DAVID C. VOCAL, DDS
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HIPAA Privacy Rule of Patient Authorization Agreement

Authorization for the Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.508(a))

I, _____, [patient] understand that as part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment;
- a means of communication among the health professionals who may contribute to my healthcare;
- a source of information for applying my diagnosis and surgical information to my bill;
- a means by which a third-party payer can verify that services billed were actually provided;
- a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I have read this facility's ***Notice of Privacy Practices*** [on the reverse side of this Agreement] which provides a more complete description of information uses and disclosures.

I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review this facility's notice prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified below for the purposes and to the parties designated by me.

Privacy Rule of Patient Consent Agreement

Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.506(a))

I understand that:

- I have the right to review this facility's Notice of Information practices prior to signing this consent;
- This facility reserves the right to change the notice and practices and that prior to implementation will mail a copy of any revised notice to the address I've provided if requested;
- I have the right to request restrictions as to how my protected health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that this facility is not required by law to agree to the restrictions requested.
- I may revoke this consent in writing at any time, except to the extent that this facility has already taken action in reliance thereon.
- It is this facility's procedure to share Protected Health Information with labs, x-rays, consulting physicians and hospitals. We will call the pharmacy of your choice regarding your prescriptions. We will only exchange minimum necessary Protected Health Information for each transaction.

_____ _____

Signature of Patient Witness

Printed Name: _____

Date: _____

DAVID C. VOCAL, DDS
NOTICE OF PRIVACY PRACTICES

This describes how health data about you may be used and shared and how you can get access to this data.

I. How we may use health data about you:

a. Treatment – We may use or share your health data to give you medical treatment or other types of health services.
b. Payment – We may use or share your health data to bill you or a third party for payment for services provided to you.
c. Health Care Operations – We may use and share health data about you for our own operations such as quality control, compliance monitoring, outcome evaluation, audit, etc.

II. Disclosures where we do not have to give you a chance to agree or object:

a. To you.
b. As required by federal, state, or law.
c. If child abuse or neglect is suspected.
d. Public health risks for public health activities to prevent and control of disease.
e. Lawsuits and disputes in response to a court or administrative order.
f. Law enforcement to help law enforcement officials respond to criminal activities.
g. Coroners, medical examiners, and funeral directors.
h. Organ and tissue donation facilities if you are an organ donor.
i. To avert a threat to individual or public health or safety.

III. Disclosures where we have to give you a chance to agree or object:

a. Patient directories – You can decide what health data, if any, you want to be listed in patient directories.
b. Persons involved in your care or payment for your care – we may share health data with a family member, a close friend or other person that you named as being involved with your health care.

IV. Other uses of health data: other uses not covered by this notice or the laws that apply to us will be made only with your written consent.

V. You have these rights for the health data we keep about you:

1. Right to inspect your health record and to receive a copy of your health record upon request.
2. Right to amend information in your health record you believe is inaccurate or incomplete.
3. Right to know to whom we have disclosed your health information.
4. Right to ask for limits on the health information data we give out about you.
5. Right to receive communication from us about your health information in alternative ways.
6. Right to a paper copy of the complete Notice of Privacy Practices.

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84 Maine Street - Brunswick, Maine 04011

NEW PATIENT INFORMATION FORM

NAME: (Last, First, Middle): _____ TITLE: _____

PREFERRED NAME: _____ SS #:_____ DOB:_____

ADDRESS: _____

CITY:_____ STATE: _____ ZIP: _____

HOME PHONE: (___)_____-_____ MARITAL: _____

WORK PHONE: (___)_____-_____ SEX: _____

CELL PHONE: (___)_____-_____ EMAIL: _____@_____

Who may we thank for referring you to our office? _____

How would you prefer we contact you to confirm your appointments? _____

Who should we contact in case of emergency? _____ TEL: _____

PRIMARY DENTAL INSURANCE COVERAGE

INSURED'S NAME: _____ RELATIONSHIP TO PATIENT _____

INSURED'S SS #: _____ DOB:_____

EMPLOYER:_____

INSURANCE PLAN: _____ GROUP # _____

INSURANCE ADDRESS: _____

SECONDARY DENTAL INSURANCE COVERAGE

INSURED'S NAME: _____ RELATIONSHIP TO PATIENT _____

INSURED'S SS #: _____ DOB:_____

EMPLOYER:_____

INSURANCE PLAN: _____ GROUP # _____

INSURANCE ADDRESS: _____

RESPONSIBLE PARTY FOR THE ACCOUNT

I understand that I am financially responsible for any deductibles, co-insurance, and/or any other service not paid or covered by my insurance company.

NAME: _____

ADDRESS: _____

SIGNATURE: _____DATE: _____

MEDICAL HISTORY

NAME:_____DOB:_____

Correct answers to the following questions will allow your dentist to treat you on a more individual basis, providing the care appropriate to your particular needs. Circle yes or no, whichever applies, in response to the following questions. Your answers are for our records only and will be considered confidential.

