Your full name, Mr., Mrs., Miss, Ms., Dr. _____ Age _____ D.O.B. _____

Bt what name would you prefer to be called in our office? _____ Social Security number _____

Residence Address _____ City _____ Zip _____

Mailing Address _____ City _____ Zip _____

Residence Phone _____ Business Phone _____

Employer Name and Address _____ Occupation _____

Dental Insurance coverage, if any _____ Policy # _____

Medical Insurance coverage _____ Policy # _____

If covered by spouse's / parent's insurance, list their name and employer's name and address _____

_____

Name of nearest relative not residing with you _____ Phone # _____

Is your problem accident related? _____ Referred by _____

General Dentist _____ Physician _____

INSTRUCTIONS: Please answer all the questions as accurately, as honestly, and in as much detail as possible. The accuracy and completeness of your answers directly affect the diagnostic decisions made on your behalf. Although some questions may seem "strange" or not applicable to you, there is a specific reason behind each question asked. Your confidentiality will be respected. Please give this your "best effort".

I. MEDICINES:

1. Please list all medications you are now taking:

   1. _____ 2. _____ 3. _____ 4. _____ 5. _____

2. Please list all medications you are sensitive or allergic to:

   1. _____ 2. _____ 3. _____ 4. _____

II. FOOD ALLERGIES:

1. Please list all foods that you are sensitive or allergic to including those that regularly "upset your stomach".

   1. _____ 2. _____ 3. _____ 4. _____

III. NUTRITIONAL HISTORY:

1. Do you usually eat:

   Breakfast Yes ☐ No ☐ Lunch Yes ☐ No ☐ Dinner Yes ☐ No ☐

   Between Meals Yes ☐ No ☐ Before Bed Yes ☐ No ☐

2. How often do you have:

	How Many Times Daily?	—OR—	How Many Times Weekly?	—OR—	Never?
Milk					
Dairy Products					
Coffee and/or Tea					
De-caff Coffee					
Refined Sugar					
White Bread					
Artificial Sweeteners					
Soft Drinks (Regular)					
Soft Drinks (Diet)					
Pastries					
Alcohol					
Beer					
Wine					
Salt					
Vegetables					

	How Many Times Daily?	—OR—	How Many Times Weekly?	—OR—	Never?
Hot Dogs					
Cold Cuts					
Salads					
Fresh Fruits					
Frozen Fruits					
Canned Fruits					
Red Meats					
Seafood					
Poultry					
T.V. Dinners					
Italian Food					
Chinese Food					
Fast Food *(i.e. McDonalds)*					
Smoking					
Candy					
Ice Cream					
Other					

IV. MEDICAL HISTORY:

1. Mark an X in the appropriate space indicating whether you have ever had, have had in the past year, or now have any of the following conditions or symptoms:

	Have Never Had	Previous Condition	Current Condition
1. Swollen, stiff or painful joints; where?	☐	☐	☐
2. Osteoarthritis (neck, joints, etc.)	☐	☐	☐
3. Rheumatoid arthritis	☐	☐	☐
4. Cortisone therapy	☐	☐	☐
5. Heart trouble	☐	☐	☐
6. Heart murmur	☐	☐	☐
7. Pains or tightness in chest	☐	☐	☐
8. Fast pulse, heart palpations, thumping, or racing heart	☐	☐	☐
9. Low blood pressure (hypotension)	☐	☐	☐
10. High blood pressure (hypertension)	☐	☐	☐
11. Poor circulation	☐	☐	☐
12. Fainting spells or feeling faint	☐	☐	☐
13. Swollen ankles or feet	☐	☐	☐
14. Hands or feet get cold	☐	☐	☐
15. Rheumatic fever	☐	☐	☐
16. Scarlet fever	☐	☐	☐
17. Total joint replacement	☐	☐	☐
18. Brittle fingernails	☐	☐	☐
19. Tendency to be too hot or cold	☐	☐	☐
20. Bruise easily	☐	☐	☐
21. Slow healing sores	☐	☐	☐
22. Muscle soreness or stiffness; where?	☐	☐	☐
23. Diabetes	☐	☐	☐
24. More thirsty than usual	☐	☐	☐
25. High or low blood sugar	☐	☐	☐
26. Shortness of breath	☐	☐	☐
27. Frequent colds	☐	☐	☐
28. Feel exhausted or fatigued most of the time	☐	☐	☐

