

Patient Information

Patient's Name	_____	_____	_____	Date	_____
	<small>Last</small>	<small>First</small>	<small>Middle</small>		
Address	_____	_____	_____	_____	_____
	<small>Street</small>	<small>City</small>	<small>State</small>	<small>Zip</small>	
Home Phone	_____	Cell Phone	_____	E-mail Address	_____
Birthdate	_____	Social Security #	_____		
If patient is a minor, give parent's or guardian's name _____					
Whom may we thank for referring you to our office? _____					

Responsible Party Information

Name	_____	_____	_____	_____	_____
	<small>Last</small>	<small>First</small>	<small>Middle</small>	<small>Marital Status</small>	
Residence	_____	_____	_____	_____	_____
	<small>Street</small>	<small>City</small>	<small>State</small>	<small>Zip</small>	
Mailing Address	_____	_____	_____	_____	_____
	<small>Street</small>	<small>City</small>	<small>State</small>	<small>Zip</small>	
How long at this address	_____	Home Phone	_____	Work Phone	_____
Previous Address (if less than 3 yrs.)	_____	_____	_____	_____	_____
	<small>Street</small>	<small>City</small>	<small>State</small>	<small>Zip</small>	
Social Security #	_____	Birthdate	_____	Relationship to Patient	_____
Employer	_____	Occupation	_____	No. Years Employed	_____
Spouse's Name	_____	_____	_____	_____	_____
	<small>Last</small>	<small>First</small>	<small>Middle</small>		
Employer	_____	Occupation	_____	No. Years Employed	_____
Social Security #	_____	Birthdate	_____	Work Phone	_____

Insurance Information

Insured's Name	_____	Insured's SS# or ID#	_____
Insurer's D.O.B.	_____	Insurance Phone #	_____
		Group No.	_____
Insurance Co. Name	_____		
Insured's Employer	_____		
Do you have dual coverage?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If yes: _____
Insured's Name	_____	Insured's SS# or ID#	_____
Insurance Company	_____	Insurance Phone #	_____
		Group No.	_____
Insurance Co. Address	_____		

Emergency Information

Name of nearest relative not living with you	_____
Complete Address	_____
Phone	_____

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor) _____

Updates (date & initial) _____

MEDICAL HEALTH

General Health (please check) EXCELLENT GOOD FAIR POOR

Name and address of physician _____

Last complete physical? _____

Are you taking any medication now? Yes No For what purpose? _____

Do you have or have you ever had:

- Heart disease..... Yes No
- Rheumatic fever..... Yes No
- Abnormal blood pressure..... Yes No
- Ulcers..... Yes No
- Tuberculosis or lung disease..... Yes No
- Diabetes..... Yes No
- Epilepsy..... Yes No
- Anemia..... Yes No
- Congenital heart lesions..... Yes No
- Headaches..... Yes No
- HIV-positive..... Yes No
- Cancer/Radiation Treatment..... Yes No
- Angina (Chest Pain)..... Yes No

- TB..... Yes No
- Heart murmur..... Yes No
- Asthma or hay fever..... Yes No
- Sinus trouble..... Yes No
- Hepatitis..... Yes No
- Arthritis..... Yes No
- Stroke..... Yes No
- Glaucoma..... Yes No
- Pacemaker..... Yes No
- AIDS..... Yes No
- Joint Replacements..... Yes No
- Dry Mouth..... Yes No

Are you allergic to: Penicillin Codeine Local injected anesthetics Other medications _____

Are you subject to prolonged bleeding? Yes No

Are you subject to fainting spells? Yes No

Do you have excessive urination and/or thirst? Yes No

(women)

Are you pregnant? Yes No Due date _____

DENTAL HEALTH

Reason for visit: _____

When was your last dental visit? _____

Have you ever had any serious problem associated with previous dental treatment? Yes No

Are you having any tooth or mouth pain? Yes No

Would you like to speak with us about straightening your teeth? Yes No

Overall, are you satisfied with the appearance of your teeth? Yes No

How often do you brush your teeth? _____

What texture brush do you use? SOFT MEDIUM HARD NYLON NATURAL

How often do you floss? _____

Do your gums bleed while brushing? Yes No

Do your gums bleed when flossing? Yes No

Do you avoid brushing any part of your mouth because of pain? Yes No

If yes, what part? _____

Portsmouth Dental Care
**ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES**

****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

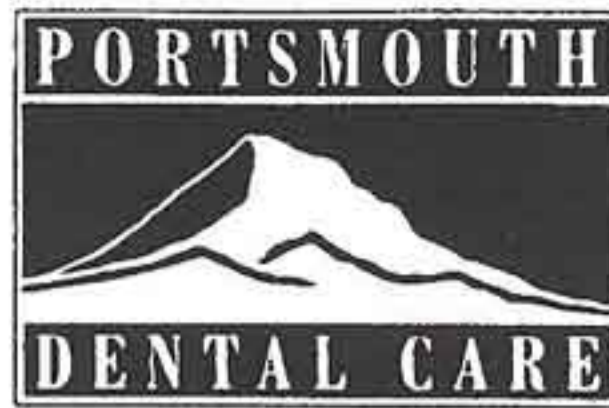
We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

© 2002 American Dental Association
All Rights Reserved

Reproduction and use of this form by dentists and their staff is permitted. Any other use, duplication or distribution of this form by any other party requires the prior written approval of the American Dental Association.

This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).



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 (01/01/2009), 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.

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 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 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 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 as voicemail messages, text messages, emails, 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 may 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.

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 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 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 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. James V. Frohnmayer

Telephone: 503-289-7043

Fax: 503-289-1425

E-mail: portsmouthdentalcare@comcast.net

Address: 5228 N Lombard St. Portland, OR 97203

©2002, 2009 American Dental Association. All Rights Reserved

Reproduction and use of this form by dentists and their staff is permitted. Any other use, duplication or distribution of this form by any other party requires the prior written approval of the American Dental Association.

This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002; April 30, 2009).