

# Health Information and History

**Patient's Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

If You are Completing This form For Another Person:

Your Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

**Emergency Contact:**(If Not Listed Above)

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

**Primary Physician:** \_\_\_\_\_ Phone: \_\_\_\_\_ City & State: \_\_\_\_\_

**Date of Last Physical Examination:** \_\_\_\_\_ **Date of Last Blood Test/Workup:** \_\_\_\_\_

**Other Physicians & Specialists**

Name: \_\_\_\_\_ Specialty: \_\_\_\_\_ Phone: \_\_\_\_\_ City & State: \_\_\_\_\_

Name: \_\_\_\_\_ Specialty: \_\_\_\_\_ Phone: \_\_\_\_\_ City & State: \_\_\_\_\_

**Within the Last 3 Years Have You Been Hospitalized or Had Surgery?** Yes No

If Yes, Please Give Reasons and Dates: \_\_\_\_\_

**Have You Ever Been Instructed to Take ANY Medications or Take ANY Special Precautions Before Any Dental Appointments\*?** Yes No

If Yes, Please Explain: \_\_\_\_\_

**1. Are You Taking ANY Drugs, Medications, or Treatments at This Time?** Yes No

(If You Brought a Complete Written List With You, Give That to the Receptionist Instead)

Prescribed \_\_\_\_\_

u. Over- The- Counter Medications (Such as Aspirin, Advil, Allergy Medication, Sleeping Aids, Etc.)

v. Vitamins, Natural or Herbal Preparations and/or Dietary Supplements

x. Are You Having or Ever Had Radiation or Chemotherapy Treatments\*? Yes No

If Yes, for How Long? \_\_\_\_\_ Name of Facility Performing the Therapy: \_\_\_\_\_

**2. Are You Allergic to or Have You Ever Experienced an Unusual Reaction to:**

\_\_\_ Latex      \_\_\_ Metals or Jewelry      \_\_\_ Dental Anesthesia (Local)

\_\_\_ Fluoride      \_\_\_ Nitrous Oxide (Laughing Gas)      \_\_\_ General Anesthesia

**3. Are You Allergic to or Have You Ever Had Any Reaction to Any of the Following Drugs?**

\_\_\_ Penicillin (or Related Drugs)      \_\_\_ Tranquilizers (Valium)      \_\_\_ Tetracycline      \_\_\_ Codeine

\_\_\_ Aspirin / Ibuprofen (Advil, Motrin, Nuprin)      \_\_\_ Keflex (Cephalexin)      \_\_\_ Sulfa Drugs      \_\_\_ Iodine

\_\_\_ NSAID (Celebrex, Vioxx, Anaprox)      \_\_\_ Clindamycin (Cleocin)      \_\_\_ Erythromycin

**3z. Have You Had An Allergic Reaction or Unusual Response to ANY Other Medications, Drugs, Pills, or Treatments?** Yes No