	Have Never Had	Previous Condition	Current Condition
29. Do you consider yourself a nervous person	☐	☐	☐
30. Difficulty falling asleep or staying asleep	☐	☐	☐
31. Do you feel you are under a significant amount of stress or tension	☐	☐	☐
32. Psychological or psychiatric care	☐	☐	☐
33. Frequently irritable	☐	☐	☐
34. Ulcers, heartburn, or digestive problems	☐	☐	☐
35. Skin problems, rashes, psoriasis, etc.	☐	☐	☐
36. Convulsions or epilepsy	☐	☐	☐
37. Present or previous use of tranquilizer; which?	☐	☐	☐
38. Present or previous use of mood elevators; which?	☐	☐	☐
39. Endocrine or hormone problems	☐	☐	☐
40. Birth control pills	☐	☐	☐
41. Venereal Disease	☐	☐	☐
42. Drug overuse	☐	☐	☐
43. Alcohol overuse	☐	☐	☐
44. Familial Mediterranean Fever	☐	☐	☐

V. FAMILY HISTORY:

1. Has you mother or father, or their parents had any of the following disorders? ***Indicate which relative.***

1. Diabetes _____ 2. Arthritis _____ 3. Alcoholism _____

4. Thyroid _____ 5. Cancer _____

VI. Personal History:

1. Please list your most serious illnesses and injuries:

_____

_____

_____

_____

_____

2. Please list your hospitalization history:

_____

_____

_____

_____

_____

3. Are you now, or have you been, in the last five years under the care of a physician? Please write reason:

_____

_____

_____

_____

_____

VII. HEAD, NECK AND FACE SYMPTOMS:

1. Mark an X in the appropriate space indicating whether you have had, or now have, any of the following symptoms or conditions and whether it occurred on the left side or right side or both:

	Have Never Had	Previous Condition	Current Condition	Right	Left
45. Accident or trauma to head, face or neck* (even as a child)	☐	☐	☐	☐	☐
*Please explain _____					
46. Pain in, around, or behind eyes	☐	☐	☐	☐	☐
47. Eyes blink or water most of time	☐	☐	☐	☐	☐
48. Eyesight blurs	☐	☐	☐	☐	☐
49. Eyesight getting worse	☐	☐	☐	☐	☐
50. Sinus problems	☐	☐	☐	☐	☐
51. Nose stuffed when don't have a cold	☐	☐	☐	☐	☐
52. Nose runs when you don't have a cold	☐	☐	☐	☐	☐
53. Dizziness or lightheadedness	☐	☐	☐	☐	☐
54. Itchiness or stuffiness in ears	☐	☐	☐	☐	☐
55. Running ears	☐	☐	☐	☐	☐
56. Excessive ear wax formed	☐	☐	☐	☐	☐
57. Ringing, hissing or buzzing sounds in ears	☐	☐	☐	☐	☐
58. Grating noise in ears (like sand particles	☐	☐	☐	☐	☐
59. Earache or ear pain	☐	☐	☐	☐	☐
60. Hearing loss	☐	☐	☐	☐	☐
61. Accident to teeth	☐	☐	☐	☐	☐
62. Broken jaw	☐	☐	☐	☐	☐
63. Pain in or around jaw joint	☐	☐	☐	☐	☐
64. Any Noise in Jaw Joints	☐	☐	☐	☐	☐
65. Mouth goes to one side when fully opened	☐	☐	☐	☐	☐
66. Difficult or painful to swallow (food, pills)	☐	☐	☐	☐	☐
67. Generally sore mouth	☐	☐	☐	☐	☐
68. Dry mouth (not enough saliva)	☐	☐	☐	☐	☐
69. Painful or burning tongue	☐	☐	☐	☐	☐
70. Painful or sore teeth	☐	☐	☐	☐	☐
71. Teeth sensitive to hot or cold	☐	☐	☐	☐	☐
72. Gum disease or bleeding gums	☐	☐	☐	☐	☐
73. Oral surgery	☐	☐	☐	☐	☐
74. Wisdom teeth extracted	☐	☐	☐	☐	☐
75. General anesthesia	☐	☐	☐	☐	☐
76. Teeth ground on by dentist	☐	☐	☐	☐	☐
77. Orthodontia (braces)	☐	☐	☐	☐	☐
78. Neck injury or operation	☐	☐	☐	☐	☐
79. Twisting neck quickly, makes noises	☐	☐	☐	☐	☐
80. Lumps or swelling in neck	☐	☐	☐	☐	☐
81. Chronic stiff neck	☐	☐	☐	☐	☐
82. Neckaches	☐	☐	☐	☐	☐
83. Whiplash neck injury	☐	☐	☐	☐	☐
84. Cervical traction neck collar	☐	☐	☐	☐	☐
85. Chronic dry cough	☐	☐	☐	☐	☐
86. Throat hoarse or sore when you don't have a cold	☐	☐	☐	☐	☐
87. Chronic feeling of foreign object (chicken bone) in the throat	☐	☐	☐	☐	☐

