Kirkpatrick DENTAL CARE

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____ have received a copy of the Notice Of Privacy Practice of this office.

_____ _____

Signature Date

Please note: It is your right to refuse to sign this acknowledgement.

Office Use Only

We tried to obtain written acknowledgement by the individual noted above of receipt of Notice of Privacy Practices, but it could not be obtained because:

_____ An Emergency prevented us from obtaining acknowledgement.

_____ A communication barrier prevented us from obtaining acknowledgement

_____ The Individual was unwilling to sign

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.

Practice Covered By This Notice

This notice describes the privacy practices of Knoxville Centre for Advanced Dentistry (" KCAD ").

Information Covered By This Notice

We create and maintain records about the dental care and services you receive at KCAD. Having these records helps us to provide you with quality care and to comply with certain legal requirements. This notice applies to health information about you that we create or receive and that identifies you. This notice tells you about the ways we may use and disclose health information about you. It also describes your rights and certain obligations we have with respect to your health information.
We are required by law to: maintain the privacy of health information that identifies you; give you this notice of our legal duties and privacy practices with respect to that information; and abide by the terms of our privacy notice that is currently in effect.

How We May Use and Disclose Health Information About You

We describe below the reasons we may use and disclose health information about you. For each category, we will explain what we mean and give you examples. **Treatment.** We may use health information about you to provide you with dental treatment or services. We may disclose health information about you to dental specialists, physicians, or other health care professionals involved in your care. For example, a periodontist treating you for periodontal disease may need to know if you have a heart condition because it could necessitate antibiotics before treatment. **Payment.** We may use and disclose your health information so the treatment and services you receive may be billed to, and payment may be collected from, an insurance carrier or other entity. For example, we may need to give your health insurance provider information about care you received at our office so they will pay us or reimburse you for the services. **Health Care Operations.** We may use and disclose health information about you in connection with a wide range of health care operations. These uses and disclosures are necessary to run our practice and to help ensure that our patients receive appropriate care. For example, we may use health information about you to review our treatment and services and evaluate the performance of our staff of health care professionals. **Appointment Reminders.** We may use or disclose health information about you when contacting you to remind you of a dental appointment. We may contact you by using a postcard, letter, voicemail, or e-mail. **Treatment Alternatives.** We may use and disclose health information about you to tell you about or recommend possible treatment options or alternatives that may be of interest to you. **Health-related Benefits and Services.** We may use and disclose health information about you to tell you about health-related benefits and services that may be of interest to you. **Disclosure to Individuals Involved in Your Care or Payment for Your Care.** We may disclose health information about you to a family member or friend who is involved with your care or payment for your care. If you do not object, or if you are not present and we believe it is in your best interest to do so, we may tell your family or others responsible for your care of your location, condition, or death. In addition, we may disclose health information about you to an entity assisting in a disaster relief effort so your family or others responsible for your care can be notified about your location, condition, or death. **Disclosures Required by Law.** We may use or disclose health information about you to the extent we are required by law to do so. **Public Health Activities.** We may disclose health information about you for certain public health activities and purposes. These activities and purposes generally include the following: preventing or controlling disease, injury or disability; reporting births or deaths; reporting child abuse or neglect; reporting adverse reactions to medications or foods; reporting product defects; notifying people of recalls of products they may be using; and notifying a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition. **Victims of Abuse, Neglect or Domestic Violence.** Under certain circumstances, we may disclose to the appropriate government authority health information about an individual whom we believe is a victim of abuse, neglect or domestic violence. We will make this disclosure only (i) if you agree or (ii) to the extent required or authorized by law and we believe the disclosure is necessary to prevent serious harm. **Health Oversight Activities.** We may disclose health information about you to a health oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, licensure actions and other activities necessary for the government to provide appropriate oversight of the health care system, certain government benefit programs, and compliance with certain civil rights laws. **Lawsuits and Legal Actions.** If you are involved in a lawsuit or other legal action, we may disclose health information about you in response to a court or administrative order. We also may disclose health information about you in response to a subpoena, discovery request, or other lawful process that is not ordered by a court, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested. **Law Enforcement Purposes.** We may disclose health information about you for a law enforcement purpose to a law enforcement official: as required by law or in response to a court order, warrant, subpoena, summons or similar process; to identify or locate a suspect, fugitive, material witness or missing person; if you are an actual or suspected victim of a crime and you agree to the disclosure or, under certain limited circumstances, if we are unable to obtain your agreement; to alert law enforcement of your death if we suspect it may have resulted from criminal conduct; if we believe the information shows evidence of criminal conduct at our office; or if we are providing care in response to a medical emergency, if necessary to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime. **Coroners, Medical Examiners and Funeral Directors.** We may disclose health information to a coroner or medical examiner to identify a deceased person, determine the cause of death or undertake other authorized duties. We also may release health information to funeral directors as necessary to carry out their duties. **Organ, Eye and Tissue Donation.** We may use or disclose health information

