

## PATIENT INFORMATION (CONFIDENTIAL)

NAME \_\_\_\_\_ DATE \_\_\_\_\_  
FIRST MI LAST  
 ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE/PROV. \_\_\_\_\_ ZIP/P.C. \_\_\_\_\_  
 E-MAIL \_\_\_\_\_ CELL PHONE \_\_\_\_\_ HOME PHONE \_\_\_\_\_  
 SS#/SIN \_\_\_\_\_ BIRTHDATE \_\_\_\_\_  
 CHECK APPROPRIATE BOX:  MINOR  SINGLE  MARRIED  DIVORCED  WIDOWED  SEPARATED  
 IF COLLEGE STUDENT, F.T. / P.T., NAME OF SCHOOL \_\_\_\_\_ CITY \_\_\_\_\_ STATE/PROV. \_\_\_\_\_  
 PATIENT'S OR PARENT'S/GUARDIAN'S EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_  
 BUSINESS ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE/PROV. \_\_\_\_\_ ZIP/P.C. \_\_\_\_\_  
 SPOUSE OR PARENT'S/GUARDIAN'S NAME \_\_\_\_\_ EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_  
 WHOM MAY WE THANK FOR REFERRING YOU? \_\_\_\_\_  
 PERSON TO CONTACT IN CASE OF AN EMERGENCY \_\_\_\_\_ PHONE \_\_\_\_\_

## RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_  
 ADDRESS \_\_\_\_\_ HOME PHONE \_\_\_\_\_  
 DRIVER'S LICENSE # \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ SS#/SIN \_\_\_\_\_  
 EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_  
 IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE?  YES  NO

## INSURANCE INFORMATION

NAME OF INSURED \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_  
 BIRTHDATE \_\_\_\_\_ SS#/SIN \_\_\_\_\_ DATE EMPLOYED \_\_\_\_\_  
 NAME OF EMPLOYER \_\_\_\_\_ UNION OR LOCAL # \_\_\_\_\_ WORK PHONE \_\_\_\_\_  
 EMPLOYER ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE/PROV. \_\_\_\_\_ ZIP/P.C. \_\_\_\_\_  
 INSURANCE CO. \_\_\_\_\_ TEL. # \_\_\_\_\_ GRP # \_\_\_\_\_ POLICY / I.D. # \_\_\_\_\_  
 INS. CO. ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE/PROV. \_\_\_\_\_ ZIP/P.C. \_\_\_\_\_  
 HOW MUCH IS YOUR DEDUCTIBLE? \_\_\_\_\_ HOW MUCH HAVE YOU USED? \_\_\_\_\_ MAX ANNUAL BENEFIT? \_\_\_\_\_

DO YOU HAVE ANY ADDITIONAL INSURANCE?  YES  NO IF YES, COMPLETE THE FOLLOWING:

NAME OF INSURED \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_  
 BIRTHDATE \_\_\_\_\_ SS#/SIN \_\_\_\_\_ DATE EMPLOYED \_\_\_\_\_  
 NAME OF EMPLOYER \_\_\_\_\_ UNION OR LOCAL # \_\_\_\_\_ WORK PHONE \_\_\_\_\_  
 EMPLOYER ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE/PROV. \_\_\_\_\_ ZIP/P.C. \_\_\_\_\_  
 INSURANCE CO. \_\_\_\_\_ TEL. # \_\_\_\_\_ GRP # \_\_\_\_\_ POLICY / I.D. # \_\_\_\_\_  
 INS. CO. ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE/PROV. \_\_\_\_\_ ZIP/P.C. \_\_\_\_\_  
 HOW MUCH IS YOUR DEDUCTIBLE? \_\_\_\_\_ HOW MUCH HAVE YOU USED? \_\_\_\_\_ MAX ANNUAL BENEFIT? \_\_\_\_\_

ITEM 07-0515767/27000

**X**  
SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR

\_\_\_\_\_  
PATIENT NUMBER

# REGISTRATION

# PATIENT MEDICAL HISTORY

PATIENT'S NAME \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_

ALTHOUGH DENTAL PERSONNEL PRIMARILY TREAT THE AREA IN AND AROUND YOUR MOUTH, YOUR MOUTH IS A PART OF YOUR ENTIRE BODY. HEALTH PROBLEMS THAT YOU MAY HAVE, OR MEDICATION THAT YOU MAY BE TAKING, COULD HAVE AN IMPORTANT INTERRELATIONSHIP WITH THE DENTISTRY THAT YOU WILL BE RECEIVING. THANK YOU FOR ANSWERING THE FOLLOWING QUESTIONS.

