

Health History Form



American Dental Association
www.ada.org

E-mail: _____ Today's Date: _____

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

| | | |
|----------------------------|--------------------------------------|---|
| Name: | Home Phone: <i>Include area code</i> | Business/Cell Phone: <i>Include area code</i> |
| Last First Middle _____ | () | () |
| Address: | City: | State: Zip: |
| Mailing address | | |
| Occupation: | Height: | Weight: Date of birth: Sex: M F |
| SS# or Patient ID: | Emergency Contact: | Relationship: Home Phone: Cell Phone: |
| | | () () <i>Include area codes</i> |

If you are completing this form for another person, what is your relationship to that person?

Your Name _____ Relationship _____

| Do you have any of the following diseases or problems: | (Check DK if you Don't Know the answer to the question) | Yes | No | DK |
|--|---|--------------------------|--------------------------|--------------------------|
| Active Tuberculosis..... | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Persistent cough greater than a 3 week duration..... | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Cough that produces blood..... | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Been exposed to anyone with tuberculosis..... | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

Dental Information *For the following questions, please mark (X) your responses to the following questions.*

| | Yes | No | DK | | Yes | No | DK |
|---|--------------------------|--------------------------|--------------------------|---|--------------------------|--------------------------|--------------------------|
| Do your gums bleed when you brush or floss? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Do you have earaches or neck pains? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Are your teeth sensitive to cold, hot, sweets or pressure? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Do you have any clicking, popping or discomfort in the jaw? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Does food or floss catch between your teeth? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Do you brux or grind your teeth? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Is your mouth dry?..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Do you have sores or ulcers in your mouth? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you had any periodontal (gum) treatments?..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Do you wear dentures or partials? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had orthodontic (braces) treatment?..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Do you participate in active recreational activities?..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you had any problems associated with previous dental treatment?..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had a serious injury to your head or mouth?..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Is your home water supply fluoridated? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Date of your last dental exam: | | | |
| Do you drink bottled or filtered water?..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | What was done at that time? | | | |
| If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY | | | | Date of last dental x-rays: | | | |
| Are you currently experiencing dental pain or discomfort?..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | |
| What is the reason for your dental visit today? | | | | | | | |
| How do you feel about your smile? | | | | | | | |

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

| | Yes | No | DK | | Yes | No | DK |
|--|--------------------------|--------------------------|--------------------------|---|--------------------------|--------------------------|--------------------------|
| Are you now under the care of a physician? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Have you had a serious illness, operation or been hospitalized in the past 5 years? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Physician Name: _____ Phone: <i>Include area code</i> | | | | If yes, what was the illness or problem? | | | |
| Address/City/State/Zip: _____ | | | | Are you taking or have you recently taken any prescription or over the counter medicine(s)? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you in good health? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements: | | | |
| Has there been any change in your general health within the past year? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ | | | |
| If yes, what condition is being treated? | | | | _____ | | | |
| Date of last physical exam: | | | | _____ | | | |

