Patient Information Questionnaire

Last Name | First | MI | Date of Birth | Social Security #

Preferred Name | Home Phone # | Cell Phone # | Work Phone #

Patient's Address | Street | City | Zip | E-MAIL

Who may we thank for referring you to our office? | Pharmacy location/phone #

EMERGENCY CONTACT INFORMATION

Name of Contact | Relationship

Home Phone # | Cell Phone # | Work Phone #

INSURANCE INFORMATION

Insurance Company Name | Insurance Address | Insurance Phone #

Subscriber's Name | Patient's Relationship to Subscriber: ◯ Self ◯ Spouse ◯ Dependent | Subscribers DOB | Subscriber's ID#

Group/Program # | Employer

CONFIRMATIONS

Do you prefer a confirmation call?

◯ Yes, it is a helpful reminder

◯ No, I would like to be contacted by email or text

I consent to making of videotapes, photographs, and xrays before, during and after treatment, and to use the same by the doctor in scientific papers or demonstrations.

I certify that I have read this form and agree with its contents.

Patient's Signature | Date

DENTAL HISTORY

Patient Name _____ Nickname _____ Age _____

Referred by _____ How would you rate the condition of your mouth? ☐Excellent ☐Good ☐Fair ☐Poor

Previous Dentist _____ How long have you been a patient? _____ Months/Years

Date of most recent dental exam ____ /____ /____ Date of most recent x-rays ___ /____ /____

Date of most recent treatment (other than a cleaning) ____ /____ /____

I routinely see my dentist every ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

	YES	NO
PERSONAL HISTORY		
1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [____]	☐	☐
2. Have you had an unfavorable dental experience?	☐	☐
3. Have you ever had complications from past dental treatment?	☐	☐
4. Have you ever had trouble getting numb or had any reactions to local anesthetic?	☐	☐
5. Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age?	☐	☐
6. Have you had any teeth removed, missing teeth that never developed or lost teeth due to injury or facial trauma?	☐	☐
GUM AND BONE		
7. Do your gums bleed sometimes or are they ever painful when brushing or flossing?	☐	☐
8. Have you ever been treated for gum disease, had scaling and root planing, or been told you have lost bone around your teeth?	☐	☐
9. Have you ever noticed an unpleasant taste or odor in your mouth?	☐	☐
10. Is there anyone with a history of periodontal disease in your family?	☐	☐
11. Have you ever experienced gum recession, or can you see more of the roots of your teeth?	☐	☐
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple?	☐	☐
13. Have you experienced a burning or painful sensation in your mouth not related to your teeth?	☐	☐
TOOTH STRUCTURE		
14. Have you had any cavities within the past 3 years?	☐	☐
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food?	☐	☐
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth?	☐	☐
17. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth?	☐	☐
18. Do you have grooves or notches on your teeth near the gum line?	☐	☐
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?	☐	☐
20. Do you frequently get food caught between any teeth?	☐	☐
BITE AND JAW JOINT		
21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)	☐	☐
22. Do you feel like your lower jaw is being pushed back when you try to bite your back teeth together?	☐	☐
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods?	☐	☐
24. In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed?	☐	☐
25. Are your teeth becoming more crooked, crowded, or overlapped?	☐	☐
26. Are your teeth developing spaces or becoming more loose?	☐	☐
27. Do you have trouble finding your bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together?	☐	☐
28. Do you place your tongue between your teeth or close your teeth against your tongue?	☐	☐
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?	☐	☐
30. Do you clench or grind your teeth together in the daytime or make them sore?	☐	☐
31. Do you have any problems with sleep (i.e. restlessness or teeth grinding), wake up with a headache or an awareness of your teeth?	☐	☐
32. Do you wear or have you ever worn a bite appliance?	☐	☐
SMILE CHARACTERISTICS		
33. Is there anything about the appearance of your mouth (smile, lips, teeth, gums) that you would like to change (shape, color, size, display)?	☐	☐
34. Have you ever bleached (whitened) your teeth?	☐	☐
35. Have you felt uncomfortable or self conscious about the appearance of your teeth?	☐	☐
36. Have you been disappointed with the appearance of previous dental work?	☐	☐

