



# 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.

Patient # \_\_\_\_\_

SS#/SIN \_\_\_\_\_

Date \_\_\_\_\_

Patient's Sex  F  M

## Patient Information (CONFIDENTIAL)

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Home Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State/Prov. \_\_\_\_\_ Zip/P.C. \_\_\_\_\_

Email \_\_\_\_\_ Cell Phone \_\_\_\_\_

Do you prefer to receive calls at your:  Home  Work  Cell Phone

Check Appropriate Box:  Minor  Single  Married  Divorced  Widowed  Separated

If Student, Name of School/College \_\_\_\_\_ City \_\_\_\_\_ State/Prov. \_\_\_\_\_  Full Time  Part Time

Patient or Parent/Guardian's Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Business Address \_\_\_\_\_ City \_\_\_\_\_ State/Prov. \_\_\_\_\_ Zip/P.C. \_\_\_\_\_

Spouse or Parent/Guardian's Name \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Person to contact in case of emergency \_\_\_\_\_ Phone \_\_\_\_\_

## Responsible Party

Name of Person Responsible for this Account \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_

Email \_\_\_\_\_ Cell Phone \_\_\_\_\_

Driver's License# \_\_\_\_\_ Birthdate \_\_\_\_\_ Financial Institution \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_ SS#/SIN \_\_\_\_\_

Is this person currently a patient in our office?  Yes  No

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

Cash  Personal Check  Credit Card  VISA  MasterCard  I wish to discuss the office's payment policy.

## Insurance Information

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Birthdate \_\_\_\_\_ SS#/SIN \_\_\_\_\_ Date Employed \_\_\_\_\_

Name of Employer \_\_\_\_\_ Union or Local # \_\_\_\_\_ Work Phone \_\_\_\_\_

Address of Employer \_\_\_\_\_ City \_\_\_\_\_ State/Prov. \_\_\_\_\_ Zip/P.C. \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Policy/ID # \_\_\_\_\_

Ins. Co. Address \_\_\_\_\_ City \_\_\_\_\_ State/Prov. \_\_\_\_\_ Zip/P.C. \_\_\_\_\_

How much is your deductible? \_\_\_\_\_ How much have you used? \_\_\_\_\_ Max. annual benefit \_\_\_\_\_

DO YOU HAVE ANY ADDITIONAL INSURANCE?  Yes  No IF YES, COMPLETE THE FOLLOWING:

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Birthdate \_\_\_\_\_ SS#/SIN \_\_\_\_\_ Date Employed \_\_\_\_\_

Name of Employer \_\_\_\_\_ Union or Local # \_\_\_\_\_ Work Phone \_\_\_\_\_

Address of Employer \_\_\_\_\_ City \_\_\_\_\_ State/Prov. \_\_\_\_\_ Zip/P.C. \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Policy/ID # \_\_\_\_\_

Ins. Co. Address \_\_\_\_\_ City \_\_\_\_\_ State/Prov. \_\_\_\_\_ Zip/P.C. \_\_\_\_\_

How much is your deductible? \_\_\_\_\_ How much have you used? \_\_\_\_\_ Max. annual benefit \_\_\_\_\_