	YES	NO		YES	NO
1. ARE YOU IN GOOD HEALTH .....	<input type="checkbox"/>	<input type="checkbox"/>	10. HAVE YOU EVER REQUIRED A BLOOD TRANSFUSION .....	<input type="checkbox"/>	<input type="checkbox"/>
2. HAVE THERE BEEN ANY CHANGES IN YOUR GENERAL HEALTH WITHIN THE PAST YEAR .....	<input type="checkbox"/>	<input type="checkbox"/>	11. HAVE YOU HAD A RECENT WEIGHT LOSS .....	<input type="checkbox"/>	<input type="checkbox"/>
3. DATE OF YOUR LAST PHYSICAL EXAM: _____			12. HAVE YOU EVER TAKEN FEN-PHEN/REDUX .....	<input type="checkbox"/>	<input type="checkbox"/>
4. PHYSICIAN'S NAME _____ ADDRESS _____ PHONE NO. _____			13. DO YOU USE TOBACCO .....	<input type="checkbox"/>	<input type="checkbox"/>
5. ARE YOU NOW UNDER THE CARE OF A PHYSICIAN .....	<input type="checkbox"/>	<input type="checkbox"/>	14. DO YOU OR HAVE YOU USED CONTROLLED SUBSTANCES .....	<input type="checkbox"/>	<input type="checkbox"/>
6. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS PLEASE EXPLAIN. _____	<input type="checkbox"/>	<input type="checkbox"/>	15. ARE YOU WEARING CONTACT LENSES .....	<input type="checkbox"/>	<input type="checkbox"/>
7. ARE YOU TAKING ANY MEDICINE(S) INCLUDING NON-PRESCRIPTION MEDICINE .... IF YES, WHAT MEDICINE(S) ARE YOU TAKING _____	<input type="checkbox"/>	<input type="checkbox"/>	16. DO YOU HAVE A PERSISTENT COUGH OR THROAT CLEARING NOT ASSOCIATED WITH A KNOWN ILLNESS (LASTING MORE THAN 3 WEEKS) .....	<input type="checkbox"/>	<input type="checkbox"/>
8. HAVE YOU HAD ANY ABNORMAL BLEEDING .....	<input type="checkbox"/>	<input type="checkbox"/>	17. DO YOU HAVE ANY DISEASE, CONDITION OR PROBLEM NOT LISTED ABOVE THAT YOU THINK I SHOULD KNOW ABOUT .....	<input type="checkbox"/>	<input type="checkbox"/>
9. DO YOU BRUISE EASILY .....	<input type="checkbox"/>	<input type="checkbox"/>	<b>WOMEN ONLY:</b> ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT .....		
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>