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

MEDICAL HISTORY

Patient Name _____ Nickname _____ Age _____

Name of Physician/and their specialty _____

Most recent physical examination _____ Purpose _____

What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

DO YOU HAVE or HAVE YOU EVER HAD:	YES	NO
1. hospitalization for illness or injury _____	☐	☐
2. an allergic or bad reaction to any of the following:	☐	☐
○ aspirin, ibuprofen, acetaminophen, codeine _____		
○ penicillin _____		
○ erythromycin _____		
○ tetracycline _____		
○ sulfa _____		
○ local anesthetic _____		
○ fluoride _____		
○ chlorhexidine (CHX) _____		
○ Iodine _____		
○ metals (nickel, gold, silver, _____)		
○ latex _____		
○ nuts _____		
○ fruit _____		
○ milk _____		
○ red dye _____		
○ other _____		
3. heart problems, or cardiac stent within the last six months _____	☐	☐
4. history of infective endocarditis _____	☐	☐
5. artificial heart valve, repaired heart defect (PFO) _____	☐	☐
6. pacemaker or implantable defibrillator _____	☐	☐
7. orthopedic or soft tissue implant (e.g joint replacement, breast implant) ___	☐	☐
8. heart murmur, rheumatic or scarlet fever _____	☐	☐
9. high or low blood pressure _____	☐	☐
10. a stroke (taking blood thinners) _____	☐	☐
11. anemia or other blood disorder _____	☐	☐
12. prolonged bleeding due to a slight cut (or INR > 3.5) _____	☐	☐
13. pneumonia, emphysema, shortness of breath, sarcoidosis _____	☐	☐
14. chronic ear infections, tuberculosis, measles, chicken pox _____	☐	☐
15. breathing problems (e.g. asthma, stuffy nose, sinus congestion) _____	☐	☐
16. sleep problems (e.g. sleep apnea, snoring, insomnia, restless sleep, bedwetting) __	☐	☐
17. kidney disease _____	☐	☐
18. liver disease or jaundice _____	☐	☐
19. vertigo (e.g. "the room is spinning") _____	☐	☐
20. thyroid, parathyroid disease, or calcium deficiency _____	☐	☐
21. hormone deficiency or imbalance (e.g. poly cystic ovarian syndrome) ____	☐	☐
22. high cholesterol or taking statin drugs _____	☐	☐
23. diabetes (HbA1c = _____) _____	☐	☐
24. stomach or duodenal ulcer _____	☐	☐
25. digestive or eating disorders (e.g. celiac disease, gastric reflux, bulimia, anorexia) _____	☐	☐

	YES	NO
26. osteoporosis/osteopenia or ever taken anti-resorptive medications (e.g. bisphosphonates) _____	☐	☐
27. arthritis or gout _____	☐	☐
28. autoimmune disease (e.g. rheumatoid arthritis, lupus, scleroderma) _____	☐	☐
29. glaucoma _____	☐	☐
30. contact lenses _____	☐	☐
31. head or neck injuries _____	☐	☐
32. epilepsy, convulsions (seizures) _____	☐	☐
33. neurologic disorders (e.g. Alzheimer's disease, dementia, prion disease) _	☐	☐
34. viral infections and cold sores _____	☐	☐
35. any lumps or swelling in the mouth _____	☐	☐
36. hives, skin rash, hay fever _____	☐	☐
37. STI/STD/HPV _____	☐	☐
38. hepatitis (type ____) _____	☐	☐
39. HIV/AIDS _____	☐	☐
40. tumor, abnormal growth _____	☐	☐
41. radiation therapy _____	☐	☐
42. chemotherapy, immunosuppressive medication _____	☐	☐
43. emotional difficulties _____	☐	☐
44. psychiatric treatment or antidepressant medication _____	☐	☐
45. concentration problems or ADD/ADHD _____	☐	☐
46. alcohol/recreational drug use _____	☐	☐
ARE YOU:		
47. presently being treated for any other illness _____	☐	☐
48. aware of a change in your health in the last 24 hours (e.g., fever, chills, new cough, or diarrhea) _____	☐	☐
49. taking medication for weight management _____	☐	☐
50. taking dietary supplements, vitamins, and/or probiotics _____	☐	☐
51. often exhausted or fatigued _____	☐	☐
52. experiencing frequent headaches or chronic pain _____	☐	☐
53. a smoker, smoked previously or other (e.g. smokeless tobacco, vaping, e-cigarettes, and cannabis) _____	☐	☐
54. considered a touchy/sensitive person _____	☐	☐
55. often unhappy or depressed _____	☐	☐
56. taking birth control pills _____	☐	☐
57. currently pregnant _____	☐	☐
58. diagnosed with a prostate disorder _____	☐	☐

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections) _____

List all medications, supplements, vitamins, and/or probiotics taken within the last two years.