Over Please



# Patient Medical History

Physician \_\_\_\_\_ Office Phone \_\_\_\_\_ Date of Last Exam \_\_\_\_\_

- |   |                              |                             |  |                              |                             |
|---|------------------------------|-----------------------------|--|------------------------------|-----------------------------|
| 1. Are you under medical treatment now? .....   | Yes <input type="checkbox"/> | No <input type="checkbox"/> | 10. Are you wearing contact lenses? .....  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? ... | <input type="checkbox"/>     | <input type="checkbox"/>    | 11. Are you allergic to or have you had any reactions to the following?  |                              |                             |
| If yes, please explain _____  |                              |                             | Local Anesthetics (e.g. Novocain) .....  | <input type="checkbox"/>     | <input type="checkbox"/>    |
| 3. Are you taking any medication(s) including non-prescription medicine? .....                                | <input type="checkbox"/>     | <input type="checkbox"/>    | Penicillin or any other Antibiotics .....  | <input type="checkbox"/>     | <input type="checkbox"/>    |
| If yes, what medication(s) are you taking? _____  |                              |                             | Sulfa Drugs .....  | <input type="checkbox"/>     | <input type="checkbox"/>    |
| 4. Have you ever taken Fen-Phen/Redux? .....  | <input type="checkbox"/>     | <input type="checkbox"/>    | Barbiturates .....   | <input type="checkbox"/>     | <input type="checkbox"/>    |
| 5. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates? .....   | <input type="checkbox"/>     | <input type="checkbox"/>    | Sedatives .....  | <input type="checkbox"/>     | <input type="checkbox"/>    |
| 6. Have you taken Viagra, Revati, Cialis or Levitra in the last 24 hours? .....                               | <input type="checkbox"/>     | <input type="checkbox"/>    | Iodine .....   | <input type="checkbox"/>     | <input type="checkbox"/>    |
| 7. Do you use tobacco? .....  | <input type="checkbox"/>     | <input type="checkbox"/>    | Aspirin .....  | <input type="checkbox"/>     | <input type="checkbox"/>    |
| 8. Do you use controlled substances? .....  | <input type="checkbox"/>     | <input type="checkbox"/>    | Any Metals (e.g. nickel, mercury, etc.) .....  | <input type="checkbox"/>     | <input type="checkbox"/>    |
| 9. Do you have or have you had any of the following?  |                              |                             | Latex Rubber .....   | <input type="checkbox"/>     | <input type="checkbox"/>    |
|   |                              |                             | Other _____  |                              |                             |
|   |                              |                             | 12. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?.. | <input type="checkbox"/>     | <input type="checkbox"/>    |
|   |                              |                             | 13. Women Only:  |                              |                             |
|   |                              |                             | a) Are you pregnant or think you may be pregnant? .....  | <input type="checkbox"/>     | <input type="checkbox"/>    |
|   |                              |                             | b) Are you nursing? .....  | <input type="checkbox"/>     | <input type="checkbox"/>    |
|   |                              |                             | c) Are you taking oral contraceptives? .....   | <input type="checkbox"/>     | <input type="checkbox"/>    |

- |                              |                              |                             |                                    |                              |                             |                             |                              |                             |
|------------------------------|------------------------------|-----------------------------|------------------------------------|------------------------------|-----------------------------|-----------------------------|------------------------------|-----------------------------|
| High Blood Pressure .....    | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Heart Disease .....                | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Chest Pains .....           | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Heart Attack .....           | <input type="checkbox"/>     | <input type="checkbox"/>    | Cardiac Pacemaker .....            | <input type="checkbox"/>     | <input type="checkbox"/>    | Easily Winded .....         | <input type="checkbox"/>     | <input type="checkbox"/>    |
| Rheumatic Fever .....        | <input type="checkbox"/>     | <input type="checkbox"/>    | Heart Murmur .....                 | <input type="checkbox"/>     | <input type="checkbox"/>    | Stroke .....                | <input type="checkbox"/>     | <input type="checkbox"/>    |
| Swollen Ankles .....         | <input type="checkbox"/>     | <input type="checkbox"/>    | Angina .....                       | <input type="checkbox"/>     | <input type="checkbox"/>    | Hay Fever / Allergies ..... | <input type="checkbox"/>     | <input type="checkbox"/>    |
| Fainting / Seizures .....    | <input type="checkbox"/>     | <input type="checkbox"/>    | Frequently Tired .....             | <input type="checkbox"/>     | <input type="checkbox"/>    | Tuberculosis .....          | <input type="checkbox"/>     | <input type="checkbox"/>    |
| Asthma .....                 | <input type="checkbox"/>     | <input type="checkbox"/>    | Anemia .....                       | <input type="checkbox"/>     | <input type="checkbox"/>    | Radiation Therapy .....     | <input type="checkbox"/>     | <input type="checkbox"/>    |
| Low Blood Pressure .....     | <input type="checkbox"/>     | <input type="checkbox"/>    | Emphysema .....                    | <input type="checkbox"/>     | <input type="checkbox"/>    | Glaucoma .....              | <input type="checkbox"/>     | <input type="checkbox"/>    |
| Epilepsy / Convulsions ..... | <input type="checkbox"/>     | <input type="checkbox"/>    | Cancer .....                       | <input type="checkbox"/>     | <input type="checkbox"/>    | Recent Weight Loss .....    | <input type="checkbox"/>     | <input type="checkbox"/>    |
| Leukemia .....               | <input type="checkbox"/>     | <input type="checkbox"/>    | Arthritis .....                    | <input type="checkbox"/>     | <input type="checkbox"/>    | Liver Disease .....         | <input type="checkbox"/>     | <input type="checkbox"/>    |
| Diabetes .....               | <input type="checkbox"/>     | <input type="checkbox"/>    | Joint Replacement or Implant ..... | <input type="checkbox"/>     | <input type="checkbox"/>    | Heart Trouble .....         | <input type="checkbox"/>     | <input type="checkbox"/>    |
| Kidney Diseases .....        | <input type="checkbox"/>     | <input type="checkbox"/>    | Hepatitis / Jaundice .....         | <input type="checkbox"/>     | <input type="checkbox"/>    | Respiratory Problems .....  | <input type="checkbox"/>     | <input type="checkbox"/>    |
| AIDS or HIV Infection .....  | <input type="checkbox"/>     | <input type="checkbox"/>    | Sexually Transmitted Disease ..... | <input type="checkbox"/>     | <input type="checkbox"/>    | Mitral Valve Prolapse ..... | <input type="checkbox"/>     | <input type="checkbox"/>    |
| Thyroid Problem .....        | <input type="checkbox"/>     | <input type="checkbox"/>    | Stomach Troubles / Ulcers .....    | <input type="checkbox"/>     | <input type="checkbox"/>    | Other .....                 | <input type="checkbox"/>     | <input type="checkbox"/>    |