DENTAL

1. Are you having any discomfort at this time? YES ___ NO ___
2. Have you ever had any serious trouble associated with previous dental treatment?. YES ___ NO ___

If yes, please explain_____

3. Does dental treatment make you nervous? No ___ Slightly ____ Moderately ____ Extremely ____
4. When was your last dental cleaning?_____
5. Have you ever been treated for periodontal disease (gum disease, trench mouth)? YES ___ NO ___
6. How often do you brush your teeth? _____
   Brush type: Soft Medium Hard Electronic
7. Do you use any of the following? Floss Fluoride Rinse Other
8. Do you have or have had any of the following?

MOUTH		TEETH	
Bleeding / Sore gums	YES NO	Loose Teeth	YES NO
Unpleasant / Bad Breath	YES NO	Sensitive to Hot	YES NO
Swelling / Lumps in Mouth	YES NO	Sensitive to Cold	YES NO
Ortho Treatment (braces)	YES NO	Clenching / Grinding	YES NO
Clicking / Popping jaw	YES NO	Shifting in Bite	YES NO
Difficulty opening/closing jaw	YES NO	Change in Bite	YES NO
Frequent blisters, lip/mouth	YES NO		

MEDICAL

1. Has there been any change in your health within the last year? YES NO
2. My last physical examination was on _____
3. Are you now under the care of a physician? YES NO
   If yes, explain_____
4. The name and address of my primary physician is: _____
   _____
5. Have you had any serious illness within the past 5 years? YES NO
   If so, explain_____
6. Have you been hospitalized or had an operation within the past 5 years? YES NO
   If so, explain_____
7. Do you have or have you had any of the following disease or problems?
   a. Heart Murmur, rheumatic fever, or rheumatic heart disease?..... YES NO
   b. Mitral valve prolapse?..... YES NO
   c. Cardiovascular disease?..... YES NO
   d. High / Low Blood pressure?..... YES NO
   e. Artificial or replacement valves? ..... YES NO
   f. Pacemaker?..... YES NO

g. Sinus Trouble?.....YES NO
h. Asthma or hay fever? .....YES NO
i. Fainting spells? .....YES NO
j. Diabetes Type I or Type II? .....YES NO
k. If diabetic, have you taken insulin today? .....YES NO
l. Hepatitis, jaundice or liver disease? .....YES NO
m. Arthritis or inflammatory rheumatism? .....YES NO
n. Artificial or replacement joints?.....YES NO
o. Digestive disorders (ulcers or stomach disorders)? .....YES NO
p. Kidney trouble? .....YES NO
q. Tuberculosis? .....YES NO
r. Immune System Disorders (including AIDS, HIV, ARC)? .....YES NO
s. Venereal Disease? .....YES NO
t. Other? .....YES NO

8. Have you had abnormal bleeding with previous extractions, surgery, etc?
   a. Do you bruise easily? .....YES NO
   b. Have you ever had a blood transfusion?
   If so, explain circumstances and when? _____
9. Do you have a blood disorder such as anemia? .....YES NO
10. Have you had surgery or x-ray treatment for a tumor, growth, or condition?.....YES NO
11. Are you taking any of the following?
   a. Antibiotics or sulfa drugs? .....YES NO
   b. Anticoagulants (blood thinners)? .....YES NO
   c. Medicine for High blood pressure? .....YES NO
   d. Cortisone? .....YES NO
   e. Tranquilizers? .....YES NO
   f. Antihistamines? .....YES NO
   g. Aspirin? .....YES NO
   h. Insulin, tolutamide (Orinase) or similar drug for diabetes? .....YES NO
   i. Digitalis or drugs for heart trouble? .....YES NO
   j. Nitroglycerin? .....YES NO
   k. Other medications? If yes, please list:

_____

_____

_____

12. Are you allergic or have you reacted adversely to:
   a. Local anesthetics? .....YES NO
   b. Penicillin or other antibiotics? .....YES NO
   c. Sulfa drugs? .....YES NO
   d. Barbiturates, sedatives, or sleeping pills? .....YES NO
   e. Aspirin? .....YES NO
   f. Iodine? .....YES NO
   g. Codeine or other narcotics? .....YES NO
   h. Latex? .....YES NO
   i. Other?_____

13. Do you use any tobacco products? .....YES NO
If so, what and how much per day?_____
14. Do you use any alcohol products? .....YES NO
If so, how much per day / week / month and what?_____
15. Do you use any caffeinated products (coffee, tea, chocolate, etc.) .....YES NO
If so, how much per day and what?_____
16. Do you have any disease, condition, or problem not listed above?.....YES NO

If yes, please describe: _____

_____

17. Are you employed in any situation which exposes you regularly to x-rays or other radiation?
.....YES NO

WOMEN

18. Are you pregnant?.....YES NO
19. Are you taking birth control or hormone therapy.....YES NO

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

_____ _____
Signature of Patient/Guardian Today's Date