Notice of Privacy Practices
Acknowledgement and Consent Form
Dental Professional of Glen Carbon
Keith Bryant, D.M.D., P.C.
4224 South State Route 159, Suite #1
Glen Carbon, IL 62034

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), 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 form third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have been informed and 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 of 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.

I authorize Dental Professionals of Glen Carbon, Dr. Keith Bryant, and his staff to discuss my past, present and future dental treatment and records to _____.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

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

Date Initials Reason

NOTICE OF PRIVACY PRACTICES

Effective Date: _____

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

CONTACT INFORMATION

For more information about our privacy practices, to discuss questions or concerns, or to get additional copies of this notice, please contact our Privacy Officer.

Title: Privacy Officer Telephone: (_____) _____–_____ Fax: (_____) _____–_____

Email: Address:

OUR LEGAL DUTY

We are required by law to protect the privacy of your protected health information ("medical information"). We are also required to send you this notice about our privacy practices, our legal duties, and your rights concerning your medical information.

We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect on the date set forth at the top of this page, and will remain in effect unless 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 any change in our privacy practices and the new terms of our notice applicable to all medical information we maintain, including medical information we created or received before we made the change.

We may amend the terms of this notice at any time. If we make a material change to our policy practices, we will provide to you the revised notice. Any revised notice will be effective for all health information that we maintain. The effective date of a revised notice will be noted. A copy of the current notice in effect will be available in our facility and on our website if applicable. You may request a copy of the current notice at any time.

We collect and maintain oral, written and electronic information to administer our business and to provide products, services and information of importance to our patients. We maintain physical, electronic and procedural security safeguards in the handling and maintenance of our patients' medical information, in accordance with applicable state and federal standards, to protect against risks such as loss, destruction or misuse.

USES AND DISCLOSURES OF YOUR MEDICAL INFORMATION

Treatment: We may disclose your medical information, without your prior approval, to another dentist, a physician or other health care provider working in our facility or otherwise providing you treatment for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, your health information may be disclosed to an oral surgeon to determine whether surgical intervention is needed.

Payment: We provide dental services. Your medical information may be used to seek payment from your insurance plan. For example, your insurance plan may request and receive information on dates that you received services at our facility in order to allow your employer to verify and process your insurance claim.

Health Care Operations: We may use and disclose your medical information, without your prior approval, for health care operations. Health care operations include:

- healthcare quality assessment and improvement activities;
- reviewing and evaluating dental care provider performance, qualifications and competence, health care training programs, provider accreditation, certification, licensing and credentialing activities;
- conducting or arranging for medical reviews, audits, and legal services, including fraud and abuse detection and prevention; and
- business planning, development, management, and general administration, including customer service, complaint resolutions and billing, de-identifying medical information, and creating limited data sets for health care operations, public health activities, and research.

We may disclose your medical information to another dental or medical provider or to your health plan subject to federal privacy protection laws, as long as the provider or plan has or had a relationship with you and the medical information is for that provider's or plan's health care quality assessment and improvement activities, competence and qualification evaluation and review activities, or fraud and abuse detection and prevention.

Your Authorization: You (or your legal personal representative) may give us written authorization to use your medical information or to disclose it to anyone for any purpose. Once you give us authorization to release your medical information, we cannot guarantee that the person to whom the information is provided will not disclose the information. You may take back or "revoke" your written authorization at any time in writing, except if we have already acted based on your authorization. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give us a written authorization, we will not use or disclose your medical information for any purpose other than those described in this notice. We will obtain your authorization prior to using your medical information for marketing, fundraising purposes or for commercial use. Once authorized, you may opt out of any of these communications.

Family, Friends, and Others Involved in Your Care or Payment for Care: We may disclose your medical information to a family member, friend or any other person you involve in your care or payment for your health care. We will disclose only the medical information that is relevant to the person's involvement.

We may use or disclose your name, location, and general condition to notify, or to assist an appropriate public or private agency to locate and notify, a person responsible for your care in appropriate situations, such as a medical emergency or during disaster relief efforts.

We will provide you with an opportunity to object to these disclosures, unless you are not present or are incapacitated or it is an emergency or disaster relief situation. In those situations, we will use our professional judgment to determine whether disclosing your medical information is in your best interest under the circumstances.

Health-Related Products and Services: We may use your medical information to communicate with you about health-related products, benefits, services, payment for those products and services, and treatment alternatives.

Reminders: We may use or disclose medical information to send you reminders about your dental care, such as appointment reminders.

Plan Sponsors: If your dental insurance coverage is through an employer's sponsored group dental plan, we may share summary health information with the plan sponsor.