# Patient Dental History

Name of Previous Dentist and Location \_\_\_\_\_ Date of Last Exam \_\_\_\_\_

- |   |                              |                             |   |                              |                             |
|---|------------------------------|-----------------------------|---|------------------------------|-----------------------------|
| 1. Do your gums bleed while brushing or flossing? .....                 | Yes <input type="checkbox"/> | No <input type="checkbox"/> | 8. Do you have frequent headaches? .....  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 2. Are your teeth sensitive to hot or cold liquids/foods? .....         | <input type="checkbox"/>     | <input type="checkbox"/>    | 9. Do you clench or grind your teeth? .....   | <input type="checkbox"/>     | <input type="checkbox"/>    |
| 3. Are your teeth sensitive to sweet or sour liquids/foods? .....       | <input type="checkbox"/>     | <input type="checkbox"/>    | 10. Do you bite your lips or cheeks frequently? .....   | <input type="checkbox"/>     | <input type="checkbox"/>    |
| 4. Do you feel pain to any of your teeth? .....                         | <input type="checkbox"/>     | <input type="checkbox"/>    | 11. Have you ever had any difficult extractions in the past? .....                                    | <input type="checkbox"/>     | <input type="checkbox"/>    |
| 5. Do you have any sores or lumps in or near your mouth? .....          | <input type="checkbox"/>     | <input type="checkbox"/>    | 12. Have you ever had any prolonged bleeding following extractions? .....                             | <input type="checkbox"/>     | <input type="checkbox"/>    |
| 6. Have you had any head, neck or jaw injuries? .....                   | <input type="checkbox"/>     | <input type="checkbox"/>    | 13. Have you had any orthodontic treatment? .....   | <input type="checkbox"/>     | <input type="checkbox"/>    |
| 7. Have you ever experienced any of the following problems in your jaw? |                              |                             | 14. Do you wear dentures or partials? .....   | <input type="checkbox"/>     | <input type="checkbox"/>    |
| Clicking .....  | <input type="checkbox"/>     | <input type="checkbox"/>    | If yes, date of placement _____   |                              |                             |
| Pain (joint, ear, side of face) .....                                   | <input type="checkbox"/>     | <input type="checkbox"/>    | 15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums? ..... | <input type="checkbox"/>     | <input type="checkbox"/>    |
| Difficulty in opening or closing .....                                  | <input type="checkbox"/>     | <input type="checkbox"/>    | 16. Do you like your smile? .....   | <input type="checkbox"/>     | <input type="checkbox"/>    |
| Difficulty in chewing .....   | <input type="checkbox"/>     | <input type="checkbox"/>    |   |                              |                             |

# Authorization and Release

**Payment is due in full at the time of treatment unless prior arrangements have been approved.**  
 This office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered to my insurance company.  
 I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

X \_\_\_\_\_ Date \_\_\_\_\_  
 Signature of patient (or parent/guardian) \_\_\_\_\_

**Sinquefield Family Dentistry  
Dr. Jess Sinquefield  
Dr. Brent Lee  
522 A Brandies Circle  
Murfreesboro, TN 37128**

**OFFICE POLICIES**

I understand and give my permission to **Sinquefield Family Dentistry** to perform diagnostic services to help better determine the appropriate treatment needed for my proper dental care. These diagnostic services may include any or all of the following: x-rays, oral examination, biopsy, periodontal evaluation, probing, or any other necessary service to help **Sinquefield Family Dentistry** make an adequate diagnosis.