If Yes, Please List : \_\_\_\_\_

**Continue on Following Pages....**

**Do You Have or Have You Ever Had Any of the Following?** (Please Check Yes or No for Each Question)

	Yes	No		Yes	No
<b>4.</b> a. Congenital Heart Defects*	___	___	<b>5.</b> a. Asthma	___	___
b. Angina or Chest Pains	___	___	b. Hay Fever, Skin or Food Allergies	___	___
c. Atherosclerosis	___	___	or Allergies in General	___	___
d. Congestive Heart Failure	___	___	c. Sinus Problems	___	___
e. Coronary Artery Disease	___	___	d. Tuberculosis, Emphysema or Lung Disorder	___	___
f. Heart Surgery	___	___	e. Skin Problems	___	___
If Yes, Date _____			f. A Sore or Wound that Bleeds Easily		
g. Heart Attack	___	___	or Does not Heal	___	___
If Yes, Date _____			g. A Thyroid Problem or Disease	___	___
h. Rheumatic Heart Disease / Rheumatic Fever*	___	___	h. Arthritis	___	___
i. Heart Murmur*	___	___	i. Glaucoma or Any Eye Diseases	___	___
j. Heart Valve(s) Damage / Mitral Valve Prolapse*	___	___	j. Epilepsy or Other Seizure Disorder	___	___
k. Artificial Heart Valve*	___	___	k. Any Kidney Problems	___	___
l. Pacemaker	___	___	l. Ulcers, Acid Reflux, or Stomach Problems	___	___
m. Stroke or CVA	___	___	m. A Compromised Immune System*	___	___
n. High Blood Pressure	___	___	(Lupus, HIV, AIDS, Radiation Immune Problem, etc)		
o. Low Blood Pressure	___	___	n. An Active Sexually Transmitted Disease (STD)	___	___
p. Anemia	___	___	o. Any Mental Health Issues	___	___
q. Hemophilia or Bleeding Disorder	___	___	p. Been Treated for Any Psychiatric Condition	___	___
r. Excessive Bleeding from Any Cut or Incident	___	___			
s. Diabetes or Blood Sugar Problems	___	___	<b>6. Women Only:</b>	<b>Yes</b>	<b>No</b>
t. Any Artificial Joint, Joint Surgery, or Prosthesis*	___	___	Are You Pregnant	___	___
If Yes, What Joint or Area: _____			If Yes, What is Your Due Date: _____		
When was Operation Done: _____			Do You Think You Might Be Pregnant	___	___
u. Hepatitis, Jaundice, or Other Liver Problems	___	___	Are You Presently Nursing	___	___
v. Any Form of Cancer	___	___	Are You Using Birth Control Medication	___	___
w. An Organ Transplant*	___	___	Are You Taking Hormone Replacement Therapy	___	___

**7. Do You Have Any Other Conditions, Diseases, or Medical Problems, or is There ANY Other Information That You Would Like Us to Know About or That We Should Be Made Aware Of?**

If So, Please Explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

# Dental and Oral Health Information

Please Describe Any Specific Dental Problem or Discomfort You Are Having at This Time.

How Long Has It Been Present? \_\_\_\_\_

**If You Have Had Any of the Following Dental Care Please List the Dentists and Approximate Dates:**

Periodontal (Gum) Treatment or Surgery \_\_\_\_\_

“Braces” or Any Type of Orthodontic Treatment: \_\_\_\_\_

Dental Implants: \_\_\_\_\_

Any Other Type of Oral Surgery: \_\_\_\_\_

**Do You Have or Had Any of the Following or Noticed Any of These Signs or Symptoms in Your Head, Neck, or Mouth?**

(Please Check Yes or No for Each Question)	Yes	No		Yes	No
Teeth that are Sensitive to:			A Clicking, Snapping or Difficulty When Chewing	___	___
Hot, Cold, Sweets, or Biting Pressure	___	___	Difficulty Opening or Moving the Jaws	___	___
An Unpleasant Taste or Persistent Bad Breath	___	___	Difficulty Speaking or Changes in Your Voice	___	___
Does Food Catch Between Your Teeth	___	___	Difficulty Moving Your Tongue or “Tongue Tied”	___	___
Do Your Gums Bleed When Brushing	___	___	Loose or Separating Teeth	___	___
Red, Swollen, Tender, Bleeding, or Sore Gums	___	___	Changes in the Way Your Teeth Fit Together	___	___
Gums That Have Pulled Away from the Teeth	___	___	A Color Change of the Tissues in Your Mouth	___	___
Pus Between the Teeth and Gums	___	___	Pain, Tenderness, Numbness, or Earaches	___	___
Avoid Any Area When Brushing or Chewing	___	___	Any Lumps Swelling or Swollen Glands	___	___
Do You Clench or Grind Your Teeth	___	___	Sores, Ulcers, or Rough Spots in Your Mouth	___	___

**Your Dental Health:**

**How Do You Rate Your Overall Dental Health?**  Good     Fair     Poor

**How Many Times a Day Do You Brush Your Teeth?** \_\_\_\_\_ **How Many Times a Week Do You Floss Your Teeth?** \_\_\_\_\_

**Do You Use Any of the Following? (Please Check Yes or No for Each Question)** **Yes**    **No**

- Mechanical (Electric) Toothbrush \_\_\_ \_\_\_
- If Yes, What Type or Brand?     Sonicare     Oral-B/Braun     Disposable     Other \_\_\_\_\_ \_\_\_ \_\_\_
- Flossing Aids (Floss Holders, Threaders, Etc.) \_\_\_ \_\_\_
- Oral Irrigating Device (Water Pik) \_\_\_ \_\_\_
- Fluoride Treatments or Supplements at Home. If Yes, What: \_\_\_\_\_ \_\_\_ \_\_\_
- Mouthwashes or Oral Rinses. If Yes, What Brand? \_\_\_\_\_ \_\_\_ \_\_\_