	YES	NO		YES	NO
<b>ARE YOU ALLERGIC TO OR HAVE YOU HAD REACTIONS TO:</b>			HIVES OR SKIN RASH .....	<input type="checkbox"/>	<input type="checkbox"/>
LOCAL ANESTHETICS LIKE NOVOCAINE .....	<input type="checkbox"/>	<input type="checkbox"/>	FAINTING OR DIZZY SPELLS .....	<input type="checkbox"/>	<input type="checkbox"/>
PENICILLIN OR OTHER ANTIBIOTICS .....	<input type="checkbox"/>	<input type="checkbox"/>	DIABETES .....	<input type="checkbox"/>	<input type="checkbox"/>
SULFA DRUGS .....	<input type="checkbox"/>	<input type="checkbox"/>	AIDS OR HIV INFECTION .....	<input type="checkbox"/>	<input type="checkbox"/>
BARBITURATES, SEDATIVES OR SLEEPING PILLS ..	<input type="checkbox"/>	<input type="checkbox"/>	THYROID PROBLEMS .....	<input type="checkbox"/>	<input type="checkbox"/>
ASPIRIN .....	<input type="checkbox"/>	<input type="checkbox"/>	ALLERGIES .....	<input type="checkbox"/>	<input type="checkbox"/>
IODINE .....	<input type="checkbox"/>	<input type="checkbox"/>	ARTHRITIS OR RHEUMATISM .....	<input type="checkbox"/>	<input type="checkbox"/>
ANY METALS (E.G., NICKEL, MERCURY, ETC.) ....	<input type="checkbox"/>	<input type="checkbox"/>	JOINT REPLACEMENT OR IMPLANT .....	<input type="checkbox"/>	<input type="checkbox"/>
LATEX / RUBBER .....	<input type="checkbox"/>	<input type="checkbox"/>	STOMACH ULCER .....	<input type="checkbox"/>	<input type="checkbox"/>
OTHER (PLEASE LIST) _____			KIDNEY TROUBLE .....	<input type="checkbox"/>	<input type="checkbox"/>
<b>DO YOU HAVE OR HAVE YOU EVER HAD THE FOLLOWING:</b>			TUBERCULOSIS .....	<input type="checkbox"/>	<input type="checkbox"/>
RHEUMATIC HEART DISEASE OR RHEUMATIC FEVER	<input type="checkbox"/>	<input type="checkbox"/>	PERSISTENT COUGH .....	<input type="checkbox"/>	<input type="checkbox"/>
SCARLET FEVER .....	<input type="checkbox"/>	<input type="checkbox"/>	COUGH THAT PRODUCES BLOOD .....	<input type="checkbox"/>	<input type="checkbox"/>
HEART DEFECT OR HEART MURMUR .....	<input type="checkbox"/>	<input type="checkbox"/>	CHEMOTHERAPY (CANCER, LEUKEMIA) .....	<input type="checkbox"/>	<input type="checkbox"/>
HEART TROUBLE, HEART ATTACK, OR ANGINA ...	<input type="checkbox"/>	<input type="checkbox"/>	SEXUALLY TRANSMITTED DISEASE .....	<input type="checkbox"/>	<input type="checkbox"/>
CHEST PAIN .....	<input type="checkbox"/>	<input type="checkbox"/>	EPILEPSY OR SEIZURES .....	<input type="checkbox"/>	<input type="checkbox"/>
SHORTNESS OF BREATH .....	<input type="checkbox"/>	<input type="checkbox"/>	ANEMIA .....	<input type="checkbox"/>	<input type="checkbox"/>
PACEMAKER .....	<input type="checkbox"/>	<input type="checkbox"/>	GLAUCOMA .....	<input type="checkbox"/>	<input type="checkbox"/>
HEART SURGERY .....	<input type="checkbox"/>	<input type="checkbox"/>	NERVOUSNESS .....	<input type="checkbox"/>	<input type="checkbox"/>
HIGH/LOW BLOOD PRESSURE .....	<input type="checkbox"/>	<input type="checkbox"/>	TONSILLITIS .....	<input type="checkbox"/>	<input type="checkbox"/>
CONGENITAL HEART PROBLEM .....	<input type="checkbox"/>	<input type="checkbox"/>	TUMORS .....	<input type="checkbox"/>	<input type="checkbox"/>
SWELLING OF FEET, ANKLES, HANDS .....	<input type="checkbox"/>	<input type="checkbox"/>	MENTAL HEALTH CARE .....	<input type="checkbox"/>	<input type="checkbox"/>
HEPATITIS, JAUNDICE OR LIVER DISEASE .....	<input type="checkbox"/>	<input type="checkbox"/>	BACK PROBLEMS .....	<input type="checkbox"/>	<input type="checkbox"/>
STROKE .....	<input type="checkbox"/>	<input type="checkbox"/>	CHEMICAL DEPENDENCY .....	<input type="checkbox"/>	<input type="checkbox"/>
SINUS TROUBLE .....	<input type="checkbox"/>	<input type="checkbox"/>	MITRAL VALVE PROLAPSE .....	<input type="checkbox"/>	<input type="checkbox"/>
LUNG OR BREATHING PROBLEMS .....	<input type="checkbox"/>	<input type="checkbox"/>	CORTISONE TREATMENT .....	<input type="checkbox"/>	<input type="checkbox"/>
ASTHMA OR HAY FEVER .....	<input type="checkbox"/>	<input type="checkbox"/>	COLD SORES/FEVER BLISTERS .....	<input type="checkbox"/>	<input type="checkbox"/>
			HYPOGLYCEMIA .....	<input type="checkbox"/>	<input type="checkbox"/>
			EATING DISORDERS .....	<input type="checkbox"/>	<input type="checkbox"/>