about you to organ procurement organizations or others that obtain, bank or transplant cadaver organs, eyes or tissue for donation and transplant. **Serious Threat to Health or Safety.** We may use or disclose health information about you if we believe it is necessary to do so to prevent or lessen a serious threat to anyone's health or safety. We would make such a disclosure only to someone able to help prevent or lessen the threat or, under certain circumstances, if the disclosure is necessary for law enforcement authorities to identify and apprehend an individual. **Specialized Government Functions.** If you are a member of the armed forces, we may, under certain circumstances, use and disclose health information about you as required by military command authorities. We also may use and disclose health information about foreign military personnel to the appropriate foreign military authority. We may disclose health information about you to authorized federal officials to (i) conduct certain national security activities, (ii) provide protection to the President or other authorized people, or (iii) conduct certain investigations. We may disclose to a correctional institution or law enforcement official having custody of an individual health information about that individual. **Workers' Compensation.** We may disclose health information about you to comply with laws relating to workers' compensation or similar programs that provide benefits for work-related injuries or illness. **Other Uses of Health Information.** We will make other uses and disclosures of health information not discussed in this notice only with your written authorization. If you authorize us to use or disclose health information about you, you may revoke that authorization at any time. Your revocation must be in writing. If you revoke your prior authorization, we will no longer use or disclose health information about you for the reasons covered by that authorization. You cannot revoke your authorization to the extent that we have already taken action based on that authorization. For example, we are unable to take back any disclosures we have already made with your authorization.

Your Rights

Right of Access. You may inspect and request a copy of certain health information we have about you. These requests must be made in writing. We will provide a copy in a format you request if it is readily producible. If not readily producible, we will provide it in a hard copy format or other format that is mutually agreeable. If you are the recipient of electronic notice, you may obtain a paper copy upon request. **Right to Amend.** If you believe that health information we have about you is incorrect or incomplete, you may ask us to amend the information. Such requests must be made in writing and must include a reason to support the request. Under some circumstances, we may deny such a request, but you are entitled to a written response within 60 days of our receipt of your written request. **Right to Request Restrictions.** You may request that we restrict uses or disclosures of certain health information about you to carry out treatment, payment, or health care operations. We may not (and are not required to) agree to requested restrictions. We will not use or disclose any health information about you in violation of any restrictions that we agree to other than in providing emergency treatment. **Confidential Communications: Alternative Means, Alternative Locations.** You may ask to receive communications of health information by alternative means or at an alternative location. We will accommodate all reasonable requests. You must provide this type of request to us in writing and provide an alternative method of contact or alternative address. We will provide an estimate of the fee for this service in advance and ask that you provide information as to how payment will be handled. **Accounting of Disclosures.** You have a right to receive an accounting of disclosures we have made of health information about you for the six years prior to the date that the accounting is requested except for disclosures to carry out treatment, payment, health care operations, and certain other disclosures. The first such accounting we provide within any 12 month period will be without charge to you. We will charge a reasonable, cost-based fee for each subsequent request for an accounting within a 12-month period. We will notify you in advance of this fee. **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 the notice at any time. Even if you have agreed to receive the notice electronically, you may still obtain a paper copy. To obtain a paper copy, ask any staff member.

Changes to This Notice

We reserve the right to change the terms of this notice and to make the changed notice provisions effective for all health information we have about you or create or receive in the future. We will promptly revise, post, and distribute a revised notice whenever there is a material change to the uses or disclosures, individual's rights, our legal duties, or other privacy practices discussed in this notice. Our privacy notice will contain on the first page, in the top right-hand corner, the effective date.

Complaints

If you have any complaints about your privacy rights or how your health information has been used or disclosed, you may file a complaint with us by contacting: Knoxville Centre for Advanced Dentistry, 121 S. Weisgarber Road, Knoxville, TN 37919 (865)588-5749.

You may also file a written complaint with the U.S. Department of Health and Human Services by contacting:

The U.S. Department of Health and Human Services
200 Independence Avenue, S.W., Washington, D.C. 20201
Toll Free: 1-877-696-6775

PATIENT NUMBER

welcome

Patient's Name _____
Last First Initial Date of Birth

CIRCLE THE APPROPRIATE ANSWER, IF YOU DON'T KNOW THE CORRECT ANSWER PLEASE WRITE "DON'T KNOW" ON THE LINE AFTER THE QUESTION