		Have Never Had	Previous Condition	Current Condition		Right	Left
88.	Numbness of shoulder, arms, hands, fingers	☐	☐	☐		☐	☐
89.	Shoulder pain	☐	☐	☐		☐	☐
90.	Scoliosis (curvature of spine)	☐	☐	☐		☐	☐
91.	Backaches, where _____	☐	☐	☐		☐	☐
92.	Unequal leg length	☐	☐	☐		☐	☐
93.	Inability to sit still for prolonged period of time	☐	☐	☐		☐	☐
94.	Do you tend to rest your tongue between your teeth	☐	☐	☐		☐	☐
95.	Do you tend to bite or chew the side of your tongue	☐	☐	☐		☐	☐
96.	Do you tend to bite or chew your lip	☐	☐	☐		☐	☐
97.	Do you tend to bite or chew your cheek	☐	☐	☐		☐	☐
98.	Do you tend to bite your nails or cuticles	☐	☐	☐		☐	☐
99.	Do you tend to hold objects between you teeth	☐	☐	☐		☐	☐
100.	Do you tend to cradle the telephone	☐	☐	☐		☐	☐
101.	Clench teeth during day	☐	☐	☐		☐	☐
102.	Grind teeth during day or night	☐	☐	☐		☐	☐
103.	Frequently find that your teeth are together during day or night	☐	☐	☐		☐	☐
104.	Chew gum	☐	☐	☐		☐	☐
105.	Chew tobacco	☐	☐	☐		☐	☐
106.	Chew on pens or pencils	☐	☐	☐		☐	☐
107.	Smoke a pipe	☐	☐	☐		☐	☐
108.	Cup your chin with your hands	☐	☐	☐		☐	☐
109.	Rest your hand on the sides of your face	☐	☐	☐		☐	☐
110.	Play a musical instrument	☐	☐	☐	Which? _____		
111.	Thrust your jaw forward	☐	☐	☐		☐	☐

Please feel free to explain — (give number(s) being explained) _____

		Yes	No
112.	Do you feel your bite is overclosed	☐	☐
113.	Does your bite feel uncomfortable to you	☐	☐
114.	Have you ever had difficulty getting your jaw closed	☐	☐
115.	Has there ever been a time when your jaw locked or had a catch as you tried to open	☐	☐
116.	Do you have difficulty opening your mouth wide	☐	☐
117.	How long have you had this problem? _____		
	Do your jaw muscles become tired during eating	☐	☐
	a. when you awaken in the morning	☐	☐
	b. after or during routine dental visits	☐	☐
118.	Do your teeth hurt from biting	☐	☐
119.	Does your face ever feel swollen	☐	☐
120.	Do you sleep on your		
	back,	☐	☐
	stomach,	☐	☐
	side	☐	☐
121.	Are you afraid your problem may be serious	☐	☐

	Yes	No
122. Do you feel you need treatment for this problem	☐	☐

Please feel free to explain _____

_____

_____

VIII. LOCATION OF FACIAL PAIN:

1. Do you have frequent headaches, facial pain, or jaw joint pain; check appropriate box
   - Headaches ☐
   - Facial pain ☐
   - Jaw pain ☐
   - Jaw joint pain ☐
2. Where is pain located? (Please list in order of frequency or seriousness.)