Drug	Purpose	Drug	Purpose

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

ASA _____ **(1-6)** 

Patient Name:

Date of Birth:

Informed Consent for Radiographs, Exam and Cleaning

☐ **INFORMED CONSENT FOR X-RAYS, EXAM AND CLEANING** I authorize the Dentist and Staff to perform an examination, which may include x-rays. If diagnosed with prophy (regular cleaning), I consent to having the procedure done.

☐ **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.

☐ **RADIOGRAPHS (X-RAYS)** This office follows the guidelines of the American Dental Association and recommends that FULL MOUTH X-RAYS (FMX) BE TAKEN ONCE EVERY 3 TO 5 YEARS and BITEWING X-RAYS every year for caries active patients and 1-2 years for routine cases. Current X-rays will be necessary before any diagnosis can be finalized. NO TEETH WILL BE EXTRACTED without a current PA (periapical x-ray showing the root and surrounding bone and soft tissue). No fillings will be placed without current bitewings and/or PAs of the tooth. NO EXCEPTIONS.
CHILDREN If any decay or dental infection (abscess) is obvious on visual inspection, x-rays will be necessary to assess the extent of damage to the tooth structure. If your child is uncooperative. you will be referred to a pediatric dentist for treatment. Bite-wings and occlusal films are recommended for school age children 5 yrs and up. Bite-wing x rays may be suggested at age 3.5 to 4 yrs if there is no spacing between the teeth and if we suspect caries.
PREGNANT WOMEN X-RAYS WILL BE AVOIDED UNLESS IT IS AN EMERGENCY. Please inform this office if you think you are pregnant and x-rays will be postponed.

☐ **ROUTINE CLEANING** Treatment involves removing the bacterial substance known as plaque, which is the principal cause of periodontal disease and calculus, which is an accumulation of hard deposits on the tooth above the gingival margin. I understand that my gums may bleed or swell and I may experience moderate discomfort for several hours. There may be slight soreness for a few days. I will notify the office if conditions persist beyond a few days. I understand that because cleanings involve contact with bacteria and infected tissue in my mouth, I may also experience an infection, which would be treated with antibiotics. I understand that holding my mouth open during treatment may temporarily leave my jaw feeling stiff and sore and may make it difficult for me to open wide for several days afterwards. However, this can occasionally be an indication of a further problem. I must notify your office if this or other concerns arise. I understand that as my gum tissues heal, they may shrink somewhat, exposing some of the root surface. This could make my teeth more sensitive to hot or cold. I understand that I may receive a local anesthetic and/or other medication. In rare instances patients may have a reaction to the anesthetic, which could require emergency medical attention, or find that it reduces their ability to control swallowing. This increases the normal chance of swallowing foreign objects during treatment. Depending on the anesthesia and medications administered, I may need a designated driver to take me home. Rarely, temporary or permanent nerve injury can result from an injection.

Signature: _____ Date: _____
(patient/parent/guardian)

Relationship (if patient is a minor)_____

Witness: _____ Date: _____

FINANCIAL POLICY

Welcome! Thank you for choosing us for your dental home. Our goal is to provide you and your family with optimal dental care, and to be a place where patients feel welcomed and valued. We encourage you to ask questions and to be involved in treatment decisions, while we help educate you about your oral health and the importance of prevention.

FINANCIAL AGREEMENT:
Patients are expected to pay for their treatment the day services are rendered. Our patients who have dental insurance are expected to pay the amount of their ESTIMATED co-pay and deductible at the time of service. We will do our best to give you a rough estimate of your investment in your dental health for each upcoming visit, based on your individual treatment plan.

DISCOUNTS & PAYMENT OPTIONS:
Payments may be made using: Cash, Check, or Credit Card. We also offer Care Credit, a 0% financing option available only for healthcare expenses, which allows monthly payments.

1. Full Pay Cash/Check Discount for Non-Insured Patients: We are happy to offer a 10% cash/check courtesy for all services over $500.00 paid in full prior to rendering of services.

2. Full Pay Credit Card Discount for Non-Insured Patients: We are happy to offer a 5% Credit Card courtesy for all services over $500.00 paid in full prior to rendering of services.

3. Care Credit: We will be happy to help you apply for Care Credit, a 0% credit card used for healthcare services, which allows you to make affordable monthly payments. You may qualify for interest free financing for up to 24 months. Ask for an application, or go to: www.carecredit.com to start the pre-approval process today! There will be a fee for any additional procedure NOT included in the original treatment plan.

