correctional institution.

Serious Threats: As permitted by applicable law and standards of ethical conduct, we may use or disclose protected health information if we, in good faith, believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

Information that is not personally identifiable: We may use or disclose information about you in a way that does not personally identify you.

Section 2:
Protected Health Information Use and Disclosure That Requires an Opportunity for You to Agree or Object

Family and Friends: We may disclose your protected health information to your family or friends or any other individual identified by you when they are involved in your care or the payment of your care. We will only disclose the protected health information directly relevant to their involvement in your care or payment. If you are available, we will give you an opportunity to object to these disclosures, and we will not make these disclosures if you object.

If you are not available, we will determine whether a disclosure to your family or friends is in your best interest, and we will disclose only the protected health information that is directly relevant to their involvement in your care.

Section 3:
Protected Health Information That Cannot Be Disclosed Without Your Specific Authorization:

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below.

You may revoke this authorization by notifying us in writing at any time.

Your Rights as a Patient:

◊ **You have the right to inspect and copy your protected health information.**
You may inspect and obtain a copy of your protected health information maintained in our office. We may charge you for the cost of copying, mailing or associated supplies.

Under federal law, however, you may not inspect or copy psychotherapy notes or information compiled in reasonable anticipation of a civil, criminal or administrative action or proceeding. Certain documents pertaining to laboratory services are also exempt under federal law.

You have the right to an electronic copy of your records however this office does not have electronic records. However we will copy your paper chart if requested in writing.

You have the right to request your records be sent via e-mail with the understanding that we will try and verify your email before sending. E-mail is not always secure and you are acknowledging this fact. This request must be done in writing.

Under certain circumstances, we may not grant your request. If we deny your request, then you may appeal our decision.

We require that requests to access your protected health information be made in writing. You can arrange to do this through our Privacy Officer.

◊ **You have the right to request a restriction of your protected health information.**
You may ask us not to disclose your protected health information for treatment, payment or health care operations. You may also request that any part of your protected health information not be disclosed to friends and/or family members involved in your care.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency care.

In order to request a restriction, you must do so in writing. The request must specifically state what information is restricted and to whom the restriction applies.

You may request a restriction form from our Privacy Officer.

◊ **You have the right to request to receive confidential communications from us by alternative means or at an alternative location.**
You may request that we communicate with you in a certain way or at a specific location. We will attempt to accommodate all reasonable requests.

Please contact our Privacy Officer to make this request in writing. Your request must specify where or how the communication is to be directed.

◊ **You have the right to request that we amend your protected health information.**
If you believe that protected health information we have about you is incorrect or incomplete, you may request an amendment to this information.

We may not grant your request if we determine that the protected health information that is the subject of your request:
- ◊ was not created by our organization
- ◊ is not a part of your medical or billing records
- ◊ is information that you are not permitted to inspect or copy
- ◊ is already a complete and accurate record

Amendment requests must be made in writing and must include a reason for requesting the amendment. If you wish to amend your record, you may contact our Privacy Officer for a form.

◊ **You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.**
You have the right to receive an accounting of disclosures of protected health information made by us to individuals or entities other than you, except for disclosures:
- ◊ to carry out treatment, payment and health care operations as described above
- ◊ to persons involved in your care or for other notification purposes as provided by law
- ◊ for national security or intelligence purposes as provided by law
- ◊ to correctional institutions or law enforcement officials as provided by law
- ◊ that occurred prior to April 14, 2003

You are allowed one free disclosure per each twelve-month period. If you wish additional disclosures within that twelve-month period, we may charge you the cost of providing the disclosure list.

Your request for a disclosure accounting must be made in writing. Please contact our Privacy Officer to obtain a form.

◊ **You have the right to file a complaint.**
If you believe that your privacy rights have been violated, you have a right to file a complaint in the form of a written letter with our office and with the Secretary of Health and Human Services without fear of retaliation.

A letter of complaint filed with this office should be sent to our Privacy Officer at the address listed below.

◊ **You have the right to request and receive a paper copy of this notice from our office.**

Revisions to Our Privacy Notice:

We are required to abide by the terms of this Privacy Notice. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at that time. This notice is in effect as of September 23, 2013 Upon your request, we will provide you with a revised Privacy Notice. You may obtain this by calling our office and requesting that a revised copy be sent to you in the mail, or by asking for one at the time of your next appointment.

Questions/Contact:

If you have questions about this document, or have questions about privacy or patient rights, please contact our Privacy Officer.

Privacy Officer Name: Office Manager

Address: 2225 Mission St Suite 100 Salem, Or 97302

Phone Number: 503-585-8688

Cochell Family Dentistry

PRIVACY NOTICE ACKNOWLEDGEMENT

To Our Patients:

Federal law requires that we provide you with a copy of our Privacy Notice.

The Privacy Notice explains how we may use and disclose health information about you. We ask that you sign this form for our records so that we may document your receipt of the Notice.

If you have questions about the Privacy Notice, please feel free to direct these to our Privacy Officer at any time. The name and contact number of the Privacy Officer is listed on your copy of the Privacy Notice.

Patient Name:_____ Date of Birth:_____

Patient to complete this section

I have received a copy of the Privacy Notice for this organization on today's date.

Signed:_____ Date: _____

If patient is unable to acknowledge receipt, staff member providing notice to complete this section

The Privacy Notice was provided to

Patient Name:_____ On _____

The patient was unable to acknowledge receipt of the Privacy Notice for the following reason:

_____
_____
_____

Signed:_____

File this form in the patient's chart

Authorization to Release & Discuss Dental Information

The HIPPA privacy law requires that we are only authorized to communicate with patients themselves, guardians, insurance providers, physicians and specialists, unless we have authorization in writing by the patient to communicate with others on their behalf. Please provide all family members or friends you want us to be able to speak with. **Spouses are not automatically included; their names must be explicitly stated below.** You may opt out by checking the "Do not Release Information" box below.

Name of authorized person: _____ Relationship: _____

____Appointments ____Financial ____Dental Treatment ____Insurance ____Other

Name of authorized person: _____ Relationship: _____

____Appointments ____Financial ____Dental Treatment ____Insurance ____Other

Name of authorized person: _____ Relationship: _____

____Appointments ____Financial ____Dental Treatment ____Insurance ____Other

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___DO NOT release information to anyone.

With my signature below, I acknowledge and understand that this information will be kept in my dental record and the above listed will remain in effect until revoked by me in writing. **It is my responsibility to notify my dental office should I wish to change one or more contacts listed above.**

Patient's Name: _____ Date of Birth: _____

_____ Date: _____

Signature of patient or patient's authorized representative

Thank You!