OBROCHTA CENTER FOR DENTAL HEALTH

NOTICE OF PRIVACY PRACTICE

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 effect. This Notice takes effect 4/14/03, 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 or privacy practices, we will change this Notice and make the new Notice available on 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.

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 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.

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 reasonable believe that you're 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: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

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 $0.99 for each page, $20.00 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 restriction 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. Your 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 with the U.S. Department of Health and Human Services.

Contact Officer: Janet Walker
Telephone: (727) 321-4464 Fax: (727) 323-3248
E-Mail: docobroc@aol.com
Address: 4464 Central Avenue; St. Petersburg, FL 33711

OBROCHTA CENTER FOR DENTAL HEALTH

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.

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Please Print Name

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Signature

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Date

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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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OBROCHTA CENTER FOR DENTAL HEALTH

4464 CENTRAL AVENUE
ST. PETERSBURG, FL 33711
(727) 321-4464

Please fill out both sides.

PATIENT INFORMATION: ***THANK YOU FOR CHOOSING OUR PRACTICE FOR YOUR DENTAL NEEDS. PLEASE COMPLETE THIS FORM IN INK. IF YOU HAVE ANY QUESTIONS, DO NOT HESITATE TO ASK FOR ASSISTANCE. WE WILL BE HAPPY TO HELP.***		
NAME: (FIRST, MI, LAST) - PLEASE PRINT		DATE:
ADDRESS:	CITY:	STATE/ ZIP:
	CELL PHONE #	HOME PHONE #:
SOCIAL SECURITY #:	DATE OF BIRTH:	
DRIVER LICENSE NUMBER / STATE:	**E-MAIL ADDRESS:**	
ARE YOU: (CIRCLE ONE) MINOR SINGLE MARRIED SEPARATED DIVORCED WIDOWED		
NAME OF YOUR EMPLOYER:		OCCUPATION:
BUSINESS ADDRESS/ CITY/ STATE/ ZIP		WORK PHONE #:
IF YOU ARE A STUDENT, NAME OF SCHOOL/ COLLEGE:		
CONTACT IN CASE OF EMERGENCY:		PHONE #:
WHOM MAY WE THANK FOR REFERRING YOU TO US?		
NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT:		RELATIONSHIP TO PATIENT:
ADDRESS/ CITY/ STATE/ ZIP		HOME PHONE #:
NAME OF EMPLOYER:		WORK PHONE #:

PRIMARY DENTAL INSURANCE INFORMATION		
NAME OF INSURED:		RELATIONSHIP TO PATIENT:
SOCIAL SECURITY #:	DATE OF BIRTH:	DATE EMPLOYED:
EMPLOYER NAME:		WORK PHONE #:
NAME OF INSURANCE COMPANY:		GROUP #:
INSURANCE ADDRESS/ CITY/ STATE/ ZIP		PHONE #:

Continued

SECONDARY DENTAL INSURANCE INFORMATION		
NAME OF INSURED:		RELATIONSHIP TO PATIENT:
SOCIAL SECURITY #:	DATE OF BIRTH:	DATE EMPLOYED:
NAME OF INSURANCE COMPANY:		GROUP #:
INSURANCE ADDRESS/ CITY/ STATE/ ZIP		PHONE #:

DENTAL HISTORY INFORMATION

FORMER DENTIST	ADDRESS/ CITY/ STATE/ ZIP		
DATE OF LAST DENTAL EXAM:	DATE OF LAST X-RAYS:	HOW OFTEN DO YOU BRUSH?	HOW OFTEN DO YOU FLOSS?
REASON FOR TODAY'S VISIT:			

PLEASE CIRCLE ANY OF THE FOLLOWING CONDITIONS THAT APPLY TO YOU:
BAD BREATH / BLEEDING GUMS / CLICKING OR POPPING JAW / FOOD COLLECTION BETWEEN TEETH / GRINDING TEETH / LOOSE TEETH OR BROKEN FILLINGS / PERIODONTAL TREATMENT / SENSITIVITY TO COLD / SENSITIVITY TO HOT OR SWEET / SENSITIVITY TO BITING / SORES OR GROWTHS IN YOUR MOUTH

MEDICAL HISTORY

PHYSICIAN:			DATE OF LAST VISIT:
HAVE YOU EVER TAKEN ANY OF THE FOLLOWING: Actonel___ Didronel___ Skelid___ Fosamax___ Aredia___ Zometa___		ALLERGIES:	
PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING:			
HAVE YOU IN PAST OR PRESENT TAKEN ANY WEIGHT MANAGEMENT SUPPLEMENTS?	ARE YOU PREGNANT?	NURSING?	TAKING BIRTH CONTROL PILLS?

DO YOU HAVE A HISTORY OF THE FOLLOWING:

AIDS
ANEMIA
ARTHRITIS, RHEUMATISM
ARTIFICIAL HEART VALVES
ARTIFICIAL JOINTS
ASTHMA
__ BACK PROBLEMS
BLOOD DISEASE
__ CANCER* *PLEASE SPECIFY*_________
CHEMICAL DEPENDENCY
__ CHEMOTHERAPY
__ CIRCULATORY PROBLEMS
__ SEXUALLY TRANSMITTED DISEASE

CORTISONE
COUGH, PERSISTENT
COUGH UP BLOOD
DIABETES
EPILEPSY
FAINTING
__ GLAUCOMA
HEADACHES
__ HEART MURMUR
HEART PROBLEMS
DESCRIBE_______________
__ HEMOPHILIA

HEPATITIS
HIGH BLOOD PRESSURE
HIV POSITIVE
JAW PAINS
KIDNEY DISEASE
LIVER DISEASE
__ MITRAL VALVE PROLAPSE
NERVOUS PROBLEM
__ PACEMAKER
PSYCHIATRIC CARE
__ RADIATION TREATMENT* (PAST OR PENDING)
__ RESPIRATORY DISEASE

RHEUMATIC FEVER
SCARLET FEVER
SHORTNESS OF BREATH
SKIN RASH
STROKE
SWOLLEN FEET/ANKLES
__ THYROID PROBLEMS
TOBACCO HABIT
__ TONSILLITIS
TUBERCULOSIS
__ ULCER
__ NONE

AUTHORIZATION

I CERTIFY THAT I HAVE READ AND UNDERSTAND THAT THE ABOVE INFORMATION IS TRUE 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 CHILDREN DURING THE PERIOD OF SUCH DENTAL CARE TO THIRD PARTY PAYOR AND/OR HEALTH PRACTITIONER. 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 CARRIER MY PAY LESS THAN THE ACTUAL BILL FOR SERVICES. I AGREE TO BE RESPONSIBLE FOR PAYMENT OF SERVICES RENDERED ON MY BEHALF OR MY DEPENDENTS.

PATIENT'S SIGNATURE (OR PARENT IF A MINOR):	**DATE:**