Medical Information Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

| | | | | | | | | | | | |
|--|--|--|--------------------------|--------------------------|--------------------------|---|------------------|--|--------------------------|--------------------------|--------------------------|
| (Check DK if you Don't Know the answer to the question) | | | Yes No DK | | | | Yes No DK | | | | |
| Do you wear contact lenses? | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Do you use controlled substances (drugs)?..... | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Do you use tobacco (smoking, snuff, chew, bidis)? | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Date: _____ If yes, have you had any complications? _____ | | | | | | If so, how interested are you in stopping? (Circle one) VERY / SOMEWHAT / NOT INTERESTED | | | | | |
| Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease? | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Do you drink alcoholic beverages? | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | If yes, how much alcohol did you drink in the last 24 hours? _____ | | | | | |
| Date Treatment began: _____ | | | | | | If yes, how much do you typically drink in a week? _____ | | | | | |
| Allergies - Are you allergic to or have you had a reaction to: To all yes responses, specify type of reaction. | | | Yes No DK | | | | Yes No DK | | | | |
| Local anesthetics _____ | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Metals _____ | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Aspirin _____ | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Latex (rubber) _____ | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Penicillin or other antibiotics _____ | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Iodine _____ | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Barbiturates, sedatives, or sleeping pills _____ | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hay fever/seasonal _____ | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sulfa drugs _____ | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Animals _____ | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Codeine or other narcotics _____ | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Food _____ | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Other _____ | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems. | | | | | | | | | | | |
| | | | Yes No DK | | | | Yes No DK | | | | Yes No DK |
| Artificial (prosthetic) heart valve | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Autoimmune disease | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Previous infective endocarditis | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Rheumatoid arthritis | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Damaged valves in transplanted heart | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Systemic lupus erythematosus. | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Congenital heart disease (CHD) | | | | | | Asthma | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Unrepaired, cyanotic CHD | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Bronchitis..... | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Repaired (completely) in last 6 months | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Emphysema | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Repaired CHD with residual defects | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sinus trouble | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | | | | Tuberculosis | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <i>Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.</i> | | | | | | Cancer/Chemotherapy/ Radiation Treatment | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Yes No DK | | | | Yes No DK | | | | Yes No DK |
| Cardiovascular disease. | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Chest pain upon exertion | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Angina | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Chronic pain | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Arteriosclerosis | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes Type I or II | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Congestive heart failure | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Eating disorder..... | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Damaged heart valves..... | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Malnutrition | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart attack | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Gastrointestinal disease..... | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart murmur | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | G.E. Reflux/persistent heartburn | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Low blood pressure..... | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Ulcers | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| High blood pressure..... | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Thyroid problems..... | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Other congenital heart defects | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Stroke..... | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Hepatitis, jaundice or liver disease | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Recurrent Infections | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Epilepsy | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Type of infection: _____ | | | | | |
| Fainting spells or seizures..... | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Kidney problems..... | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Neurological disorders..... | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Night sweats..... | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, specify: _____ | | | | | | Osteoporosis | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sleep disorder | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Persistent swollen glands in neck | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Mental health disorders | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Severe headaches/ migraines | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Specify: _____ | | | | | | Severe or rapid weight loss | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Type of infection: _____ | | | | | | Sexually transmitted disease | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Kidney problems..... | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Excessive urination..... | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Night sweats..... | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | |
| Osteoporosis | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | |
| Persistent swollen glands in neck | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | |
| Severe headaches/ migraines | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | |
| Severe or rapid weight loss | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | |
| Sexually transmitted disease | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | |
| Excessive urination..... | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | |
| Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? | | | | | | | | | | | |
| Name of physician or dentist making recommendation: | | | | | | | | | Phone: | | |
| Do you have any disease, condition, or problem not listed above that you think I should know about? | | | | | | | | | | | |
| Please explain: _____ | | | | | | | | | | | |

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
 I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: _____ Date: _____

FOR COMPLETION BY DENTIST

Comments: _____

Kevin M. Lacour, DDS, P.C.

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 July 1, 2006, 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. For adult patients who claim someone other than them self as financially responsible, our practice policy is to inform the financially responsible party of your health information for consent of treatment and payment.

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. Our practice policy is to use an outside mailing company for the purpose of mailing newsletters and calendars.

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, Patient Surveys/Newsletters/Calendars: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, messages left at home or work, postcards, or letters), patient surveys/newsletters/calendars.

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 will 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. If you request copies, we will charge you \$0.10 for each page, \$10.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. 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 will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

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: Barbara Hartsfield

Telephone: 770-921-6606

Fax: 770-921-6919

E-mail: kevinlacourdds@bellsouth.net

Address: 5400 Lawrenceville Highway, Lilburn, GA 30047

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

Kevin M. Lacour, DDS, P.C.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient Number: _____ Social Security Number: _____

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Barbara Hartsfield

Telephone: 770-921-6606

Fax: 770-921-6919

E-mail: _____

Address: 5400 Lawrenceville Highway, Lilburn, GA 30047

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

**YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.**

REVOCACTION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will *not* affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____

Kevin M. Lacour, DDS, P.C.

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)

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

Kevin M. Lacour, DDS, P.C.
5400 Lawrenceville Highway
Lilburn, GA 30047

Welcome to our office! We are pleased to have you as a patient and look forward to caring for your dental health. We sincerely hope that the quality of your treatment will exceed your expectations. We do appreciate your time in completing the paperwork. It is important for us to know about your medical and dental histories to set up your personal records in our office, and we would like you to know what to expect of us in regard to office policies. We will be happy to answer any questions you may have. Thank you for your help.