ITEM 07-0515775/27011

PATIENT NUMBER \_\_\_\_\_

# PATIENT DENTAL HISTORY

PATIENT'S NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

REASON FOR THIS VISIT \_\_\_\_\_

WHEN WAS YOUR LAST DENTAL VISIT \_\_\_\_\_ WHAT WAS DONE THEN \_\_\_\_\_

HOW OFTEN DID YOU VISIT THE DENTIST BEFORE THEN \_\_\_\_\_

PREVIOUS DENTIST (NAME AND LOCATION) \_\_\_\_\_

HAVE YOU HAD A COMPLETE SERIES OF DENTAL FILMS (X-RAYS) TAKEN WHEN WHERE \_\_\_\_\_

HOW OFTEN DO YOU BRUSH YOUR TEETH \_\_\_\_\_ HOW OFTEN DO YOU FLOSS YOUR TEETH \_\_\_\_\_

IS YOUR DRINKING WATER FLUORIDATED \_\_\_\_\_

	YES	NO		YES	NO
DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING.....	<input type="checkbox"/>	<input type="checkbox"/>	DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY.	<input type="checkbox"/>	<input type="checkbox"/>
ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOODS.....	<input type="checkbox"/>	<input type="checkbox"/>	HAVE YOU NOTICED ANY LOOSENING OF YOUR TEETH.....	<input type="checkbox"/>	<input type="checkbox"/>
ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS/FOODS.....	<input type="checkbox"/>	<input type="checkbox"/>	DOES FOOD TEND TO BECOME CAUGHT BETWEEN YOUR TEETH.....	<input type="checkbox"/>	<input type="checkbox"/>
DO YOU FEEL PAIN TO ANY OF YOUR TEETH.....	<input type="checkbox"/>	<input type="checkbox"/>	HAVE YOU EVER HAD PERIODONTAL TREATMENT (GUMS).....	<input type="checkbox"/>	<input type="checkbox"/>
DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH.....	<input type="checkbox"/>	<input type="checkbox"/>	EVER WORN A BITE PLATE OR OTHER APPLIANCE ..	<input type="checkbox"/>	<input type="checkbox"/>
HAVE YOU HAD ANY HEAD, NECK OR JAW INJURIES.	<input type="checkbox"/>	<input type="checkbox"/>	HAVE YOU EVER HAD ANY DIFFICULT EXTRACTIONS IN THE PAST.....	<input type="checkbox"/>	<input type="checkbox"/>
HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING PROBLEMS IN YOUR JAW?			HAVE YOU EVER HAD ANY PROLONGED BLEEDING FOLLOWING EXTRACTIONS.....	<input type="checkbox"/>	<input type="checkbox"/>
CLICKING.....	<input type="checkbox"/>	<input type="checkbox"/>	DO YOU WEAR DENTURES OR PARTIALS.....	<input type="checkbox"/>	<input type="checkbox"/>
PAIN (JOINT, EAR, SIDE OF FACE).....	<input type="checkbox"/>	<input type="checkbox"/>	IF YES, DATE OF PLACEMENT _____		
DIFFICULTY IN OPENING OR CLOSING.....	<input type="checkbox"/>	<input type="checkbox"/>	HAVE YOU EVER RECEIVED ORAL HYGIENE INSTRUCTIONS REGARDING THE CARE OF YOUR TEETH AND GUMS.....	<input type="checkbox"/>	<input type="checkbox"/>
DIFFICULTY IN CHEWING.....	<input type="checkbox"/>	<input type="checkbox"/>			
DO YOU HAVE FREQUENT HEADACHES.....	<input type="checkbox"/>	<input type="checkbox"/>			
DO YOU CLENCH OR GRIND YOUR TEETH.....	<input type="checkbox"/>	<input type="checkbox"/>			

