SISKIYOU ENDODONTICS

PATIENT INFORMATION (Please Print)

Name: _____
Birth Date: _____ **Male** _____ **Female** _____
Mailing Address: _____
City: _____ **State:** _____ **Zip Code:** _____
Phones: Home: _____ **Work:** _____ **Ext:** _____
Mobile: _____ **Email:** _____
Employer: _____ **Phone:** _____
Referred By: _____ **General Dentist:** _____
Spouse Name: _____

PERSON RESPONSIBLE FOR ACCOUNT (if other than patient)

First Name: _____ **MI:** _____ **Last Name:** _____
Relationship to Patient: _____ **Birth Date:** _____
Mailing Address: _____
City: _____ **State:** _____ **Zip Code:** _____

Phones: Home: _____ **Work:** _____ **Ext:** _____
Mobile: _____ **Employer:** _____

DENTAL INSURANCE INFORMATION

Primary Insurance	Secondary Insurance
Ins. Co: _____	**Ins. Co:** _____
Group #: _____	**Group #:** _____
Phone: _____	**Phone:** _____
Employer: _____	**Employer:** _____
Employee (if other than patient)	**Employee (if other than patient)**
Name: _____	**Name:** _____
Birth Date: _____ **Soc. Sec.:**_____	**Birth Date:** _____ **Soc. Sec.:**_____
Subscriber #: _____	**Subscriber #:** _____

I certify that the above information is accurate and I agree that Siskiyou Endodontics may bill my insurance for any necessary treatment. I also understand that my insurance may not pay as much as estimated and that I am responsible for any unpaid treatment.

Patient/Parent/Guardian Signature: _____**Date:** _____

HEALTH HISTORY

Name _____ Birthdate _____

Please answer the following questions:

Are you in good health? Y N

Physician Name _____ When last seen _____

Have you ever had an unfavorable reaction following dental treatment? Y N

Have you ever experienced excessive bleeding requiring special treatment? Y N

Have you ever been required to take Premedication prior to dental treatment? Y N

Have you had prosthetic joint replacement? Y N If so, when? _____

Please circle any of the following you have or have had:

Stroke	Asthma	Kidney trouble	Heart trouble	Tuberculosis
Diabetes	Epilepsy	High Blood Pressure	Jaundice	Mitral Valve Prolapse
Hepatitis	Cancer	Rheumatic Fever	Nervous disorders	

Have you ever been diagnosed with an immune system deficiency or compromised? Y N

Are you currently, or have you ever taken a bisphosphonate class of medication (eg: Zometa, Aredia, Fosamax, Boniva)? Y N If so, please explain

Female patients: Are you pregnant? Y N If so, which month?

Are you sensitive or allergic to Latex, Penicillin, Sulfa or any other medication? Y N If so, please list.

Are you taking any medication now? Y N If so, please list.

The above medical history is accurate to the best of my knowledge. I, the undersigned, consent to the performing of any procedure necessary to evaluate, diagnose and treat my condition. I authorize and request the administration of such drugs and/or anesthetics as may be deemed advisable by the dentist. I have also received a copy of this office's Privacy Practices. (HIPAA)

Patient/Parent/Guardian Signature _____ Date_____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information used or disclosed to us in any form, whether electronically, on paper, or orally, to be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by law, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment and health care operations.

- **Treatment** means providing, coordinating or managing health care and related services by one or more health care providers. For example, we may need to share information with other health care providers or specialists involved in the continuation of your care.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. For example, we may disclose treatment information when billing a dental plan for your dental services.
- **Health Care Operations** include the business aspects of running our practice. For example, patient information may be used for training purposes, or quality assessment.

Unless you request otherwise, we may use or disclose health information to a family member, friend, personal representative, or other individual to the extent necessary to help with your health care or with payment for your health care. In the event of an emergency or your incapacity, we will use our professional judgment in disclosing only the protected health information necessary to facilitate needed care. In addition, we may use your confidential information to remind you of appointments by sending reminder postcards and/or leaving messages at home and/or work. Your protected health information may also be used by our office to recommend treatment alternatives or to provide you with information about health related benefits and services that may be of interest to you. In addition, we may disclose your health information for public health oversight activities, judicial or administrative proceedings in response to a subpoena or court order, or to military authorities of Armed Forces personnel, to federal officials for lawful intelligence, counterintelligence, and other national security activities, to correctional institutions or law enforcement officials, and/or to report suspected abuse, neglect, or domestic violence. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have certain rights in regards to your protected health information, which you may exercise by presenting a written request to our Privacy Officer at the practice listed below:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to request to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to access, inspect and copy your protected health information, with limited exceptions. A reasonable fee may be assessed.
- The right to request an amendment to your protected health information. We may deny your request in certain situations.
- The right to receive an accounting of disclosures of protected health information made outside of treatment, payment, or health care operations…or based on your previous authorization.
- The right to obtain a paper copy of this notice from us upon request, even if you have agreed to receive the notice electronically.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of August 1, 2008, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office. You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about our Privacy Practices, please contact:
Privacy Officer: Kelly Cox
Office Name: Siskiyou Endodontics
Address: 254 Palm Ave
City, State, Zip: Ashland, OR 97520
Phone: 541-482-9654

For more information about HIPAA or to file a complaint:
The US Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, SW
Washington, DC 20201
877-696-6775 (toll-free)