**Do You Have Any Missing Teeth That Have Not Been Replaced?** \_\_\_ \_\_\_

Why Have You Not Had Them Replaced? \_\_\_\_\_

**Do You Wear Any Removable Dental Appliances? If Yes, What Type and For How Long?** \_\_\_\_\_ \_\_\_ \_\_\_

**Have You Ever Had Your Teeth Whitened or Bleached?** \_\_\_ \_\_\_

Would You Like to Have Your Teeth Whitened or Bleached? \_\_\_ \_\_\_

**How Do You Feel About the Appearance of Your Smile and What Would You Change If You Could?** \_\_\_\_\_

**Are You Concerned About the Finances Required to Return Your Mouth to Excellent Health?** \_\_\_ \_\_\_

**Are You Frustrated Because You Always Need Something Treated or Repaired When You Visit a Dentist?** \_\_\_ \_\_\_

**Do You Feel You Will Eventually Wear Artificial Dentures?** \_\_\_ \_\_\_

**Have You Ever Had Any Complications From An Extraction or Dental Treatment?** \_\_\_ \_\_\_

If Yes, Please Explain \_\_\_\_\_

**Have You Ever Had Any Other Dental Conditions, Major Trauma or Injury to Your Head, Neck, or Mouth?** \_\_\_ \_\_\_

If Yes, Please Specify: \_\_\_\_\_

**If You are a New Patient to the Benjamin Dental Group:**

Date of Last Dental Visit \_\_\_\_\_ Dentist’s Name \_\_\_\_\_ City & State \_\_\_\_\_

# Oral Health Risk Factors

## 1. Do You or Have You EVER Smoked?

Yes No

(If No, Proceed to Question 2)

**The Amount that You are Presently Smoking** (Check ALL that Apply)

- None (Quit Smoking Completely)
- Less than 1 Pack of Cigarettes per Day\*
- An Occasional Cigar\*
- Cigars on a Daily / Regular Basis\*
- An Occasional Cigarette\*
- 1-2 Packs of Cigarettes per Day\*
- An Occasional Pipe Smoker\*
- A Few Cigarettes Daily\*
- 2 or More Packs of Cigarettes per Day\*
- A Pipe on a Daily / Regular Basis\*

**If You Have Quit Smoking, When Did You Quit?**

- Less than 6 Months Ago\*
- 6 Months to a Year\*
- 1 to 3 Years Ago\*
- Over 3 Years Ago

**How Many Years Have You or Did You Smoke?**

- Less than 2 Years
- 2-5 Years
- 5-10 Years
- 10-20 Years
- Over 20 Years

## 2. Do You or Have You EVER Chewed Tobacco or Used Snuff?

Yes No

(If No, Proceed to Question 3)

**Are You STILL Using Smokeless Tobacco or Snuff?\***

Yes No

**If No, WHEN Did You Quit?**

- Less than 6 Months Ago\*
- 6 Months to a Year\*
- 1 to 3 Years Ago\*
- Over 3 Years Ago

**How Many Years Did You or Have You Used Smokeless Tobacco?**

- Less than 1 Year
- 1-2 Years
- 2-5 Years
- Over 5 Years\*

## 3. Approximate Average Amount of Alcoholic Beverages Presently Consumed per Week.

- None
- Less than 1 per Week
- 1-5 Drinks
- 11-20 Drinks
- 6-10 Drinks
- Over 20 Drinks\*

## 4. Do You Have or Have You Ever Had a Substance Abuse Problem?\*

Yes No

Describe \_\_\_\_\_

## 5. Do You Presently Use Any Recreational Drugs?\*

Yes No

List \_\_\_\_\_

## 6. Do You Have or Have You Ever Had an Eating Disorder?\*

Yes No

If Yes, Please Specify: \_\_\_\_\_

## 7. Do You Have or Ever Had Any Head, Neck or Mouth Piercing(s)? (Other than Ears)

Yes No

List \_\_\_\_\_

**APPOINTMENTS**— A minimum charge will be made for failed or canceled appointments without prior notification of at least 48 hours. This fee covers only a portion of the overhead such as salaries, electric, heat, etc., which still has to be paid whether you are present or not. Once an appointment is made, please remember this time has been reserved just for you. Any change in your appointments affects many patients; please be considerate.

