
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 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 privacy practices that are described in this Notice while it is in effect. This Notice takes effect 04/16/03, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of the Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy policies 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 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 questions. 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 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 providing performance, conducting training programs, accreditation, 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 the Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of the Notice. We may disclose your health information to a family member, friend or other person to the extent 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) 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 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 a reasonable inference 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 a 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 the Notice. If you request copies, we will charge you \$ 1.00 for each page, \$ 20.00 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 disclosures 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 the 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 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: Dr. Russell W. Roderick, DMD

Telephone: 480-515-0404 Fax: 480-515-2587

E-Mail: _____

Address: 26232 N. Tatum Boulevard, Suite 400

Phoenix, Arizona 85050

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(This Form is educational only, does not constitute legal advice, and covers only federal, not state, law in effect or proposed as of March 27, 2002. Subsequent law changes may require Form revision).

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF
PRIVACY PRACTICE**

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
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

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(This form is educational only, does not constitute legal advice, and covers only federal, not state, law in effect or proposed as of March 27, 2002. Subsequent law changes may require Form revision).

Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)
 Gender: _____ Family Status: _____
 Social Security #: _____ Birth Date: _____
 Phone (Home): _____ (Work): _____ (Cell): _____ (E-Mail): _____
 Address: _____
Street Apartment #

City State Zip Code

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

Are you allergic to any medications or substances? Please circle below:

Aspirin Penicillin Codeine Acrylic Metal Latex Rubber Dental Anesthesia Other (_____)

Women (Please Check): ___Pregnancy- (Due Date: _____) ___Trying to get pregnant ___Nursing
 ___Taking Oral Contraceptives – Discuss _____

Have you ever had any of the following? Please check those that apply:

*If yes to any of the starred conditions, please call prior to your appointment...premedication may be required.

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Fainting | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Allergies (Dust / Mold) | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Sulfa Allergy |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Growths | <input type="checkbox"/> Mitral Valve Prolapse* | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Artificial Joints * | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Renal Dialysis | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Heart Murmur* | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Valve* | <input type="checkbox"/> Rheumatic Fever | OTHER: |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Drug/Alcohol Addiction | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Stomach Problems | |
| <input type="checkbox"/> Ever Taken Phen-Fen* | <input type="checkbox"/> Jaundice | | |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Kidney Disease | | |

• Have you ever had any complications following dental treatment? Yes No
 If yes, please explain: _____

• Have you been admitted to a hospital or needed emergency care during the past two years? Yes No
 If yes, please explain: _____

• Are you now under the care of a physician? Yes No
 If yes, please explain: _____

Please list all medications you are currently taking: _____

• Name of Physician: _____ Phone: _____

• Do you have any health problems that need further clarification? Yes No
 If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

X _____ Date: _____
 Signature of patient, parent or guardian

Reviewed by
 Doctor _____ date: _____ BP _____
 History Review and Significant Findings _____

Referral Information

Whom May We Thank For Referring You To Our Practice? _____

Dental History

Please Circle

- | | YES | NO |
|--|-----|----|
| Do you have a specific dental problem? | | |
| Do you have dental examinations on a routine basis?
Last Visit _____
Last Cleaning _____ | | |
| Do you wear removable dental appliances? | | |
| Have you ever had orthodontic (braces) treatment? | | |
| Do you have spaces or crowding, misaligned teeth you wish could be taken care of without braces? | | |
| Have you ever had any periodontal (gum) treatments? | | |
| Do you have active decay or gum disease? | | |
| Do you brush and floss on a routine basis? Discuss _____ | | |
| Do your gums ever bleed? | | |
| Does your breath always feel fresh? | | |
| Are you aware or self-conscious of bad breath? | | |
| Does food catch between your teeth? | | |
| Do you have any loose teeth? | | |
| Are your teeth sensitive to cold, hot, sweets or pressure? | | |
| Do you want to keep your remaining teeth? | | |
| Do you have headaches, earaches or neck pains? | | |
| Do you ever have clicking, popping or discomfort in the jaw joint? | | |
| Do you Brux or Grind? | | |
| Have your past experiences in a dental office always been positive? | | |
| Do you smoke or chew tobacco? | | |
| Any sores or growths in your mouth? Discuss _____ | | |
| If we could offer you a simple, inexpensive way to whiten your teeth, would you be interested? | | |
| How do you feel about the appearance of your teeth? _____ | | |
| If you could change your smile, what would it be? _____ | | |

Employment Information

The following is for: _____ patient/guardian (please circle)

Employer Name: _____ Occupation: _____

Address: _____
Street City State Zip Code Phone

Insurance Information

Primary

Name of insured: _____ Is insured a patient? Yes/No

Last First MI

Insured's Birth Date: _____ ID# _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name: and Address: _____

Secondary

Name of Insured: _____ Is insured a patient? Yes/No

Last First MI

Insured's Birth Date: _____ ID#: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Address: _____

Consent for Services

I hereby grant permission to Dr. Roderick and members of his team to perform an examination, take necessary x-rays and/or oral impressions to determine a dental diagnosis and treatment recommendations. The method of treatment for proper dental care will be explained by Dr. Roderick and his team. I am free and encouraged to ask questions at any time. After dental treatment recommendations are determined and discussed with me, I grant permission for dental restorations, oral surgery, and the administration of anesthetics, analgesics, antibiotics, sedatives and emergency services to be performed. I grant permission to use my dental x-rays and/or photos taken in the office for display and educational purposes.

I have read the above Consent for Services. I understand and agree to their full content.

Signature of Patient, Parent, Guardian (Relationship to Patient)

Date