1. Our goal is to see you promptly at your scheduled time. Please inform us as soon as possible in the event that you will need to change an appointment.
2. Payment is due when services are rendered (this includes any insurance deductibles and/or co-pays). We accept cash, checks, Visa, Mastercard, and Discover. In regard to minors: the parent requesting services for a minor child is financially responsible for those services provided.
3. For patients with dental insurance: We will be happy to assist you in filing your insurance claim, although you are ultimately responsible for your bill. We will file your insurance form for you after you have supplied us with a copy of your insurance card and the required information. This form must be signed on both sides to allow us to release the necessary information and allow the insurance company to remit payments to our office. Any co-payments and/or deductibles are due at the time services are rendered.
4. **FEMALE PATIENTS: Before each dental visit, please inform us if you are pregnant or may possibly be pregnant before x-rays are taken or anesthesia (including nitrous oxide or “gas”) is administered.**
5. **Medicare does not cover most procedures performed in this office.** Please see the “Advance Medicare Directive” published by the American Dental Association posted in the office – it offers more information on this subject. We will be happy to provide a copy of this information.
6. We have provided you with a copy of our “Notice of Privacy Practices”. Please sign both sides of the form titled “Consent for Use and Disclosure of Health Information” and “Acknowledgement of Receipt of Notice of Privacy Practices” and return it to the Front Desk along with the rest of your paperwork.

I have read and understand these Office Policies. I acknowledge that any questions I had in reference to the above have been answered to my satisfaction. **I, the undersigned (Patient or Legally Responsible Party), authorize treatment to be rendered and assume full financial responsibility. I acknowledge that all accounts over sixty (60) days old will be charged a service fee of 1.5% per month (18% annually) on the unpaid balance. Any collection and/or attorney fees incurred to collect this account will be borne by the account.**

Patient Name (please print)

Signature of Patient/Guardian

Date

Please complete both sides of this form. Thank you.

Kevin M. Lacour, DDS, P.C.
5400 Lawrenceville Highway, Lilburn, GA 30047

Please fill in the following information completely. If you have dental insurance, please provide a copy of your insurance card so that we can assist in filing your insurance claims.

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

Financial Responsibility Information:

| | | | |
|---|----------------------------------|----------------------------------|--|
| Date: _____ | SS#: _____ | | |
| Name: _____ | _____ | Date of Birth: _____ | |
| <i>Last</i> | <i>First</i> | <i>Middle Initial</i> | |
| Address: _____ | City: _____ | State: _____ | Zip: _____ |
| Home Phone: _____ | Cell Phone: _____ | Business Phone: _____ | Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female |
| Email address: _____ | | | |
| Employer: _____ | Employer Address: _____ | Occupation: _____ | |
| Marital Status: <input type="checkbox"/> Single | <input type="checkbox"/> Married | <input type="checkbox"/> Widowed | <input type="checkbox"/> Divorced <input type="checkbox"/> Separated |
| Spouse's Name: _____ | Birthdate: _____ | SS#: _____ | Occupation: _____ |
| Spouse's Employer: _____ | Spouse's Employer Address: _____ | Phone: _____ | |

Dental Insurance Information:

| | |
|----------------------------------|-------------------------------------|
| Insurance Company: _____ | Phone: _____ |
| Insurance Company Address: _____ | City: _____ State: _____ Zip: _____ |
| Employer: _____ | Group #: _____ |
| Subscriber (Employee)Name: _____ | ID#: _____ |
| SS#: _____ | DOB: _____ |
| Address: _____ | City: _____ State: _____ Zip: _____ |
| Home phone: _____ | Work Phone: _____ Cell Phone: _____ |

Secondary Insurance Information: (Please complete only if you have secondary insurance coverage.)

| | |
|--|-------------------------------------|
| Is patient covered by additional insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Insurance Company: _____ | Phone: _____ |
| Insurance Company Address: _____ | City: _____ State: _____ Zip: _____ |
| Employer: _____ | Group #: _____ |
| Subscriber (Employee)Name: _____ | ID#: _____ |
| SS#: _____ | DOB: _____ |
| Address: _____ | City: _____ State: _____ Zip: _____ |
| Home phone: _____ | Work Phone: _____ Cell Phone: _____ |

Assignment and Release: (Please read and sign.)

| | |
|---|---------------|
| I certify that I, and/or my dependent(s) have insurance coverage with _____ and assign directly to Dr. Kevin M. Lacour all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all insurance submissions. The above-named Dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. | |
| _____ Signature of Patient/Responsible Party | _____ Date |

Please complete both sides of this form. Thank you.