IF YOU COULD CHANGE ANYTHING ABOUT YOUR SMILE, WHAT WOULD YOU CHANGE? \_\_\_\_\_

\_\_\_\_\_

**AUTHORIZATION AND RELEASE**

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION TO THE BEST OF MY KNOWLEDGE. THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I AUTHORIZE THE DENTIST TO RELEASE ANY INFORMATION INCLUDING THE DIAGNOSIS AND THE RECORDS OF ANY TREATMENT OR EXAMINATION RENDERED TO ME OR MY CHILD DURING THE PERIOD OF SUCH DENTAL CARE TO THIRD PARTY PAYORS AND/OR HEALTH PRACTITIONERS. I AUTHORIZE AND REQUEST MY \_\_\_\_\_

INSURANCE COMPANY TO PAY DIRECTLY TO THE DENTIST OR DENTAL GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I UNDERSTAND THAT MY DENTAL INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL BILL FOR SERVICES. I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON MY BEHALF OR MY DEPENDENTS.

\_\_\_\_\_ DATE \_\_\_\_\_

SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR

DOCTOR'S COMMENTS \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_ SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

PATIENT NUMBER \_\_\_\_\_

**KING FAMILY DENTAL  
1293 E. MCANDREWS RD.  
MEDFORD, OR 97504  
541-772-1215 (FAX) 541-772-3210  
drking@kingfamilydental.net**

## **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**

Federal and state law requires us to maintain the privacy of your health information. That law also requires us to give you 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 applicable law permits the changes. 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 beginning of this notice.

### **USES AND DISCLOSURES OF HEALTH INFORMATION**

We use and disclose health information about you for treatment, payment, and health care operations. For example: **TREATMENT:** We may use your health information for treatment or disclose it to a dentist, physician, or other health care provider providing treatment to you.

**PAYMENT:** We may use and disclose your health information to obtain payment for services we provide to you. We may also disclose our health information to another health care provider or entity that is subject to the federal Privacy rules for its payment activities.

**HEALTH CARE OPERATIONS:** We may use and disclose your health information for our health care operations. Health care operations include quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities. We may disclose your health information to another health care provider or organization that is subject to the federal privacy rules and that has a relationship with you to support some of their health care operations. We may disclose your information to help these organizations conduct quality assessment and improvement activities, review the competence or qualifications of health care professionals, or detect or prevent health care fraud and abuse.

**ON YOUR AUTHORIZATION:** 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 uses or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose our health information for any reason except those described in this notice.

**TO YOUR FAMILY AND FRIENDS:** We may disclose your health information to a family member, friend or other person to the extent necessary to help with your health care or with payment for your health care. Before we disclose your health information to these people, we will provide you with an opportunity to object to our use or disclosure. If you are not present, or in the event of your incapacity or an emergency, we will disclose your medical information information based on our professional judgment of whether the disclosure would be in your best interest. We may 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, medial supplies, x-rays, or other similar forms of health information. We may use or disclose information about you to notify or assist in notifying a person involved in your care, of your location and general condition.

**APPOINTMENT REMINDERS:** We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters.)

**DISASTER RELIEF:** We may use or disclose your health information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

**PUBLIC BENEFIT:** We may use or disclose your medical information as authorized by law for the following purposes deemed to be in the public interest or benefit:

- As required by law
- For public health activities, including disease and vital statistic reporting, child abuse reporting, FDA oversight, and to employers regarding work-related illness or injury
- To report adult abuse, neglect, or domestic violence
- To agencies or supervisors of health
- In response to court and administrative orders and other lawful processes
- To law enforcement officials pursuant to subpoenas and other lawful processes, concerning crime victims, suspicious deaths, crimes on our premises, reporting crimes in emergencies, and for purposes of identifying or locating a suspect or other person
- To coroners, medical examiners, and funeral directors
- To an organ procurement organization
- To avert a serious threat to health or safety
- In connection with certain research activities
- To the military and to federal officials for lawful intelligence, counterintelligence, and national security activities
- To correctional institutions regarding inmates
- As authorized by state worker's compensation laws.

## 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 request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge you a reasonable cost-based fee that may include labor, copying costs, and postage. 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 may-but are not required to-prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the beginning of this notice for more information about fees.

**DISCLOSURE ACCOUNTING:** You have the right to receive a list of instances in which we or our business associates disclosed your health information over the last 6 years (but not before April 14, 2003). That list will not include disclosures for treatment, payment, health care operations, as authorized by you, and for certain other activities. If you request this accounting more than once in a 12-month periods, we may charge you a reasonable, cost-based fee for responding to these additional request. Contact us using the information listed at the beginning of this notice for more information about fees.