Public Health and Benefit Activities: We may use and disclose your medical information, without your permission, when required by law, and when authorized by law for the following kinds of public health and public benefit activities:

- for public health, including to report disease and vital statistics, child abuse, and adult abuse, neglect or domestic violence;
- to avert a serious and imminent threat to health or safety;
- for health care oversight, such as activities of state insurance commissioners, licensing and peer review authorities, and fraud prevention agencies;
- for research;
- in response to court and administrative orders and other lawful process;
- to law enforcement officials with regard to crime victims and criminal activities;
- to coroners, medical examiners, funeral directors, and organ procurement organizations;
- to the military, to federal officials for lawful intelligence, counterintelligence, and national security activities, and to correctional institutions and law enforcement regarding persons in lawful custody; and
- as authorized by state worker's compensation laws.

If a use or disclosure of health information described above in this notice is prohibited or materially limited by other laws that apply to us, it is our intent to meet the requirements of the more stringent law.

Business Associates: We may disclose your medical information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. Our business associates are required, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Data Breach Notification Purposes: We may use your contact information to provide legally-required notices of unauthorized acquisition, access, or disclosure of your health information.

Additional Restrictions on Use and Disclosure: Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including highly confidential information about you. "Highly confidential information" may include confidential information under Federal laws governing alcohol and drug abuse information and genetic information as well as state laws that often protect the following types of information:

1. HIV/AIDS;
2. Mental health;
3. Genetic tests;
4. Alcohol and drug abuse;
5. Sexually transmitted diseases and reproductive health information; and
6. Child or adult abuse or neglect, including sexual assault.

YOUR RIGHTS

Access: You have the right to examine and to receive a copy of your medical information, with limited exceptions. We will use the format you request unless we cannot practicably do so. You should submit your request in writing to our Privacy Officer.

We may charge you reasonable, cost-based fees for a copy of your medical information, for mailing the copy to you, and for preparing any summary or explanation of your medical information you request. Contact our Privacy Officer for information about our fees.

Disclosure Accounting: You have the right to a list of instances in which we disclose your medical information for purposes other than treatment, payment, health care operations, as authorized by you, and for certain other activities.

You should submit your request to our Privacy Officer. We will provide you with information about each accountable disclosure that we made during the period for which you request the accounting, except we are not obligated to account for a disclosure that occurred more than 6 years before the date of your request.

Amendment: You have the right to request that we amend your medical information. You should submit your request in writing to our Privacy Officer.

We may deny your request only for certain reasons. If we deny your request, we will provide you a written explanation. If we deny your request, you may have a statement of your disagreement added to your medical information. If we accept your request, we will make your amendment part of your medical information and use reasonable efforts to inform others of the amendment who we know may have and rely on the unamended information to your detriment, as well as persons you want to receive the amendment.

Restriction: You have the right to request that we restrict our use or disclosure of your medical information for treatment, payment or health care operations, or with family, friends or others you identify. Except in limited circumstances, we are not required to agree to your request. But if we do agree, we will abide by our agreement, except in a medical emergency or as required or authorized by law. You should submit your request to our Privacy Officer. Except as otherwise required by law, we must agree to a restriction request if:

1. except as otherwise required by law, the disclosure is to a health plan for purposes of carrying out payment or health care operations (and not for purposes of carrying out treatment); and

2. the medical information pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full by the patient.

Confidential Communication: You have the right to request that we communicate with you about your medical information in confidence by means or to locations that you specify. You should submit your request in writing to our Privacy Officer.

Breach Notification: You have the right to receive notice of a breach of your unsecured medical information. Breach may be delayed or not provided if so required by a law enforcement official. You may request that notice be provided by electronic mail. If you are deceased and there is a breach of your medical information, the notice will be provided to your next of kin or personal representatives if we know the identity and address of such individual(s).

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. Please contact our Privacy Officer to obtain this notice in written form.

COMPLAINTS

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your medical information, about amending your medical information, about restricting our use or disclosure of your medical information, or about how we communicate with you about your medical information (including a breach notice communication), you may contact to our Privacy Officer.

You also may submit a written complaint to the Office for Civil Rights of the United States Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, Washington, D.C. 20201. You may contact the Office for Civil Rights' Hotline at 1-800-368-1019.

We support your right to the privacy of your medical 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.

Patient Information (Confidential)

Name_____Date_____Male____Female _____

Address_____City_____State_____ Zip _____

SS #_____-_____-_____ Birth date _____-_____-_____ E-mail _____

Home Phone_____ Cell Phone _____Work Phone_____

Occupation _____Employer_____

Business Address_____City_____State_____Zip_____

If Student, Name of School _____City _____State _____

Circle Appropriate: Minor Single Married Separated Divorced Widowed

Spouse's Name _____Employer _____Work Phone_____

Closest Relative (name) _____Phone _____

Emergency Contact (not living with you) _____Phone _____

Whom may we thank for referring you?_____

Responsible Party

Responsible account holder_____Relationship_____

Address _____Home Phone _____

Employer _____Employer Address _____Work Phone _____

Are you covered by dental Insurance? Primary _____Secondary_____

Insured's Name _____SS # _____-_____-_____Birth date_____-_____-_____

Reason for today's visit? _____

Do you have any general health problems?_____ _____

Are you currently under the care of a physician? _____

Do you have (or have you ever had) any of the following?