INSURANCE INFORMATION:
Our office is out -of-network (non-participating) for all insurance companies. Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services regardless of dental insurance. It is your responsibility to ensure that the insurance information we have on file is accurate. We have no way of knowing when/if your insurance coverage changes.

As a courtesy to you we will help you process all your insurance claims. However, it is your obligation to familiarize yourself with your insurance coverage as benefits vary and not all services are covered. Insurance companies have a wide variety of rules, plan limitations and exclusions that our office may not be aware of. We ask that you pay the deductible and

co-payment, which is the estimated amount not covered by your insurance company at the time we provide service to you.

We must emphasize that this is only an estimate and all charges you incur are your responsibility regardless of your insurance coverage.

We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Dental insurance is a benefit for the patient provided by their employer and the contract lies between the patient, employer and the insurance company. Our office is not a party to that contract. We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Once insurance has paid their share, a statement will be sent to you for any remaining balance and will be due upon receipt. If your insurance company has not made payment within 90 days, from the date of service, the unpaid balance becomes your responsibility

USUAL AND CUSTOMARY RATES:
Frequently, insurance companies state that the reimbursement was reduced because the dentist's fee has exceeded the usual, customary, or reasonable fee ("UCR") used by the company. A statement such as this gives the impression that any fee greater than the amount paid by the insurance company is unreasonable or well above what most dentists in the area charge for a service. This can be very misleading and simply not accurate. Insurance companies set their own schedules and each company uses a different set of fees they consider allowable. These allowable fees may vary widely because each company collects fee information from claims it processed. The insurance company then takes this data and chooses a level they call the "allowable" UCR fee. Frequently this data can be three to five years old and these "allowable" fees are set by the insurance company so they can make a net 20%-30% profit.

Our office is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. Unfortunately, insurance companies imply that your dentist is "overcharging" rather than say that they are "underpaying" or that their benefits are low. You are responsible for the payment regardless of any insurance company's determination of usual and customary rates.

Please indicate your understanding and acceptance of these financial policies by signing below.

For the mutual convenience of you and the practice, it is understood that this executed copy of the Financial Policy also shall cover your dependent children who are patients of the practice.

_____

Patient's name (Please print)

_____

Patient's Signature & Date

Notice of Privacy Practices

This notice describes how your health information 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 laws require us to maintain the privacy of your health information. We are also required to provide this notice about our office's privacy practices, our legal duties and your rights regarding your health information. We are required to follow the practices that are outlined in this notice while it is in effect. This notice takes effect ____8/6/2021__ 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 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. For more information about our privacy practices or additional copies of this notice, please contact us (contact information below).

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 disclose medical information to our employees and others who are involved in providing the care you need. We may use or disclose your health information to another dentist or other health care providers providing treatment that we do not provide. We may also share your health information with a pharmacist in order to provide you with a prescription or with a laboratory that performs tests or fabricates dental prostheses or orthodontic appliances.

Payment
We may use and disclose your health information to obtain payment for services we provide to you, unless you request that we restrict such disclosure to your health plan when you have paid out-of-pocket and in full for services rendered.

Health Care Operations
We may use and disclose your health information in connection with our health care operations. Health care operations include, but are not limited to, 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.

Your Authorization
In addition to our use of your health information for treatment, payment or health care 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 is 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. You have the right to request restrictions on disclosure to family members, other relatives, close personal friends or any other person identified by you.

Unsecured Email
We will not send you unsecured emails pertaining to your health information without your prior authorization. If you do authorize communications via unsecured email, you have the right to revoke the authorization at any time.

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 your 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 health care. 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 may contact you about products or services related to your treatment, case management or care coordination or to propose other treatments or health-related benefits and services in which you may be interested. We may also encourage you to purchase a product or service when you visit our office. If you are currently an enrollee of a dental plan, we may receive payment for communications to you in relation to our provision, coordination or management of your dental care, including our coordination or management of your health care with a third party, our consultation with other health care providers relating to your care or if we refer you for health care. We will not otherwise use or disclose your health information for marketing purposes without your written authorization. We will disclose whether we receive payments for marketing activity you have authorized.

Change of Ownership
If this dental practice is sold or merged with another practice or organization, your health records will become the property of the new owner. However, you may request that copies of your health information be transferred to another dental practice.

Required by Law
We may use or disclose your health information when we are required to do so by law.