**INSURANCE**—For your convenience, we will complete any forms required by your dental insurance company. Your signature below authorizes the release of any health information to your health insurance carrier(s). It also authorizes payment directly to our office. It is your responsibility, however, to cover the balance of treatment cost, or to cover the entire cost if your insurance should fail to provide coverage. We do not render our services on the basis that insurance will pay any or all of our charges. Each fee is individual for the individual patient.

**PAYMENT**— Payment is expected when services are rendered, unless other arrangements are made in advance. A service charge of 2% per month (equivalent to 24% PER ANNUM), will be added to the unpaid balance of all accounts over 30 days. In the event we must hire an attorney or collection agency to collect this debt, you will be responsible for the payment of all costs and expenses, including all collection agency fees, court costs and reasonable attorney's fees.

**CONSENT**—To the best of my knowledge, all of the preceding information is correct and if there is ever any change in health, or medications, this practice will be informed of the changes without fail. I also consent to allow this practice to contact any healthcare provider(s) and to have the patient's health information released to aid in care and treatment. I also hereby consent to allow diagnosis, proper health care and treatment to be performed by this practice for the above named individual and to use and disclose any health information for professional education and training until further notice. I understand there are no guarantees or warranties in health or dental care

Signature \_\_\_\_\_ Date \_\_\_\_\_

(Parent or Guardian, if Patient is a Minor)

Office Use Only \_\_\_\_\_ HH04-2

## PATIENT ACCOUNT INFORMATION

Legal Name: \_\_\_\_\_ Nickname: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Business Phone #: \_\_\_\_\_ Email Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex: M or F Marital Status: S M D W Spouse's Name: \_\_\_\_\_

Social Security # (Required for all patients) \_\_\_\_\_ Driver's License #: \_\_\_\_\_

### IF STUDENT OR CHILD:

Name of School or College: \_\_\_\_\_ Age: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Mother's Name: \_\_\_\_\_

### APPOINTMENT PREFERENCES:

Day of Week: \_\_\_\_\_ Time of Day: \_\_\_\_\_ Do you wish a reminder call, if possible? Yes or No

Call me at this number: \_\_\_\_\_ How did you hear about our office? \_\_\_\_\_

Closest Relative not living with patient: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

## FAMILY PAYMENT INFORMATION

Person Responsible for paying this account: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Business Phone #: \_\_\_\_\_ Email Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security #: (Required) \_\_\_\_\_ Driver's License #: \_\_\_\_\_

Employer: \_\_\_\_\_ Section: \_\_\_\_\_

Address: \_\_\_\_\_

Relationship to this patient: Self \_\_\_\_\_ Spouse \_\_\_\_\_ Child \_\_\_\_\_ Other(specify) \_\_\_\_\_

How do you expect to pay for today's visit? Cash \_\_\_\_\_ Check \_\_\_\_\_ Credit Card: MC Visa DISCOVER

Other persons covered by this account:

Name	Date of Birth	Relationship to	Responsible Party	School/Employer
1. _____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____

**PAYMENT** – Payment is expected when services are rendered, unless other arrangements are made in advance. A service charge of 2% per month (equivalent to 24% PER ANNUM), will be added to the unpaid balance of all accounts over 60 days. In the event we must hire an attorney or collection agency to collect this debt, you will be responsible for the payment of all costs and expenses including all court costs and reasonable attorney's fees. A minimum charge will be made for failed or cancelled appointments without prior notification of at least 48 hours.

SIGNATURE \_\_\_\_\_ Date \_\_\_\_\_

(Patient or Guardian, if patient is a Minor)

IF COVERED BY DENTAL INSURANCE COMPLETE THE REVERSE SIDE

## DENTAL INSURANCE INFORMATION

Name of Person (Employee) with Dental Insurance Coverage: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Date of Birth: \_\_\_\_\_ \*Social Security #: \_\_\_\_\_ Employee's Insurance ID#: \_\_\_\_\_

Employer's Name: \_\_\_\_\_ Dept/Section: \_\_\_\_\_

Employer's Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Dental Insurance Company's Name: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone #: \_\_\_\_\_ Group Number: \_\_\_\_\_ Union Local \_\_\_\_\_