   Location one _____

   _____

   Location two _____

   _____

   Location three _____

   _____

		In Location One	In Location Two	In Location Three
3.	How often do they occur	_____	_____	_____
4.	What part of the day do they usually start . . .	_____	_____	_____
5.	How long have you been having them	_____	_____	_____
6.	What makes them better	_____	_____	_____
7.	What makes them worse	_____	_____	_____
8.	Is the pain getting worse	_____	_____	_____
9.	When did you first experience the pain for which you are seeking help — (date)	_____	_____	_____
10.	What do you think is the cause of your pain .	_____	_____	_____

11. Under what circumstances did pain begin? (Please List All That Apply.)

    Accident at work ☐

    Explain: _____

    Accident at home ☐

    Explain _____

    Other accident ☐

    Explain _____

    At work, but not an accident ☐

    Explain _____

    Following surgery ☐

    Explain _____

    Following illness ☐

    Explain _____

    Pain just began, can't relate it to anything ☐

    Explain _____

    Other reasons or circumstances ☐

    Explain _____

12. From what symptoms do you most desire relief?
In your own words, list all your symptoms from most important or serious, to least important. (In detail)

1. _____
2. _____
3. _____
4. _____
5. _____

13. Are your symptoms worse:

	Yes	No		Yes	No
Upon arising in the morning	☐	☐	When with your children	☐	☐
At work	☐	☐	Chewing	☐	☐
At the end of your work day	☐	☐	Swallowing	☐	☐
At school	☐	☐	When yawning	☐	☐
At home	☐	☐	In the fall or winter	☐	☐
Hay fever season	☐	☐	Rainy weather	☐	☐
Speaking	☐	☐			

14. Does any other member of your family have the same or similar problems
Yes ☐ No ☐
15. How many times have you been operated on for the pain
0 ☐ 1 ☐ 2 ☐ 3 ☐ More times ☐
16. Did the operation(s) bring relief from pain
Yes ☐ No ☐
17. How often do you take medication for relief of pain
Never ☐ Very seldom ☐ Once A Day ☐ More Than Once A Day ☐

IX. PERSONAL HISTORY:

1. Mark an X in the appropriate space indicating that you:
Use, or have used heroin, cocaine, LSD, uppers, downers, or similar drugs? Yes ☐ No ☐
Been told by some doctors that your pain was imaginary or "all in your head"? Yes ☐ No ☐
Have any doctors or nurses acted as if you were faking the pain? Yes ☐ No ☐

Please describe any other pertinent information, symptom, disorder, etc., not previously covered:

_____
_____
_____
_____
_____

Is there any additional information that you feel would be helpful:

_____
_____
_____
_____
_____

PLEASE READ THESE INSTRUCTIONS CAREFULLY. WE WANT YOU TO INDICATE ON THE DRAWINGS ON THE NEXT PAGE EXACTLY WHERE YOUR PAIN IS, AND HOW MUCH PAIN YOU FEEL. READ ALL INSTRUCTIONS BEFORE YOU DO ANYTHING.

