

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name _____

Relationship to Patient: _____

Signature: _____

Date _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date	Initials	Reason:

Ross K. Palioca, D.M.D., P.C.
Advanced Dental Practices
21 East Street
Wrentham, MA 02093

Name _____

Address _____

City/Town: _____ State: _____ Zip Code _____

Home phone: _____ Work phone: _____

Cell phone: _____ Email address: _____

Date of Birth: _____ Male: _____ Female: _____

Social Security Number (for insurance purposes): _____

Primary Dental Insurance: _____

Policy Holder: _____

Date of Birth: _____ Social Security Number: _____

Employer: _____

ID#: _____ Group#: _____

If Full-Time student, please list name and address of the college/university:

I understand that my dental insurance is a contract between the insurance carrier and me and **NOT** between the insurance carrier and the dentist. Therefore, I am still responsible for **ALL** dental fees. I understand that I will be charged for all dental treatment and that any payments received by the dental office from my insurance company will be credited to my account or refunded to me if I have paid for the treatment.

I agree to be responsible for all charges for dental services and materials not paid by my dental insurance plan, unless the treating dentist has a contractual agreement with my plan, prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to this claim.

Signature: _____ Date: _____

I hereby authorize payment of the dental benefits otherwise payable to me directly to the above named dental entity.

Signature: _____ Date: _____

Since I do not have dental insurance, I agree to be responsible for **ALL CHARGES** for dental services and materials.

Signature: _____ Date: _____

Ross K. Palioca, D.M.D., P.C.

Advanced Dental Practices

Medical History

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 you will receive. Thank you for answering the following questions.

Are you under a physician's care now? Yes No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: _____

Have you ever had a serious head or neck injury? Yes No If yes, please explain: _____

Are you taking any medications, pills, or drugs? Yes No If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux? Yes No _____

