

PATIENT INFORMATION (Please Print)

NAME Dr. Mr. Mrs. Ms. _____
Last First Middle

Child Single Married Age _____ Date of Birth _____

Home Address _____ City _____ State _____ Zip _____

Mailing Address if Different _____

Home ☎ _____ Business ☎ _____ Ext. # _____ Social Security# _____

Employer _____ Occupation _____

Guardian / Spouse's Name _____ Person Responsible for Bill _____

Dental Insurance Yes No If Yes Group Carrier _____ Group# _____

Name of Primary Insured _____ SS# & DOB of Primary Insured _____

Employer of Primary Insured _____

Has any member of your family been treated in our office? Yes No Name _____

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

Call in case of emergency _____ Relationship _____ Phone _____

MEDICAL HEALTH

Name and address of Physician _____

Physician's Phone _____ Last complete physical _____

Please check those conditions that now or have ever pertained to you:

YES NO

- ARE YOU CURRENTLY UNDER THE CARE OF A PHYSICIAN?
- HEART MURMUR OR CONGENITAL HEART DEFECT
- HEART SURGERY OR HEART DISEASE
- MITRAL VALVE PROLAPSE
- HEART PACEMAKER
- ABNORMAL BLOOD PRESSURE HIGH / LOW
- BLEEDING PROBLEMS
- DIABETES
- KIDNEY DISEASE
- JAUNDICE OR LIVER DISEASE
- CANCER
- HEPATITIS
- HAVE YOU EVER TESTED H.I.V. POSITIVE?
- JOINT REPLACEMENT
- CONVULSIONS OR EPILEPSY
- DIZZINESS OR FAINTING SPELLS
- STROKE
- LUNG PROBLEMS OR TUBERCULOSIS
- THYROID DISEASE
- Drug Addiction

YES NO

- GLAUCOMA
- ULCERS
- ARTHRITIS
- BLOOD DISEASE IE ANEMIA
- SINUS TROUBLE
- ARE YOU PREGNANT?
- HAVE YOU EVER TAKEN ANY DRUGS FOR OSTEOPOROSIS SUCH AS FOSOMAX, BONIVA OR I.V. ZOMETIA OR AREDIA?

ARE YOU ALLERGIC OR SENSITIVE TO:

- PENICILLIN
 - ASPIRIN
 - CODEINE
 - DEMEROL
 - LATEX RUBBER
 - LOCAL ANAESTHETICS LIKE
 - NOVACAINE
- ALLERGIES NOT LISTED**
- _____
 - _____

List all prescription medications you are currently taking:

Medication

Purpose

To better coordinate your treatment, please list the professionals you have consulted regarding your present symptoms. Please be sure to list your primary physician and family dentist. Please initial if you want us to send them a report from your visit.

Initial _____ **FAMILY PHYSICIAN**
 Name _____
 Address _____
 Phone _____

Initial _____ **DENTIST**
 Name _____
 Address _____
 Phone _____

Initial _____ **CHIROPRACTOR**
 Name _____
 Address _____
 Phone _____

Initial _____ **PHYSICAL THERAPIST**
 Name _____
 Address _____
 Phone _____

Initial _____ **ENT**
 Name _____
 Address _____
 Phone _____

Initial _____ **CARDIOLOGIST**
 Name _____
 Address _____
 Phone _____

Initial _____ **ALLERGIST**
 Name _____
 Address _____
 Phone _____

Initial _____ **NEUROLOGIST**
 Name _____
 Address _____
 Phone _____

Initial _____ **PSYCHIATRIST**
 Name _____
 Address _____
 Phone _____

Initial _____ **PSYCHOLOGIST**
 Name _____
 Address _____
 Phone _____

Initial _____ **PULMONOLOGIST**
 Name _____
 Address _____
 Phone _____

Initial _____ **OTHER**
 Name _____
 Address _____
 Phone _____

- I understand and agree to have the indicated professionals I have listed above be sent initial information and ongoing updates regarding my diagnoses and treatment.
- I do not wish to have my records sent at this time.

I certify that the above information is correct to the best of my knowledge.

PATIENT/GUARDIAN SIGNATURE _____

DATE _____

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 the Notice while it is in effect. This Notice takes effect 04/01/2003 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 significant change in our privacy practices, we will change this Notice and make the new 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 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 is 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 Patients 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 expertise 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.

JC Goodwin, DMD
3185 Clearwater Dr. Suite B
Prescott, AZ. 86305
928-708-9444

Acknowledgement of Receipt Notice of Privacy Practices

****You may decline signing this acknowledgement should you choose****

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

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
 - Other _____
-