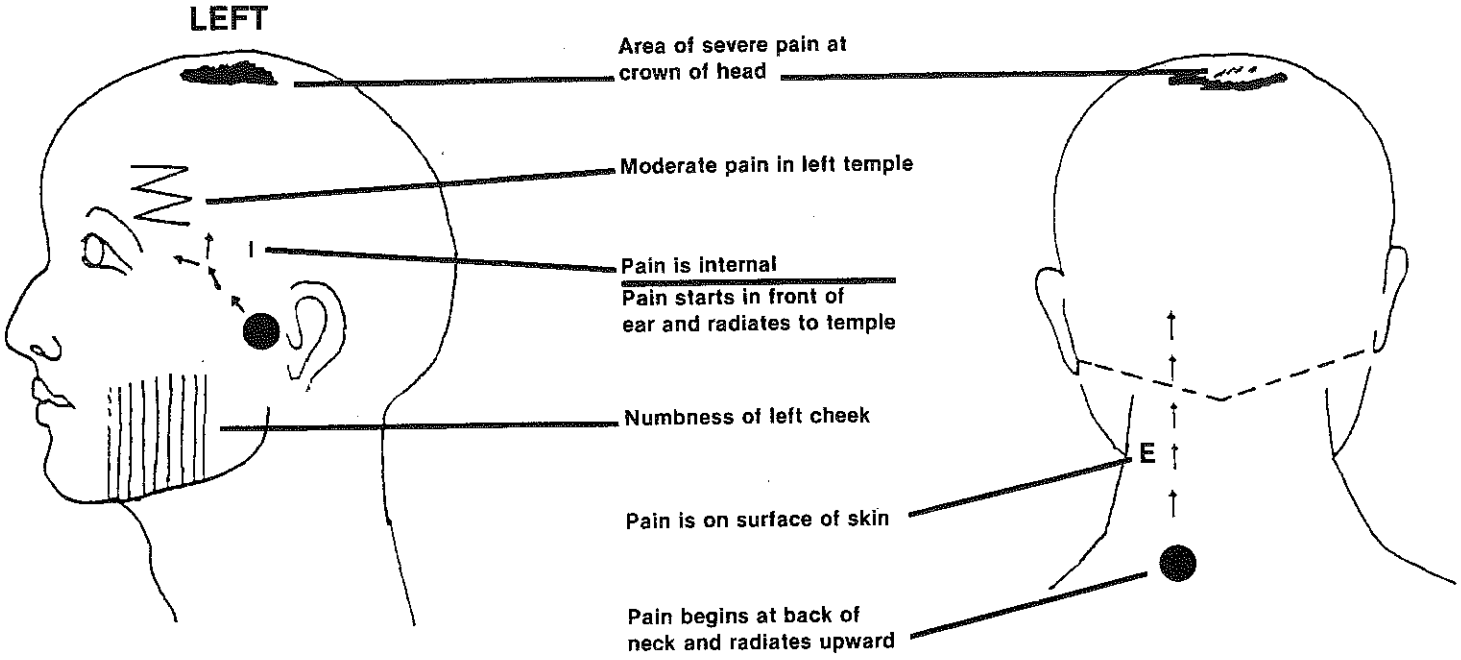
1. Mark on the drawing the exact spot(s) where your pain starts [a solid dot(s).] If the pain starts at that spot and radiates elsewhere [travels to another part of your face, head or neck], draw a line of arrows from the spot where it starts to where it ends. If it is a whole area that hurts, shade in that area with a pencil.

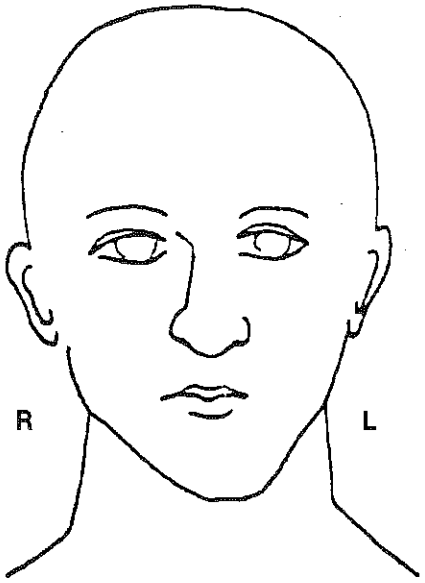
2. Next to the places on the drawing where you showed pain, put an "E" if the pain is external [skin surface] if the pain is internal [inside the body] mark this with an "I". If the pain is both internal and external, mark "EI".

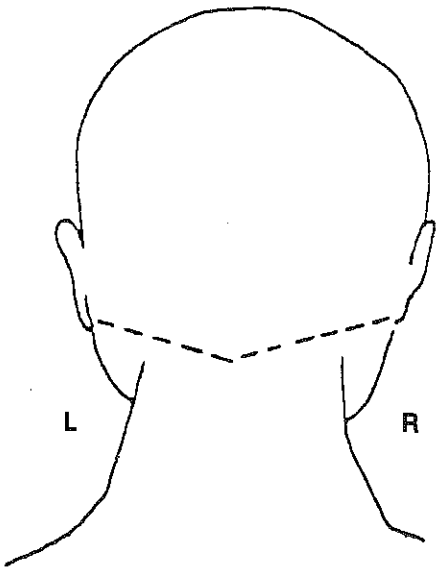
3. After you have shown where the pain is, and where it travels to, we want to know how much pain you feel. Mark the painful area with the following symbols:

PAIN	•	MODERATE PAIN	≋
EXTERNAL PAIN	E	SEVERE PAIN	▒
INTERNAL PAIN	I	SHOOTING PAIN	↑
		NUMBNESS	|||

Before you do anything to the drawings on the next page, look at the example and read the description of what it means so that you will understand perfectly what you are to do.