Are you on a special diet? Yes No _____

Do you use tobacco? Yes No _____

Do you use controlled substances? Yes No _____

Women: Are you _____

Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following? _____

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics

Other If yes, please explain: _____

Do you have, or have you had, any of the following? _____

<p>AIDS/HIV Positive <input type="radio"/> Yes <input type="radio"/> No</p> <p>Alzheimer's Disease <input type="radio"/> Yes <input type="radio"/> No</p> <p>Anaphylaxis <input type="radio"/> Yes <input type="radio"/> No</p> <p>Anemia <input type="radio"/> Yes <input type="radio"/> No</p> <p>Angina <input type="radio"/> Yes <input type="radio"/> No</p> <p>Arthritis/Gout <input type="radio"/> Yes <input type="radio"/> No</p> <p>Artificial Heart Valve <input type="radio"/> Yes <input type="radio"/> No</p> <p>Artificial Joint <input type="radio"/> Yes <input type="radio"/> No</p> <p>Asthma <input type="radio"/> Yes <input type="radio"/> No</p> <p>Blood Disease <input type="radio"/> Yes <input type="radio"/> No</p> <p>Blood Transfusion <input type="radio"/> Yes <input type="radio"/> No</p> <p>Breathing Problem <input type="radio"/> Yes <input type="radio"/> No</p> <p>Bruise Easily <input type="radio"/> Yes <input type="radio"/> No</p> <p>Cancer <input type="radio"/> Yes <input type="radio"/> No</p> <p>Chemotherapy <input type="radio"/> Yes <input type="radio"/> No</p> <p>Chest Pains <input type="radio"/> Yes <input type="radio"/> No</p> <p>Cold Sores/Fever Blisters <input type="radio"/> Yes <input type="radio"/> No</p> <p>Congenital Heart Disorder <input type="radio"/> Yes <input type="radio"/> No</p> <p>Convulsions <input type="radio"/> Yes <input type="radio"/> No</p>	<p>Cortisone Medicine <input type="radio"/> Yes <input type="radio"/> No</p> <p>Diabetes <input type="radio"/> Yes <input type="radio"/> No</p> <p>Drug Addiction <input type="radio"/> Yes <input type="radio"/> No</p> <p>Easily Winded <input type="radio"/> Yes <input type="radio"/> No</p> <p>Emphysema <input type="radio"/> Yes <input type="radio"/> No</p> <p>Epilepsy or Seizures <input type="radio"/> Yes <input type="radio"/> No</p> <p>Excessive Bleeding <input type="radio"/> Yes <input type="radio"/> No</p> <p>Excessive Thirst <input type="radio"/> Yes <input type="radio"/> No</p> <p>Fainting Spells/Dizziness <input type="radio"/> Yes <input type="radio"/> No</p> <p>Frequent Cough <input type="radio"/> Yes <input type="radio"/> No</p> <p>Frequent Diarrhea <input type="radio"/> Yes <input type="radio"/> No</p> <p>Frequent Headaches <input type="radio"/> Yes <input type="radio"/> No</p> <p>Genital Herpes <input type="radio"/> Yes <input type="radio"/> No</p> <p>Glaucoma <input type="radio"/> Yes <input type="radio"/> No</p> <p>Hay Fever <input type="radio"/> Yes <input type="radio"/> No</p> <p>Heart Attack/Failure <input type="radio"/> Yes <input type="radio"/> No</p> <p>Heart Murmur <input type="radio"/> Yes <input type="radio"/> No</p> <p>Heart Pace Maker <input type="radio"/> Yes <input type="radio"/> No</p> <p>Heart Trouble/Disease <input type="radio"/> Yes <input type="radio"/> No</p>	<p>Hemophilia <input type="radio"/> Yes <input type="radio"/> No</p> <p>Hepatitis A <input type="radio"/> Yes <input type="radio"/> No</p> <p>Hepatitis B or C <input type="radio"/> Yes <input type="radio"/> No</p> <p>Herpes <input type="radio"/> Yes <input type="radio"/> No</p> <p>High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No</p> <p>Hives or Rash <input type="radio"/> Yes <input type="radio"/> No</p> <p>Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No</p> <p>Irregular Heartbeat <input type="radio"/> Yes <input type="radio"/> No</p> <p>Kidney Problems <input type="radio"/> Yes <input type="radio"/> No</p> <p>Leukemia <input type="radio"/> Yes <input type="radio"/> No</p> <p>Liver Disease <input type="radio"/> Yes <input type="radio"/> No</p> <p>Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No</p> <p>Lung Disease <input type="radio"/> Yes <input type="radio"/> No</p> <p>Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No</p> <p>Pain in Jaw Joints <input type="radio"/> Yes <input type="radio"/> No</p> <p>Parathyroid Disease <input type="radio"/> Yes <input type="radio"/> No</p> <p>Psychiatric Care <input type="radio"/> Yes <input type="radio"/> No</p> <p>Radiation Treatments <input type="radio"/> Yes <input type="radio"/> No</p> <p>Recent Weight Loss <input type="radio"/> Yes <input type="radio"/> No</p>	<p>Renal Dialysis <input type="radio"/> Yes <input type="radio"/> No</p> <p>Rheumatic Fever <input type="radio"/> Yes <input type="radio"/> No</p> <p>Rheumatism <input type="radio"/> Yes <input type="radio"/> No</p> <p>Scarlet Fever <input type="radio"/> Yes <input type="radio"/> No</p> <p>Shingles <input type="radio"/> Yes <input type="radio"/> No</p> <p>Sickle Cell Disease <input type="radio"/> Yes <input type="radio"/> No</p> <p>Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No</p> <p>Spina Bifida <input type="radio"/> Yes <input type="radio"/> No</p> <p>Stomach/Intestinal Disease <input type="radio"/> Yes <input type="radio"/> No</p> <p>Stroke <input type="radio"/> Yes <input type="radio"/> No</p> <p>Swelling of Limbs <input type="radio"/> Yes <input type="radio"/> No</p> <p>Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No</p> <p>Tonsillitis <input type="radio"/> Yes <input type="radio"/> No</p> <p>Tuberculosis <input type="radio"/> Yes <input type="radio"/> No</p> <p>Tumors or Growths <input type="radio"/> Yes <input type="radio"/> No</p> <p>Ulcers <input type="radio"/> Yes <input type="radio"/> No</p> <p>Venereal Disease <input type="radio"/> Yes <input type="radio"/> No</p> <p>Yellow Jaundice <input type="radio"/> Yes <input type="radio"/> No</p>
---	--	--	--

Have you ever had any serious illness not listed above? Yes No If yes, please explain: _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____