

Patient Registration Form

Email:		Today's Date:		
<input type="checkbox"/> Miss <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Dr.		Preferred Name:		Referred by:
Name:		Home Phone:		Cell Phone:
Last	First	Middle	()	()
Address:		City:	State:	Zip:
SS #:		Date of Birth:	Sex: M F	
Employer:		Business Phone: ()		
Emergency Contact:		Relationship:	Phone #:	
Employment Status: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Retired				
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed				
Preferred Pharmacy:		Phone: ()		

Dental Insurance Information

Primary Insurance Information	
Name of Insured: _____	Relationship to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other
Soc Sec #: _____	Insured Birth Date: _____
Employer: _____	Ins. Company: _____
Address: _____	Address: _____
Address 2: _____	Address 2: _____
City, State, Zip: _____	City, State, Zip: _____
ID #: _____	Group #: _____
Secondary Insurance Company	
Name of Insured: _____	Relationship to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other
Insured Soc Sec #: _____	Insured Birth Date: _____
Employer: _____	Ins. Company: _____
Address: _____	Address: _____
Address 2: _____	Address 2: _____
City, State, Zip: _____	City, State, Zip: _____
ID #: _____	Group #: _____

Dental Information

	Yes	No		Yes	No
Do your gums bleed when you brush or floss?.....	<input type="checkbox"/>	<input type="checkbox"/>	Do you have earaches or neck pain?.....	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitive to cold, hot, sweets or pressure?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any clicking, popping in the jaw?	<input type="checkbox"/>	<input type="checkbox"/>
Is your mouth dry?.....	<input type="checkbox"/>	<input type="checkbox"/>	Do you brux or grind your teeth?.....	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any periodontal (gum) treatments?.....	<input type="checkbox"/>	<input type="checkbox"/>	Do you have sores or ulcers in your mouth?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any orthodontic (braces) treatments?.....	<input type="checkbox"/>	<input type="checkbox"/>	Do you wear dentures or partials?.....	<input type="checkbox"/>	<input type="checkbox"/>
Is your home water supply fluoridated?.....	<input type="checkbox"/>	<input type="checkbox"/>	Do you participate in active recreational activities?.....	<input type="checkbox"/>	<input type="checkbox"/>
Do you drink bottled or filtered water?.....	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had a serious injury to your mouth?.....	<input type="checkbox"/>	<input type="checkbox"/>
Are you currently experiencing dental pain or discomfort?	<input type="checkbox"/>	<input type="checkbox"/>	Date of last dental exam: _____		
Have you had any problems associated with previous dental treatments?.....	<input type="checkbox"/>	<input type="checkbox"/>	What was done: _____		

			Date of last dental x-rays: _____		
What is the reason for your dental visit today?					
How do you feel about your smile?					