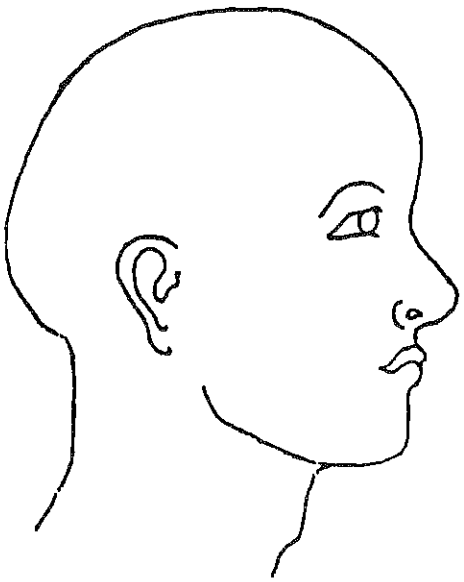


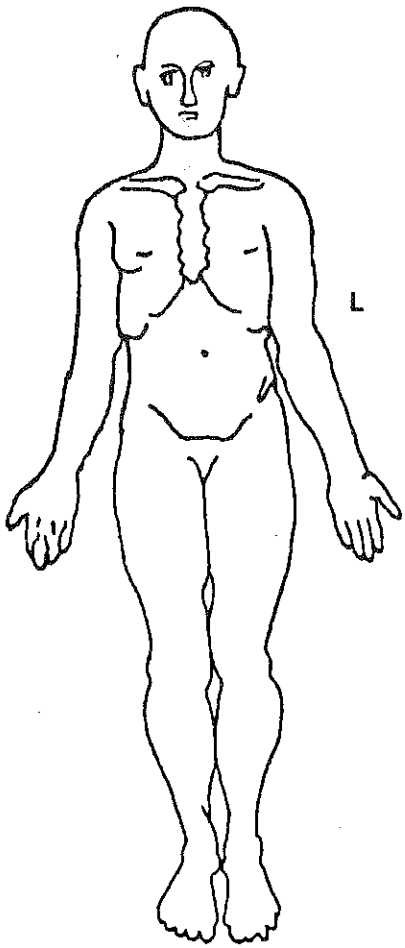


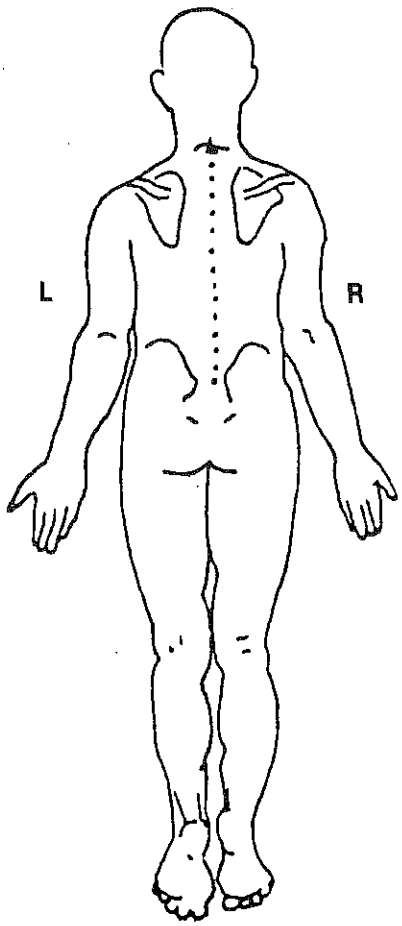
PAIN ●
EXTERNAL PAIN E
INTERNAL PAIN I
MODERATE PAIN
SEVERE PAIN
SHOOTING PAIN
NUMBNESS