Once a diagnosis is made, I will be given a treatment plan. The purpose of this plan is to make me aware of the recommended treatment, the estimated cost of the recommended treatment and the anticipated financial responsibility of the recommended treatment. **I understand that once the treatment is performed, if my insurance company denies the treatment, or if they pay less than expected, then I am responsible for any remaining balance.** Furthermore, I understand and agree that my estimated portion of any and all treatment will be paid upon the day of service. Forms of payment include Cash, Visa, MasterCard, American Express, Discover, Personal Check, and Care Credit.

**As a courtesy**, Sinquefield Family Dentistry will file a Pre-Estimate, at my request, for any recommended treatment to help me better determine what I can expect my portion to be. **Additionally, as a courtesy when treatment is performed, Sinquefield Family Dentistry will file my insurance for payment. However, I understand and agree that if my insurance company fails to pay within 30 days, or if they pay less than expected, then I become immediately responsible for the balance remaining and will pay such balance upon receipt of statement.** This office does not file secondary insurance coverage.

If my delinquent account results in collection proceedings, then all additional collection costs, court costs and legal fees will be paid by me.

Sinquefield Family Dentistry reserves time, personnel and facilities just for me when I have an appointment scheduled. **I understand and agree that Sinquefield Family Dentistry requires a 48 hour notice in advance of my scheduled appointment to avoid a \$50.00 cancellation fee per appointment.**

I grant my permission to Sinquefield Family Dentistry to telephone me at home, work or cellular phone to discuss matters related to my treatment, financial obligations or appointments.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent if Patient is a Minor

\_\_\_\_\_  
Date

however, not required to agree to a requested restriction. If we do agree to a requested restriction, we must abide by it unless you agree in writing to remove it.

The right to reasonable request to receive confidential communications of protected health information from us by alternative means or at alternative locations.

The right to inspect and copy your protected health information.

The right to amend your protected health information.

The right to receive an accounting of disclosures of protected health information.

The right to obtain a paper copy of this notice from us upon request.

### **Patient Acknowledgement**

Thank you very much for taking time to review how we are carefully using your health information. If you have any questions we want to hear from you. If not we would appreciate very much your acknowledging receipt of our policy.

Patient Signature \_\_\_\_\_

Today's Date \_\_\_\_\_

**Health Insurance Portability and Accountability Act  
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.

Federal and state law requires us to maintain the privacy of your health information. That law also requires us to give you this notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow privacy practices we describe in this notice while it is in effect. This notice takes effect April 14, 2003, and will remain in effect until we replace it.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care options.

**Treatment** means providing, coordination, or managing health care and related services by one or more health care providers. An example of this would include teeth cleaning services.

**Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

**Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. They may include postcards, letters, telephone reminders or electronic reminders such as email (unless you tell us that you do not want to receive these reminders).

Other than is stated above or where Federal, State or Local law requires us, we will not disclose your health information other than with your written authorization. You may revoke that authorization in writing at any time.

The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are,

Sinquefield Family Dentistry  
Dr. Jess Sinquefield  
Dr. Brent Lee  
522 A Brandies Circle  
Murfreesboro, TN 37128

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

**You May Refuse To Sign This Acknowledgement**

I, \_\_\_\_\_ have received a copy of Sinquefield Family Dentistry's Notice of Privacy Practices.

\_\_\_\_\_  
Please Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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**For Office Use Only**

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

- Individual Refused To Sign
- Communication Barriers Prohibited Obtaining the Acknowledgment
- An Emergency Situation Prevented Us From Obtaining Acknowledgment
- Other (Please Specify)

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

Sinquefield Family Dentistry  
Dr. Jess Sinquefield  
522 A Brandies Circle  
Murfreesboro, TN 37128

## 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 4/14/2003 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.

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### 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 the 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 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 payments 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 institutions 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).

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## 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 \$ \_\_\_\_ for each page. \$ \_\_\_\_ 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 case of 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.

**AMMENDMENT:** 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 (email), you are entitled to receive this notice in written form.

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## 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 may also 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 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.

**Telephone: 615-896-8181 Fax: 615-896-8848**

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