Medical Information

<table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:50%;"></td> <td style="width:10%; text-align: center;">Yes</td> <td style="width:10%; text-align: center;">No</td> <td style="width:10%;"></td> <td style="width:10%; text-align: center;">Yes</td> <td style="width:10%; text-align: center;">No</td> </tr> <tr> <td>Are you now under the care of a physician?.....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Physicians Name: _____</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Phone #: (____) _____</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Address/City/State/Zip: _____</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </table>		Yes	No		Yes	No	Are you now under the care of a physician?.....	<input type="checkbox"/>	<input type="checkbox"/>				Physicians Name: _____						Phone #: (____) _____						Address/City/State/Zip: _____						<p>Have you had a serious illness or been Hospitalized in the past 5 years?..... <input type="checkbox"/> <input type="checkbox"/></p> <p>If yes, what was the illness or problem? _____</p>																																																																																																																																																																			
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<p>Are you in good health?..... <input type="checkbox"/> <input type="checkbox"/></p> <p>Has there been any change in your general health within the past year?..... <input type="checkbox"/> <input type="checkbox"/></p> <p>If yes, what condition was treated? _____</p> <p>Date of last physical: _____</p>	<p>Are you taking or have recently taken any Prescription or over the counter medicines?..... <input type="checkbox"/> <input type="checkbox"/></p> <p>If so, please list all _____</p>																																																																																																																																																																																																	
<p>Do you wear contact lenses?..... <input type="checkbox"/> <input type="checkbox"/></p>	<p>Do you use controlled substances (drugs)?..... <input type="checkbox"/> <input type="checkbox"/></p>																																																																																																																																																																																																	
<p>Are you taking, or have you taken, any diet drugs Such as Pondimin (fenfluramine), Redux, or Fen-phen (fenfluramine-phentermine combo)?..... <input type="checkbox"/> <input type="checkbox"/></p>	<p>Do you use tobacco?..... <input type="checkbox"/> <input type="checkbox"/></p> <p>If so, how interested are you in stopping? Circle one: VERY / SOMEWHAT / NOT INTERESTED</p>																																																																																																																																																																																																	
<p>Are you taking or scheduled to begin taking either Of the medications Fosamax or Actonel for Osteoporosis or Paget's disease?..... <input type="checkbox"/> <input type="checkbox"/></p>	<p>Do you drink alcoholic beverages?..... <input type="checkbox"/> <input type="checkbox"/></p> <p>If yes, how much alcohol did you drink in the last 24 hours? _____</p> <p>If yes, how much do you typically drink in a week? _____</p>																																																																																																																																																																																																	
<p>Since 2001, were you treated or are you presently scheduled to begin treatment with intravenous bisphosphonates (Aredia or Zometa) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?..... <input type="checkbox"/> <input type="checkbox"/></p>	<p>WOMEN ONLY Are you:</p> <p>Pregnant?..... <input type="checkbox"/> <input type="checkbox"/></p> <p>Number of weeks? _____</p> <p>Taking birth control or hormone replacements?..... <input type="checkbox"/> <input type="checkbox"/></p> <p>Nursing?..... <input type="checkbox"/> <input type="checkbox"/></p>																																																																																																																																																																																																	
<p>Joint Replacement. Have you had an orthopedic total joint replacement (hip, knee, elbow, finger)..... <input type="checkbox"/> <input type="checkbox"/></p> <p>Date: _____ If yes, have you had any complications? _____</p>																																																																																																																																																																																																		
<p>Allergies – Are you allergic to, or have you had a reaction to: Yes No</p> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:50%;"></td> <td style="width:10%; text-align: center;">Yes</td> <td style="width:10%; text-align: center;">No</td> <td style="width:10%;"></td> <td style="width:10%; text-align: center;">Yes</td> <td style="width:10%; text-align: center;">No</td> </tr> <tr> <td>To all yes responses, specify type of reaction</td> <td></td> <td></td> <td>Metals _____</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Local anesthetics _____</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Latex (rubber) _____</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Aspirin _____</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Iodine _____</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Penicillin or other antibiotics _____</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Hay fever / seasonal _____</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Barbiturates, sedatives, or sleeping pills _____</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Animals _____</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Sulfa drugs _____</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Food _____</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Codeine or other narcotics _____</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Other _____</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table>							Yes	No		Yes	No	To all yes responses, specify type of reaction			Metals _____	<input type="checkbox"/>	<input type="checkbox"/>	Local anesthetics _____	<input type="checkbox"/>	<input type="checkbox"/>	Latex (rubber) _____	<input type="checkbox"/>	<input type="checkbox"/>	Aspirin _____	<input type="checkbox"/>	<input type="checkbox"/>	Iodine _____	<input type="checkbox"/>	<input type="checkbox"/>	Penicillin or other antibiotics _____	<input type="checkbox"/>	<input type="checkbox"/>	Hay fever / seasonal _____	<input type="checkbox"/>	<input type="checkbox"/>	Barbiturates, sedatives, or sleeping pills _____	<input type="checkbox"/>	<input type="checkbox"/>	Animals _____	<input type="checkbox"/>	<input type="checkbox"/>	Sulfa drugs _____	<input type="checkbox"/>	<input type="checkbox"/>	Food _____	<input type="checkbox"/>	<input type="checkbox"/>	Codeine or other narcotics _____	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																													
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E. Reflux/ persistent heartburn.....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Type of infection _____</td> <td></td> <td></td> </tr> <tr> <td>Damaged heart valves.....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Systemic lupus erythematosus.....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Ulcers.....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Kidney problems.....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Low blood pressure.....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Asthma.....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Thyroid problems.....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Night sweats.....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>High blood pressure.....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Bronchitis.....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Stroke.....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Osteoporosis.....</td> <td style="text-align: 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E. Reflux/ persistent heartburn.....	<input type="checkbox"/>	<input type="checkbox"/>	Type of infection _____			Damaged heart valves.....	<input type="checkbox"/>	<input type="checkbox"/>	Systemic lupus erythematosus.....	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers.....	<input type="checkbox"/>	<input type="checkbox"/>	Kidney problems.....	<input type="checkbox"/>	<input type="checkbox"/>	Low blood pressure.....	<input type="checkbox"/>	<input type="checkbox"/>	Asthma.....	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems.....	<input type="checkbox"/>	<input type="checkbox"/>	Night sweats.....	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure.....	<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis.....	<input type="checkbox"/>	<input type="checkbox"/>	Stroke.....	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis.....	<input type="checkbox"/>	<input type="checkbox"/>	Heart attack.....	<input type="checkbox"/>	<input type="checkbox"/>	Empysema.....	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma.....	<input type="checkbox"/>	<input type="checkbox"/>	Persistent swollen glands in neck.....	<input type="checkbox"/>	<input type="checkbox"/>	Congenital heart defects.....	<input type="checkbox"/>	<input type="checkbox"/>	Sinus trouble.....	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis, jaundice or liver disease.....	<input type="checkbox"/>	<input type="checkbox"/>	Severe headaches/migraines.....	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker.....	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis.....	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy.....	<input type="checkbox"/>	<input type="checkbox"/>	STD.....	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic heart disease.....	<input type="checkbox"/>	<input type="checkbox"/>	Cancer/Chemotherapy/ radiation treatment.....	<input type="checkbox"/>	<input type="checkbox"/>	Fainting spells or seizures.....	<input type="checkbox"/>	<input type="checkbox"/>	Severe weight loss.....	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal bleeding.....	<input type="checkbox"/>	<input type="checkbox"/>							Excessive urination.....	<input type="checkbox"/>	<input type="checkbox"/>
	Yes	No		Yes	No		Yes	No																																																																																																																																																																																										
Heart murmur.....	<input type="checkbox"/>	<input type="checkbox"/>	Anemia.....	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain up exertion.....	<input type="checkbox"/>	<input type="checkbox"/>	Neurological disorders.....	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																							
Mitral valve prolapse.....	<input type="checkbox"/>	<input type="checkbox"/>	Blood transfusion.....	<input type="checkbox"/>	<input type="checkbox"/>	Chronic pain.....	<input type="checkbox"/>	<input type="checkbox"/>	If yes, specify _____																																																																																																																																																																																									
Artificial heart valve.....	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia.....	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes Type I or II.....	<input type="checkbox"/>	<input type="checkbox"/>	Sleep Disorder.....	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																							
Rheumatic fever.....	<input type="checkbox"/>	<input type="checkbox"/>	AIDS or HIV.....	<input type="checkbox"/>	<input type="checkbox"/>	Eating Disorder.....	<input type="checkbox"/>	<input type="checkbox"/>	Mental health disorder.....	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																							
Cardiovascular disease.....	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis.....	<input type="checkbox"/>	<input type="checkbox"/>	Malnutrition.....	<input type="checkbox"/>	<input type="checkbox"/>	If yes, specify _____																																																																																																																																																																																									
Congestive heart failure.....	<input type="checkbox"/>	<input type="checkbox"/>	Autoimmune disease.....	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal disease.....	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent infections.....	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																																																																																																							
Coronary artery disease.....	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid arthritis.....	<input type="checkbox"/>	<input type="checkbox"/>	G. E. Reflux/ persistent heartburn.....	<input type="checkbox"/>	<input type="checkbox"/>	Type of infection _____																																																																																																																																																																																									
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<p>Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?..... <input type="checkbox"/> <input type="checkbox"/></p> <p>Name of physician or dentist making recommendation: _____ Phone: () _____</p>																																																																																																																																																																																																		
<p>Do you have any disease, condition, or problem not listed above that you think I should know about?..... <input type="checkbox"/> <input type="checkbox"/></p> <p>Please explain: _____</p>																																																																																																																																																																																																		
<p>NOTE: Both Doctor and patient is encouraged to discuss any and all relevant patient health issues prior to treatment.</p> <p>I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquires set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.</p>																																																																																																																																																																																																		
<p>Signature of Patient/Legal Guardian: _____ Date: _____</p>																																																																																																																																																																																																		