Annual Deductible: \$\_\_\_\_\_ Annual Maximum Coverage: \$\_\_\_\_\_ Have you seen any other dentists this year? YES or NO

Do you have a completed insurance form as required? YES \_\_\_ NO \_\_\_

\* We cannot submit to your insurance without the employee's social security #

Other Persons covered by this insurance plan:

	NAME	Relationship to Employee	Insurance ID#	Social Security #	School/Employer
1.	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____
4.	_____	_____	_____	_____	_____

## 2<sup>nd</sup> DENTAL INSURANCE INFORMATION

Name of Person (Employee) with Dental Insurance Coverage: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Date of Birth: \_\_\_\_\_ \*Social Security #: \_\_\_\_\_ Employee's Insurance ID#: \_\_\_\_\_

Employer's Name: \_\_\_\_\_ Dept/Section: \_\_\_\_\_

Employer's Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Dental Insurance Company's Name: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone #: \_\_\_\_\_ Group Number: \_\_\_\_\_ Union Local \_\_\_\_\_

Annual Deductible: \$\_\_\_\_\_ Annual Maximum Coverage: \$\_\_\_\_\_ Have you seen any other dentists this year? YES or NO

Do you have a completed insurance form as required? YES \_\_\_ NO \_\_\_

\* We cannot submit to your insurance without the employee's social security #

Other Persons covered by this insurance plan:

	NAME	Relationship to Employee	Insurance ID#	Social Security #	School/Employer
1.	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____
4.	_____	_____	_____	_____	_____

INSURANCE- For your convenience, we will complete any forms required by your dental insurance company. Your signature, on the reverse side, authorizes the release of any information regarding your dental claims to your insurance carrier(s). It also authorizes payment directly to our office. It is your responsibility, however, to cover the balance of treatment cost, or to cover the entire cost if your insurance should fail to provide coverage. We do not render our services on the basis that insurance will pay all our charges. Each fee is individual for the individual patient.

---

## BENJAMIN DENTAL GROUP

---

---

# NOTICE OF PRIVACY PRACTICES

---

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET 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 14th, 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, continuing professional healthcare education, 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 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.

**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 or 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 or 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 get 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 request in writing to obtain access to your health 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 \$0.50 for each page, \$ 25.00 per hour for staff time to locate and copy your health information, and postage if you want the 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 that 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 Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

---

#### **QUESTIONS AND COMPLAINTS**

If you want more information about our privacy practices or have questions or concerns, 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 using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

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

Contact Officer: **Barbara Barnhart** \_\_\_\_\_

Telephone: **607-563-2333** \_\_\_\_\_ Fax: **607-563-8946** \_\_\_\_\_

E-mail: **barb@beniamindental.com** \_\_\_\_\_

Address: **60 Union St., P.O. Box 27, Sidney, NY 13838** \_\_\_\_\_

**BENJAMIN DENTAL GROUP**

**ACKNOWLEDGEMENT OF RECEIPT OF  
NOTICE OF PRIVACY PRACTICES**

\* 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

\_\_\_\_\_  
For Office Use Only  
\_\_\_\_\_

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**BENJAMIN DENTAL GROUP**

---

**CONSENT FOR USE AND DISCLOSURE  
OF HEALTH INFORMATION**

---

**SECTION A: PATIENT GIVING CONSENT**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ E-mail: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Please indicate any other individuals to whom we may release information:

**SECTION B: TO THE PATIENT - PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY**

**Purpose of Consent:** By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations. In addition, you will consent to the transfer of your protected information via electronic means (i.e. email to laboratories, technical specialists and other health care providers)

**Notice of Privacy Practices:** You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: **Barbara Barnhart** \_\_\_\_\_

Telephone: **607-563-2333** \_\_\_\_\_ Fax: **607-563-8946** \_\_\_\_\_

E-mail: [barb@benjamindental.com](mailto:barb@benjamindental.com) \_\_\_\_\_

Address: **60 Union St., P.O. Box 27, Sidney, NY 13838** \_\_\_\_\_

**Right to Revoke:** You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

**SIGNATURE**

I, \_\_\_\_\_, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

**YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.  
Include completed Consent in the patient's chart**

**REVOCAION OF CONSENT**

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.  
I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_