EYES

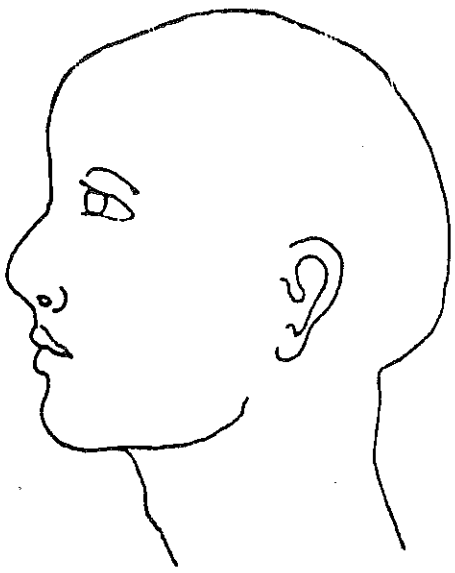
RIGHT







LEFT



Do you suffer from headaches?

Yes ☐ **No** ☐

If yes, please check symptoms which relate to you.

TYPE OF PAIN

Stabbing ☐

Burning ☐

Pulsating ☐

Tightness ☐

Pressure ☐

Bandlike ☐

Intense ☐

Burning ☐

Throbbing ☐

Excruciating ☐

Lancinating ☐

Lightening Like ☐

Other _____

LOCATION

Right Side ☐

Left Side ☐

Both Sides ☐

Around Eye(s) ☐

Temple(s) ☐

Ear ☐

Back of Head ☐

Top of head ☐

Forehead ☐

Back of neck ☐

Elsewhere _____

FREQUENCY

Often at Night ☐

Daily ☐

Worse in AM ☐

Mild in AM and
Gets Gradually Worse ☐

Once A Week ☐

More Than 2/Week ☐

Average One A Month ☐

Other _____

DURATION OF PAIN

½ - 2 Hours ☐

All Day ☐

Days ☐

30 Seconds ☐

Other _____

ASSOCIATED SYMPTOMS

Blurred Vision ☐

Tears ☐

Salivation ☐

Stuffy Nose ☐

Nausea ☐

Neck Pain ☐

Fever ☐

Malaise ☐

Triggered By Smoking ☐

Triggered by Alcohol ☐

Other _____

On the lines below, please list any physicians, dentists, neurologists, ear, nose or throat specialists, orthodontists, chiropractors, psychiatrists, or clinical teams consulted. Please list their specialty and briefly describe their diagnosis and treatment. Please list in the order you visited them.

Doctor ______________________________ MD ☐ DDS ☐
Address ______________________________
Diagnosis and treatment ______________________________
____
____

Doctor ______________________________ MD ☐ DDS ☐
Address ______________________________
Diagnosis and treatment ______________________________
____
____

Doctor ______________________________ MD ☐ DDS ☐
Address ______________________________
Diagnosis and treatment ______________________________
____
____

Doctor ______________________________ MD ☐ DDS ☐
Address ______________________________
Diagnosis and treatment ______________________________
____
____

Doctor ______________________________ MD ☐ DDS ☐
Address ______________________________
Diagnosis and treatment ______________________________
____
____

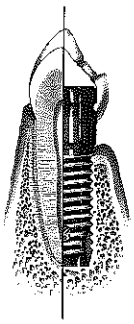
Doctor ______________________________ MD ☐ DDS ☐
Address ______________________________
Diagnosis and treatment ______________________________
____
____

Doctor ______________________________ MD ☐ DDS ☐
Address ______________________________
Diagnosis and treatment ______________________________
____
____

All information contained on pages 1-11 have been filled out by me, and to the best of my knowledge is true.

Signature ______________________________ ***Date*** ______________

DATE/FEE	TREATMENT PERFORMED		N.V.



STUART ROSS, D.M.D.
MARTIN C. NAGER, D.M.D.
BRENDA R. PIERCE, D.D.S.

Periodontics
TMJ Pain Dysfunction Syndrome
Dental Implants

OFFICE FINANCIAL POLICY

We understand that finances are a concern and make every effort to see that patients are able to have the periodontal treatment they need. Several convenient payment options are available.

