DENTISTRY & ORTHODONTICS

1011 East Ennis Ave., Suite #A • Ennis, TX 75119

Phone 469-212-1707

EnnisFamilyDental.com

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.

Ennis Dental is committed to protecting your privacy, and we have adopted privacy practices to protect the information we gather from you. We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. The Notice of Privacy Practices ("Notice") describes the privacy practices of Ennis Dental and will tell you about the ways in which we may use and disclose medical information about you and how you can get access to this information. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information with respect to your "Protected Health Information" (as defined by the Health Insurance Portability and Accountability Act of 1996 and its regulations, as amended from time to time).

We typically use or share your health information in the following ways:
• Treat you. We can use your health information and share it with other professionals who are treating you. An example of this would be a doctor treating you for an injury asks another doctor about your overall health condition.
• Bill for your services. We can use and share your health information to bill and get payment from health plans or other entities. An example of this would be sending a bill for your visit to your insurance company for payment.
• Run our office. We can use and share your health information to run our practice, improve your care, and contact you when necessary. An example would be an internal quality assessment review.

How else can we use or share your health information. We are allowed or required to share your information in other ways – usually to contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information, see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.
• Help with public health and safety issues. We can share health information for certain situations, such as: preventing disease, reporting suspected abuse, neglect, or domestic violence, preventing/reducing a serious threat to anyone's health or safety.
• Comply with law. We can share information about you if state or federal law requires is, including the Department of Health and Human Services.
• Do Research. We can use and share information for health research.
• Family and Friends: We may disclose your health information to a family member or friend who is involved in your medical care or to someone who helps pay for your care. We may also use or disclose your health information to notify (or assist in notifying) a family member, legally authorized representative or other person responsible for your care of your location, general condition or death. If you are a minor, we may release your health information to your parents or legal guardians when we are permitted or required to do so under federal and applicable state law.
• Organ and tissue donation requests. We can share information about you to organ procurement organizations
• Medical examiner or funeral director. We can share information with a coroner, medical examiner, or funeral director when an individual dies.
• Worker compensation, law enforcement requests, and other governmental requests. We can share health information for worker compensation claims, law enforcement purposes, with health oversight agencies for activities allowed by law, and other specialized government functions (e.g., military and national security)
• Lawsuits and legal actions. We can share health information in response to court or administrative order, or in response to a subpoena.

When it comes to your health information, you have certain rights, we typically use or share your health information in the following ways:
• Get an electronic or paper copy of your medical information. You have the right to inspect and/or obtain a copy of your medical information maintained in a designated record set. If we maintain your medical information electronically, you may obtain an electronic copy of the information or ask us to send it to a person or organization that you identify. To request to inspect and/or obtain a copy of your medical information, you must submit a written request to our Privacy Officer. If you request a copy (paper or electronic) of your medical information, we may charge you a reasonable, cost-based fee.
• Ask us to correct your medical record. You can ask us to correct health information about you that you think is incomplete or incorrect. We may say "no" to your request, but we'll tell you why in writing within 60 days.
• Confidential communications. You can ask us to contact you in a specific way (for instance home or office phone) or to send mail to a different address for items such as appointment reminders. We will say yes to all reasonable requests.
• Limits on what we use and share. You can ask us NOT to share certain health information for treatment, payment, or operations. We are not required to agree to your request, and if it affects your care, we may say no.
• Accounting of disclosures. You can ask for a list (accounting) of the times we have shared your health information for the prior six years. We will include all disclosures, except those about treatment, payment, and operations. We will provide one accounting for free, but may charge a reasonable, cost-based fee if you ask for another within 12 months.

• Privacy Notice. You can ask and receive a paper copy of this notice at any time.
• Complaint. You can file a complaint if you feel we have violated your rights, with the office at the address below, or you with the Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Ave, SW, Room 509F HHH Bldg., Washington, D.C. 20201, calling 1-877-696-6775, or by visiting: www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

In these cases we will never share your information unless given written permission: Marketing purposes, fundraising, and the sale of information.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may, without prior consent, use or disclose protected health information to carry out treatment, payment, or healthcare operations in the following circumstances:
• If we are required by law to treat you, and we attempt to obtain such consent but are unable to contain such consent; or
• If we attempt to obtain your consent but are unable to do so due to substantial barriers to communicating with you, and we determine that, in our professional judgment, your consent to receive treatment is clearly inferred from the circumstances.

State Law

We will not use or share your information if state law prohibits it. Some states have laws that are stricter than the federal privacy regulations, such as laws protecting HIV/AIDS information or mental health information. If a state law applies to us and is stricter or places limits on the ways we can use or share your health information, we will follow the state law. If you would like to know more about any applicable state laws, please ask our Privacy Officer.

We are required by law to maintain the privacy and security of your protected health information. We will promptly let you know if a breach occurs that may have compromised the privacy and security of your information. This notice is effective as of 2003 and we are required to abide by the terms of the Notice of Privacy Practices. We will not share your information other than described in here unless we receive written authorization. We can change the terms of notice, and any new notices will be available upon request, in our office, and on our website.