**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). Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. Your request is no binding unless our agreement is in writing.

**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. You must specify in your request the alternative means or location, and provide satisfactory explanation how you will handle payment 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 we should amend the information. We may deny your request under certain circumstances.

## QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us using the information listed at the beginning of this notice. If you believe that:

- We may have violated your privacy rights
- We made a decision about access to your health information incorrectly
- Our response to a request you made to amend or restrict the use or disclosure of your health information was incorrect
- We should communicate with you by alternative means or at alternative locations

You may contact us using the information listed above. 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.

**King Family Dental, PC  
1293 E McAndrews Rd  
Medford, OR 97504  
541-772-1215  
541-772-3210 (fax)**

**SECTION A: The Patient**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ Email: \_\_\_\_\_

**SECTION B: Acknowledgement of receipt of Privacy Practices Notice:**

\_\_\_\_\_, acknowledge that I have received a Notice of Privacy Practices from the above named practice.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I give permission for the following individual(s) to discuss my treatment or account as needed with King Family Dental.

Name: \_\_\_\_\_

Relationship to Individual: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**SECTION C: Good Faith Effort to Obtain Acknowledgement of Receipt.**

Describe your good faith effort to obtain the individual's signature on this form: \_\_\_\_\_

\_\_\_\_\_

Describe the reason why the individual would no sign this form: \_\_\_\_\_

\_\_\_\_\_

**SIGNATURE:**

I certify that the above information is correct.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Your Name: \_\_\_\_\_ Title: \_\_\_\_\_

This acknowledgement of receipt to be placed in the individual's records.

# DENTAL TREATMENT CONSENT FORM

Patient Name \_\_\_\_\_

Birthdate \_\_\_\_\_

*Please read and initial the items checked below. Then read and sign the section at the bottom of form.*

**1. WORK TO BE DONE**

I understand that I am having the following work done: Fillings \_\_\_\_\_ Bridges \_\_\_\_\_ Crowns \_\_\_\_\_ Extractions \_\_\_\_\_  
Impacted teeth removed \_\_\_\_\_ General Anesthesia \_\_\_\_\_ Root Canals \_\_\_\_\_ Other \_\_\_\_\_  
(Initials \_\_\_\_\_)

**2. DRUGS AND MEDICATIONS**

I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction).  
(Initials \_\_\_\_\_)

**3. CHANGES IN TREATMENT PLAN**

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary.  
(Initials \_\_\_\_\_)

**4. REMOVAL OF TEETH**

Alternatives to removal have been explained to me (root canal therapy, crowns, and periodontal surgery, etc.) and I authorize the Dentist to remove the following teeth \_\_\_\_\_ and any others necessary for reasons in paragraph #3. I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue (Paresthesia) that can last for an indefinite period of time (days or months) or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility.  
(Initials \_\_\_\_\_)

**5. CROWN, BRIDGES AND CAPS**

I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown, bridge, or cap (including shape, fit, size, and color) will be before cementation.  
(Initials \_\_\_\_\_)

**6. DENTURES, COMPLETE OR PARTIAL**

I realize that full or partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The problems of wearing these appliances have been explained to me, including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new dentures (including shape, fit, size, placement, and color) will be the "teeth in wax" try-in visit. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not included in the initial denture fee.  
(Initials \_\_\_\_\_)

**7. ENDODONTIC TREATMENT (ROOT CANAL)**

I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment, and that occasionally metal objects are cemented in the tooth or extend through the root, which does not necessarily affect the success of the treatment, I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy).  
(Initials \_\_\_\_\_)

**8. PERIODONTAL LOSS (TISSUE & BONE)**

I understand that I have a serious condition, causing gum and bone infection or loss and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including gum surgery, replacements and/or extractions. I understand that undertaking any dental procedures may have a future adverse effect on my periodontal condition.  
(Initials \_\_\_\_\_)

I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot guarantee results. I acknowledge that no guarantee or assurance has been made to me by anyone regarding the dental treatment that I have requested and authorized for my self or my minor child. I have had full opportunity to discuss and ask questions regarding the dental treatment, and all questions have been answered to my satisfaction.

\_\_\_\_\_  
Signature of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Please print name of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Relationship to Patient