PATIENTS WITHOUT INSURANCE

We accept Cash, Check, MasterCard, Visa and Discover Card for your payments at the time of your appointment. "Care Credit" is also available for interest-free financing that allows payments over six months. Please ask our Front Desk staff about "Care Credit" payment options.

PATIENTS WITH INSURANCE

Our office is pleased to submit any insurance claims when provided with the appropriate insurance information. While the patient is ultimately responsible for services rendered in the office, for those insurance companies that send their payments directly to the patient, you have the option of signing that payment over to us along with your co-payment, or keeping the payment and paying the total fee at the time of service. Some insurance companies send their reimbursement directly to our office. In those cases, patients only need to pay their co-payment at the time of service. "Care Credit" is also available for interest-free financing that allows payments over six months. Please ask our Front Desk staff about "Care Credit" payment options.

APPOINTMENT POLICY

Appointments times are specifically reserved for you. Should you need to change your appointment, we require 24 hours notice to avoid a broken appointment fee of $50.00. A surgical appointment requires 48 hours notice to reschedule to avoid a broken appointment fee.

YOUR GUMS, TEETH AND OVERALL HEALTH ARE IMPORTANT. OUR PRACTICE IS WORKING HARD TO MAKE SURE YOUR RECOMMENDED TREATMENT IS FINANCIALLY POSSIBLE.

INSURANCE INFORMATION NEEDED FOR NEW PATIENTS

If patient covered under spouse, please complete bottom portion only

Patient's Name _____

Date of Birth _____ Social Security No. _____

Insurance Company _____

Address _____

_____ Zip _____

Employer _____

Address _____ Zip _____

Group Number _____

Spouse's Insurance Information

Spouse's Name _____

Date of Birth _____ Social Security No.: _____

Insurance Company _____

Address _____ Zip _____

Employer _____

Address _____ Zip _____

Group Number _____

Assignment of Benefits

I, _____ hereby assign all medical and dental benefits to myself or the noted provider for professional services rendered and I authorize the release of any dental information necessary to process this claim. This assignment will remain in-effect until revoked by me in writing. I understand I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment of said benefits. This office makes no representation as to what, if any, portion of this bill will be paid by insurance. The entire bill for services rendered is the responsibility of the patient. A 1% finance charge will apply to any unpaid balance over 90 days. I understand I will be responsible for any costs and expenses associated with collection, including attorney fees.

Signature _____

EPWORTH SLEEPINESS SCALE

In contrast to just feeling tired, how likely are you to doze off or fall asleep in the following situations? Use the following scale to choose the most appropriate number for each situation:

0 = Would never doze
1 = Slight chance of dozing
2 = Moderate chance of dozing
3 = High chance of dozing

SITUATION	
Sitting and reading	_____
Watching Television	_____
Sitting inactive in a public place (i.e. theatre)	_____
As a car passenger for an hour without a break	_____
Lying down to rest in the afternoon	_____
Sitting and talking with someone	_____
Sitting quietly after lunch without alcohol	_____
In a car, while stopping for a few minutes in traffic	_____
TOTAL SCORE	_____

A score of 6 or greater indicates the possibility of a sleep breathing disorder

(Over)

DRS. ROSS, NAGER AND PIERCE

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect APRIL 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the 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 upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities; reviewing the competence or qualifications of healthcare professionals evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

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 of 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.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this 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.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use of disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. 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.

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

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

Abuse or Neglect: We may disclose your health 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 disclose your health information to the extent necessary to avert a serious threat to your health or safety, or the health and safety of others.

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 institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or obtain copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a written request to obtain access to your medical information). You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.25 for each page, $15.00 per hour for staff time to locate and copy your health information and postage if you want copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure).

Disclosure Accounting: 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 6 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.

Restriction: You have the right to request we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (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 location you request.

Amendment: You have the 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.

Electronic Notice: If you receive this Notice on our Website or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

You May Refuse To Sign This Acknowledgement

I _____ have received a copy of this office's Notice of Privacy Practices.

Please Print Name _____

Signature _____

Date _____

This Form is Educational only, does not constitute legal advice, and covers only federal, not state law (August 14, 2002).