If you have any questions or want more information about this notice or how to exercise your health information rights, you may contact our Privacy Officer, Thomas Southam by mail at: 1011 East Ennis Ave., Suite A or telephone at 469-212-1707. You have the right to exercise any of the actions in the above document, and the Privacy Officer will guide you through the process.

☐ I do NOT authorize any information to be discussed with any family members or friends.
☐ I authorize information about treatment or appointments to be discussed with the following person(s):

_____

_____

I have read and understand the above information.

_____ _____
First Name Last Name Date of Birth

_____ _____
Patient Signature (or Authorized Representative) Date

For office use only

The following patient/authorized representative _____

☐ Refused to sign the Notice of Privacy Practices because _____

☐ Was unable to sign the Notice of Privacy Practices because _____

Date_____

MEDICAL HISTORY FORM

Patient Information:

Patient's Name:_____
Last First Middle Initial

Address: _____
Address City State Zip Code

Email Address: _____ SSN:_____ - ____ - _____ Date of Birth: _____/_____ / ____ Age: _____

Sex: ☐M ☐F Home No: _____ Cell No: _____ Alt. No: _____

Parent/Guardian Insurance Information: Relationship to Patient:_____ ☐ SELF

Name: _____
Last First Middle Initial

SSN:_____ - _____-_____ Insurance No.: _____ Driver License No.:_____

Date of Birth: _____ / ____ /_____ Insurance Telephone No.: _____ Group No.: _____
Employer: _____ Address: _____
Home No: _____ Cell No: _____ Work No: _____
Name and Number of nearest relative not living with you: _____

How did you hear about us? Please mark below:

☐ Online ☐ Flyer / Mail ☐ Printed Ad ☐ Billboard
☐ Radio ☐ TV ☐ Community Event ☐ Health Fair / Screening
☐ Dr. Referral ☐ Driving / Walking by the Office ☐ Medicaid ☐ Insurance / Employer
☐ Friend / Relative ☐ Employee ☐ Other (Specify) _____

Reason for today's dental visit: _____Date of last dental visit: _____

Have you ever had an experience in a dental office that you would like to tell us about? ☐ **Yes** **No**
Please explain if yes:_____

Are you nervous about dental treatment? ☐ **Yes** ☐ **No**
Do your gums bleed, feel tender or irritated? ☐ **Yes** ☐ **No**
Are you unhappy with appearance of your teeth? ☐ **Yes** ☐ **No**
Are your teeth sensitive? ☐ **Yes** ☐ **No**
Do you have discolored teeth that bother you? ☐ **Yes** ☐ **No**
If yes, to what? ☐ **Sweets** ☐ **Hot** ☐ **Cold** ☐ **Pressure**
Are you now seeing a physician? ☐ **Yes** ☐ **No** The name & telephone number of your physician(s)_____
If so, what is the condition being treated? _____
Are you taking any medications? ☐ **Yes** ☐ **No** If yes, please list: _____
Have you or are you currently taking Aspirin? ☐ **Yes** ☐ **No**
Do you use tobacco? ☐ **Yes** ☐ **No** If yes, what kind and how much? _____
Do you drink alcohol? ☐ **Yes** ☐ **No** If yes, how many units per week? _____
If female, are you or do you suspect to be pregnant? ☐ **Yes** ☐ **No** Months: _____
Have you or are you currently taking oral Bisphosphates? ☐ Actonel ☐ Boniva ☐ Fosamax ☐ Skelif ☐ Didrone ☐ Other _____
Have you had any joint replacements? ☐ **Yes** ☐ **No** If yes, when? _____
Is there anything else we should know about your health that was not covered on this form? ☐ **Yes** ☐ **No**
If yes, Please explain: _____

Please mark any of the following which you have had or have at present: ☐ **NONE**

☐ Heart Disease ☐ Anemia ☐ Nervousness ☐ HIV + AIDS
☐ Heart Murmur ☐ Kidney Trouble ☐ Thyroid Disease ☐ Hepatitis
☐ High Blood Pressure ☐ Bone Loss ☐ Chemo: (Cancer, Leukemia) ☐ Hemophilia
☐ Blood Disease ☐ Epilepsy or Seizures ☐ Arthritis ☐ Sickle Cell Disease
☐ Rheumatic Fever ☐ Ulcers ☐ Rheumatism ☐ Bruise Easily
☐ Venereal Disease ☐ Emphysema ☐ Cortisone Medicine ☐ Pain in Jaw Joint
☐ Heart Pacemaker ☐ Tuberculosis ☐ Joint Replacement ☐ Diabetes
☐ Asthma ☐ Scarlet Fever ☐ Hay Fever ☐ Glaucoma

Please mark any of the following medical allergies: ☐ **NONE**

☐ Local Anesthetics ☐ Penicillin ☐ Codeine or other narcotics ☐ Fen-Phen
☐ Aspirin ☐ Other antibiotic: ☐ Barbiturates or sedatives ☐ Other: _____
☐ Iodine ☐ Sulfa Drugs ☐ Latex ☐ Other: _____

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in myhealth, or if any medicines change, I will inform my dentist at the next appointment.

_____
Signature of Patient/Parent/Guardian

Medical History Update:

Dr. Date Dr. Date Dr. Date