Yes No 1. Allergic reaction to any medication, latex, or metal? _____
Penicillin Aspirin Codeine Local Anesthetics Sulfa Other
Yes No 2. Heart attack or heart disease or congestive heart failure/disease _____
Yes No 3. Stroke _____
Yes No 4. High blood pressure _____
Yes No 5. Angina (chest pains) _____
Yes No 6. Irregular heart beat, heart murmur, or mitral valve prolapse _____
Yes No 7. Artificial heart valve _____
Yes No 8. Rheumatic fever, rheumatic heart disease, bacterial endocarditis _____
Yes No 9. Immunosuppressive condition (circle all that apply)
Steroid Therapy (e.g. prednisone) Radiation or Cancer Therapy SLE (Lupus)
Rheumatoid Arthritis HIV Organ Transplant Spleen removed other _____
Yes No 10. Artificial joint(s) (mark dates placed) _____
Hip_____ Knee_____ Ankle _____Shoulder_____
Yes No 11. Other artificial implants or devices _____
Yes No 12. Bleeding problems, anemia, other blood disease _____
Yes No 13. Diabetes _____
Yes No 14. Thyroid disease _____
Yes No 15. Long-term antibiotic use (greater than one month continuously) _____

Yes No 16. Nervous system disease or seizures _____
Yes No 17. Kidney disease _____
Yes No 18. Hepatitis (A, B, C, or D) or other liver disease _____
Yes No 19. Muscle or joint disease or arthritis (osteo or rheumatoid) _____
Yes No 20. Asthmas, tuberculosis, or other lung disease _____
Yes No 21. Stomach or intestinal disease _____
Yes No 22. Mental heath condition – specify _____
Yes No 23 Physical or mental disabilities that may require special care? _____
Yes No 24. Impairment or hearing, sight or speech _____
Yes No 25. Do you have or have you ever been treated for cancer? _____
Yes No 26. Are you pregnant? _____Are you nursing? _____
Yes No 27 Do you have any disease, condition, or problem not listed here? _____
Yes No 28. Have you ever been hospitalized or had surgery? _____
Yes No 29 Do you have any undiagnosed symptoms? _____
Yes No 30. Are you, or have you ever been addicted to a chemical substance? _____
Yes No 31. Do you currently drink alcohol or use recreational drugs? _____
Yes No 32. Do you smoke or use smokeless tobacco? _____
Yes No 33. What type of tobacco product(s) do you use? _____
Yes No 34. Do you regularly take herbal medicines or dietary supplements? _____

Specifically, do you take (circle all that apply):

Echinacea	Garlic	Ginger	Kava	Valerian	Turmeric
Fish Oil(>3g/day)	Feverfew	Gingko	Vitamin E	St. John's Wort	

Yes No 35. Have you undergone current or past osteoporosis therapy?
(Examples are: Fosamax, Actonel, Boniva pill form)
Yes No 36. Have you undergone current or past therapy to reduce high blood calcium?
(Bisphosphonate therapy) (Examples: intravenous Areadia, or Zometa)

DENTAL HISTORY

Why did you leave your last dentist? _____
What was the date of your last dental exam? _____
Have you had any trouble associated with previous dental treatments?_____
Do your gums bleed when you brush your teeth? _____
Do you suffer from pain in the mouth, face, eyes, neck, throat, or headache? _____
Are you happy with the appearance of your teeth? _____
What would you change about your smile? _____
Has fear ever prevented you from seeking dental treatment? _____
Circle the types of dental treatment you have experienced: _____

Orthodontic Dentures Root Canal Treatment Implants Oral Surgery TMJ

Periodontal Treatment Extractions Fillings Other _____

I certify that I have read and understand the above information to the best of my knowledge. 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 my children or me during the period of such dental care to third party payers and/or health practitioners. 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 insurance carrier may pay less then the actual bill for service. I agree to be responsible for payment services rendered on my behalf or my dependents.

Signature:_____Date: _____

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Date Initials Reason

Dental Professionals of Glen Carbon / Keith A. Bryant, D.M.D.,P.C.

Medications List

Prescription medications

Use the chart below to list **all** the brand-name and generic prescription medications you currently take. Be sure to fill in all the information for each medication. The amount of medication in each pill appears on the prescription label in milligrams (mg). This is called the dose, or strength. The label on liquids and shots lists the dose too.

Medication name	Prescribing Physician	Reason for taking the Medication	Dose (such as 2 mg, 1 tsp)	How often? (such as 3x/day)

Non-prescription (over-the-counter) medications, vitamins, supplements

List all those you take occasionally, such as aspirin for headache, as well as those you take every day, such as a multivitamin or nutritional supplement. Include any herbs or alternative medicines that you take.

Medication name	Reason for taking medication	Dose (such as 2 mg, 1 tsp)	How often? (such as 3x/day)