Public Health
We may, and are sometimes legally obligated to, disclose your health information to public health agencies for purposes related to preventing or controlling disease, injury or disability; reporting abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. Upon reporting

suspected elder or dependent adult abuse or domestic violence, we will promptly inform you or your personal representative unless we believe the notification would place you at risk of harm or would require informing a personal representative we believe is responsible for the abuse or harm.

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.

Appointment Reminders
We may contact you to provide you with appointment reminders via voicemail, postcards or letters. We may also leave a message with the person answering the phone if you are not available.

Sign-In Sheet and Announcement:
Upon arriving at our office, we may use and disclose medical information about you by asking that you sign an intake sheet at our front desk. We may also announce your name when we are ready to see you.

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 contacting our office. 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. If you request copies, there may be a charge for time spent. If you request an alternate 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 for a full explanation of our fee structure.

Disclosure Accounting
You have a right to receive a list of instances in which we disclosed your health information for purposes other than treatment, payment, health care operations and certain other activities for the last six years. 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 emergency). In the event you pay out-of-pocket and in full for services rendered, you may request that we not share your health information with your health plan. We must agree to this request.

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 of how payments will be handled under the alternative means or location you request.

Breach Notification
In the event your unsecured protected health information is breached, we will notify you as required by law. In some situations, you may be notified by our business associates.

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.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us at:

Telephone: 512-441-2098 Fax: 512-441-3550

Email: info@magnoliadentistryatx.com

Address: 4000 Menchaca Rd, Austin, TX 78704

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 send a written complaint to our office or to the U.S. Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

Magnolia Family Dentistry complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____

Printed Name

have received a copy of this office's Notice of Privacy Practices.

_____ _____

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

__ Communication barriers prohibited obtaining the acknowledgement

__ An Emergency Situation prevented us from obtaining acknowledgement

__ Other (please specify)

_____

Email Communication Consent Form

Risks of using email

For the ease of our patients, our office would like to offer the opportunity to communicate by email. Transmitting patient information poses several risks and the patient should not agree to communicate with the office via email without understanding and accepting these risks. The risks include, but are not limited to, the following:

- The privacy and security of email communication cannot be guaranteed.
- Email senders can misaddress, resulting in it being sent to many unintended recipients.
- Employers/online services may have a legal right to inspect and keep emails that pass through their system.
- Even after deletion of the email, back-up copies may exist on a computer.
- Email is easier to falsify than signed hard copies. In addition, it is impossible to verify the true identity of the sender, or to ensure that only the recipient can read the email.
- Emails can introduce viruses, generally damage, or disrupt the computer.
- Email can be used as evidence in court.

Conditions of using email

Our office will use reasonable means to protect the security and confidentiality of email information sent and received—however, we cannot guarantee the security of email communication. Thus, patients must consent to the use of email for patient information, billing, and communication. Consent to use email includes agreement with the following conditions:

- Emails to or from the patient concerning treatment may be printed in full and made part of the patient's medical record. Because they are part of the medical record, authorized individuals will have access to the medical record/email (e.g. billing staff).
- Our office may forward emails *internally* to those involved, as necessary, for healthcare operations and other handling. We will <u>not</u> forward emails to independent third parties without the patient's prior written consent, except as authorized or required by law.
- Although our office will endeavor to read and respond promptly to all emails from the patient, **it is not guaranteed that any particular email will be read and responded to within any particular period of time. The patient should not use email for medical emergencies or other time-sensitive matters.**
- If the patient's email invites a response from the office and a response is not received within a reasonable time period, it is the patient's responsibility to follow up.

Please detail any information that you would not like to be communicated over email:
(You can add to or modify this list at any time by notifying us in writing.)

We are not responsible for information loss due to technical failures associated with the patient's email software or internet service provider.

Instructions for communication by email

To communicate by email, the patient shall:

- Limit or avoid using an employer's or other third party's computer.
- Inform the office of any changes in the patient's email address body
- Take precautions to preserve the confidentiality of emails, such as using screen savers and safeguarding computer passwords.
- Should the patient require immediate assistance or has a serious or worsening condition, the patient should not rely on email. Instead the patient should call the office for an appointment or take other measures as appropriate.

Patient acknowledgment and agreement

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of email between the office and me, and consent to the conditions outlined herein, as well as any other instructions that the office may impose to communicate with patients by email. I acknowledge the dentist's right to, upon the provision of written notice, withdraw the option of communicating through email. Any questions I may have had were answered.

Patient Name: _____

Patient Email: _____

Patient Signature:_____Date:_____