1. Physician's Name _____
   Address _____
   Tel: ( )
2. Are you under a physician's care? ..... YES NO
   Since when _____ Why _____
3. When was your last complete physical exam? _____
4. Are you taking any medication or substances? ..... YES NO
   (If yes, please list medications in comments section or on the back of this form.)
5. Do you routinely take health related substances? (Vitamins, herbal supplements, natural products) .. YES NO
6. Are you allergic to any medications or substances? (please list) ..... YES NO
7. Do you have any other allergies or hives? ..... YES NO
8. Do you have any problems with penicillin, antibiotics, anesthetics or other medications? ..... YES NO
9. Are you sensitive to any metals or latex? ..... YES NO
10. Are you pregnant or suspect you may be? ..... YES NO
11. Do you use any birth control medications? ..... YES NO
12. Have you ever been treated for or been told you might have heart disease? ..... YES NO
13. Do you have a pacemaker, an artificial heart valve implant, or been diagnosed with mitral valve prolapse? ..... YES NO
14. Have you ever had rheumatic fever? ..... YES NO
15. Are you aware of any heart murmurs? ..... YES NO
16. Do you have high or low blood pressure? (please circle) ..... YES NO
17. Have you ever had a serious illness or major surgery? ..... YES NO
    If so, explain _____
18. Have you ever had radiation treatment, chemo treatment for tumor, growth or other condition? ..... YES NO
19. Have you ever taken Fosamax, Zometa, Aredia or any other oral or intravenous treatment (bisphosphonates) for bone tumors, excessive calcium in your blood, or osteoporosis? .YES NO
20. Do you have inflammatory diseases, such as arthritis or rheumatism? ..... YES NO
21. Do you have any artificial joints/prosthesis? ..... YES NO
22. Do you have any blood disorders, such as anemia, leukemia, etc? ..... YES NO
23. Have you ever bled excessively after being cut or injured? ..... YES NO
24. Do you have any stomach problems? ..... YES NO
25. Do you have any kidney problems? ..... YES NO
26. Do you have any liver problems? ..... YES NO
27. Are you diabetic? ..... YES NO
28. Do you have fainting or dizzy spells? ..... YES NO
29. Do you have asthma? ..... YES NO
30. Do you have epilepsy or seizure disorders? ..... YES NO
31. Do you or have you had venereal or any sexually transmitted disease? ..... YES NO
32. Have you tested HIV positive? ..... YES NO
33. Do you have AIDS? ..... YES NO
34. Have you had or do you test positive for hepatitis? ..... YES NO
35. Do you or have you had T.B.? ..... YES NO
36. Do you smoke, chew, use snuff or any other forms of tobacco? ..... YES NO
37. Do you regularly consume more than one or two alcoholic beverages a day? ..... YES NO
38. Do you habitually use controlled substances? ..... YES NO
39. Have you had psychiatric treatment? ..... YES NO
40. Have you taken any prescription drugs fenfluramine, fenfluramine combined with phentermine (fen-phen), dexfenfluramine (redux), or other weight loss products? ..... YES NO
41. Do you have any disease condition, or problem not listed? If so, explain _____
42. Is there anything else we should know about your health that we have not covered in this form? _____
43. Would you like to speak to the Doctor privately about any problem? ..... YES NO

COMMENTS

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S / GUARDIAN'S SIGNATURE _____ DATE _____

DENTIST'S SIGNATURE _____ DATE _____

ANEST.

MED. ALERT

Form No. T140MH

MEDICAL HISTORY

PATIENT NUMBER

welcome

Age _____ Date _____

Patient's Name _____ Date of Birth _____ ❑ Male ❑ Female
Last First Initial

If Child: Parent's Name _____

How do you wish to be addressed _____
Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed ❑ Minor ❑

Residence - Street _____

City _____ State _____ Zip _____

Business Address _____

Telephone: Res. _____ Bus. _____

Fax _____ Cell Phone # _____

eMail _____

Patient/Parent Employed By _____

Present Position _____

How Long Held _____

Spouse/Parent Name _____

Spouse Employed By _____

Present Position _____

How Long Held _____

Who is Responsible for this account _____

Drivers License No. _____

Method of Payment: Insurance ❑ Cash ❑ Credit Card ❑

Purpose of Call _____

Other Family Members in this Practice _____

_____

Whom may we thank for this referral _____

Patient/parent Social Security No. _____

Spouse/Parent Social Security No. _____

Someone to notify in case of emergency not living with you _____

_____

DENTAL INSURANCE 1ST COVERAGE

Employee Name _____ Date of Birth _____
Relationship to patient _____
Employer Name _____ Yrs. _____
Name of Insurance Co. _____
Address _____

_____

Telephone _____
Program or policy # _____
Social Security No. _____
Union Local or Group _____

DENTAL INSURANCE 2ND COVERAGE

Employee Name _____ Date of Birth _____
Relationship to patient _____
Employer Name _____ Yrs. _____
Name of Insurance Co. _____
Address _____

_____

Telephone _____
Program or policy # _____
Social Security No. _____
Union Local or Group _____

CONSENT:

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

I consent to the dentist's use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment.

I consent to the disclosure of my records (or my child's records) to the following persons who are involved in my care (or my child's care) or payment for that care.

_____

_____

My consent to disclosure of records shall be effective until I revoke it in writing.

I authorize payment directly to the dentist or dental group of insurance benefits otherwise payable to me. I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, by my dental care payor.

I attest to the accuracy of the information on this page.

PATIENT'S OR GUARDIAN'S SIGNATURE

_____

DATE _____

Form No. T110R

REGISTRATION