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs and other diagnostic aids deemed appropriate by Dr. Wynn to make a thorough diagnosis of (name of patient) _____'s dental needs.
2. Upon such diagnosis, I authorize Dr. Wynn to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetics, sedatives and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
4. I give consent to Dr. Wynn or designated staff's use and disclose of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.
5. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon date, I understand that a 1-1/2% late charge (18% APR) may be added to my account (Minimum of \$10 per month) if account is not paid within 60 days. If required, I also understand a check of my credit history may be made.

Patient's Signature _____ Date _____

Parent/Responsible Party's Signature _____

Relationship to Patient _____

Witness _____

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 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 available upon request.

USES AND DISCLOSURES OF HEALTH INFORMATION

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

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

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

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

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us 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 communication 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 authorize federal official's 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 \$0.50 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 associated disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the 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.

Restrictions: 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 alternate locations. (You must make your request in writing) Your request must specify the alternative means or location and provide satisfactory explanations how payments will be handled under the alternative means or location you request.

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.

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 U.S. Department of Health and Human Services upon request.

We support your rights 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: Mary Ellen Wynn, D.D.S
Telephone: (513) 922-4221
Fax: (513) 922-5634
E-mail: office@drmewynn.com
Address: 3356 Muddy Creek Rd, Suite 200

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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

Please Print Name

Signature

Date

I authorize release of information about my dental treatment to:

SPOUSE PARENT CHILD OTHER _____

(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)
