

Health History Form

Email: _____ 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: _____ <small>Last First Middle</small>	Home Phone: <i>Include area code</i> ()	Business/Cell Phone: <i>Include area code</i> ()
Address: _____ <small>Mailing address</small>	City: _____	State: _____ Zip: _____
Occupation: _____	Height: _____	Weight: _____ Date of Birth: _____ Sex: M F
SS# or Patient ID: _____	Emergency Contact: _____	Relationship: _____ Home Phone: <i>Include area code</i> () Cell Phone: <i>Include area code</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 the question) **Yes No DK**

Active Tuberculosis.....

Persistent cough greater than a 3 week duration.....

Cough that produces blood.....

Been exposed to anyone with tuberculosis.....

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.

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

<p style="text-align: right;">Yes No DK</p> <p>Are you now under the care of a physician?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Physician Name: _____ Phone: <i>Include area code</i> ()</p> <p>Address/City/State/Zip: _____</p> <p>Are you in good health?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Has there been any change in your general health within the past year?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>If yes, what condition is being treated?</p> <p>Date of last physical exam: _____</p>	<p style="text-align: right;">Yes No DK</p> <p>Have you had a serious illness, operation or been hospitalized in the past 5 years?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>If yes, what was the illness or problem?</p> <p>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"/></p> <p>If so, please list all, including vitamins, natural or herbal preparations and/or dietary supplements:</p> <p>_____</p> <p>_____</p> <p>_____</p>
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Medical Information Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

<p><i>(Check DK if you Don't Know the answer to the question)</i></p> <p>Do you wear contact lenses?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Date: _____ If yes, have you had any complications? _____</p> <p>Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax®, Actonel®, Atelvia, Boniva®, Reclast, Prolia) for osteoporosis or Paget's disease?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia®, Zometa®, XGEVA) 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"/></p> <p>Date Treatment began: _____</p>	<p>Do you use controlled substances (drugs)?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Do you use tobacco (smoking, snuff, chew, bidis)?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>If so, how interested are you in stopping? Circle one: VERY / SOMEWHAT / NOT INTERESTED</p> <p>Do you drink alcoholic beverages?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>If yes, how much alcohol did you drink in the last 24 hours? _____</p> <p>If yes, how much do you typically drink in a week? _____</p> <p>WOMEN ONLY Are you:</p> <p>Pregnant?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Number of weeks: _____</p> <p>Taking birth control pills or hormonal replacement?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Nursing?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
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<p>Allergies. Are you allergic to or have you had a reaction to: To all yes responses, specify type of reaction.</p> <p>Local anesthetics _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Aspirin _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Penicillin or other antibiotics _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Barbiturates, sedatives, or sleeping pills _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Sulfa drugs _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Codeine or other narcotics _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>	<p style="text-align: right;">Yes No DK</p> <p>Metals _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Latex (rubber) _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Iodine _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Hay fever/seasonal _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Animals _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Food _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Other _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
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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
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"/>
<i>Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.</i>				Tuberculosis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Cancer/Chemotherapy/ Radiation Treatment.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Yes No DK				Chest pain upon exertion.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular disease.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic pain.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Angina.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes Type I or II.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arteriosclerosis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eating disorder.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Congestive heart failure.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Malnutrition.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Damaged heart valves.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal disease.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	G.E. Reflux/persistent heartburn.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low blood pressure.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other congenital heart defects.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mitral valve prolapse.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Pacemaker.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Rheumatic fever.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Rheumatic heart disease.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Abnormal bleeding.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Anemia.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Blood transfusion.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				If yes, date:_____			
				Hemophilia.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				AIDS or HIV infection.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Arthritis.....	<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"/>
				Epilepsy.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Fainting spells or seizures.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Neurological disorders.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				If yes, specify:_____			
				Sleep disorder.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Do you snore?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Mental health disorders.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Specify:_____			
				Recurrent Infections.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Type of infection:_____			
				Kidney problems.....	<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: *Include area code*
()

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: _____

Signature of Dentist: _____ Date: _____

FOR COMPLETION BY DENTIST

Comments: _____

MAIN STREET DENTAL SAVINGS PLAN

In an effort to make dental care more affordable, our office has instated a dental savings plan. This plan allows our patients to feel comfortable knowing their preventive needs are met and also offers significant discounts on any additional treatment. Our staff and our patients can rest easier knowing there are no waiting periods, no yearly maximums, no pre-existing condition limitations and NO HASSLE from insurance companies! We believe that our dental savings plan is far more beneficial than most dental insurance policies. Our dental savings plan includes:

Existing Patients: \$249 annual enrollment

- **2** basic cleanings, **2** sets of check-up x-rays (bitewings), **2** periodic exams, and **2** fluoride treatments
- **20%** off **ANY** additional treatment, **NO** annual maximums, **NO** deductibles
- New patients are also eligible for the savings plan for an additional \$50 which will cover a comprehensive exam, full mouth x-rays, and a periodontal exam
- Additional family members are only \$200 annually, children 12 and under \$100 annually

New Patients: \$249 annual enrollment + \$50 initial fee = \$299

- Initial \$50 fee covers comprehensive exam, full mouth x-rays, and periodontal assessment
- All following exams and treatment fall under 'existing patient' category

Periodontal Maintenance Patients: \$349 annual fee includes

- 2 periodic exams, 2 check-up x-rays (bitewings), 2 fluoride treatments, up to 4 periodontal maintenance cleanings and periodontal assessments
- ****Periodontal plan does not include the Scaling and Root Planing Procedure. Scaling and Root Planing will be eligible for a 20% discount and all following maintenance visits are covered under the savings plan.**

*Any additional treatment including but not limited to extra cleanings, limited exams or x-rays will be eligible for 20% discount of standard fee.

TERMS AND CONDITIONS

Your enrollment fee will renew automatically every year on your enrollment date. Enrollment fee is non-refundable once any treatment is performed (including x-rays, exams, cleanings). Rates may change based presence or absence of periodontal disease. No charges will occur without prior notification of enrollee.

Our Dental Savings Plan is not an insurance plan, it has been designed to provide a way for our patients to obtain the dental care they need at the most affordable rate. The savings plan:

- Is standalone coverage not to be combined with insurance benefits or any other offers
- Cannot be used in a workman's compensation treatment plan
- Is for use in treatments that lie within our realm of expertise
- Cannot be used for treatment with another dentist or specialist to whom we refer
- For Orthodontics: Must remain a plan member for the duration of treatment to retain discount

I, _____ understand and agree to the terms listed above.
(Print name here)

Patient signature/Date

Staff signature/ Date

MAIN STREET DENTAL CENTER
POLICIES ACKNOWLEDGEMENT

RECORDS RELEASE

I hereby authorize Main Street Dental Center to release my dental records and any other healthcare information including but not limited to: x-rays, treatment plans, dental charts, (and all other records that pertain to me) to those individuals or healthcare providers listed below.

PERSONS APPROVED TO RECEIVE RECORDS (beyond other healthcare providers):

Spouse/Partner: _____

Family Member/s: _____

Others: _____

*Initial: _____

PRIVACY PRACTICES

By initialing below I acknowledge that I have read and understand the Privacy Practices observed by Main Street Dental Center.

*Initial: _____

EMAIL COMMUNICATION

I hereby authorize Main Street Dental Center to communicate to me, specified individuals, or other healthcare providers via email regarding my dental records or other healthcare information.

*Initial: _____

FINANCIAL POLICY

By signing below, I acknowledge that I have reviewed and understand Main Street Dental Center's financial policy. I agree to the terms and conditions listed in said policy.

*Initial: _____

By signing this document, I acknowledge that I have read and understand all Practice Policies and that I have had the opportunity to ask questions about or receive copies of said policies.

Print Name: _____ Date: _____

Signature: _____

FINANCIAL POLICY

FOR PATIENTS WITH DENTAL INSURANCE COVERAGE

As a courtesy to our patients we will gladly process your insurance claims. We participate in many insurance plans, but please inquire if we accept yours to avoid billing problems later. We ESTIMATE your deductible for the year and your portion due that is not covered by insurance. The total portion that is not covered by insurance is due the day treatment is completed. Parents must send co-pays due with minors at the time of their appointment. If your insurance plan denies coverage for services rendered, you are responsible for the remainder of the balance.

MISSED APPOINTMENTS/CANCELLATIONS

Twenty four (24) hours notice is required for cancellation of appointments. We reserve the right to charge a \$50 fee for broken appointments or ones that are not cancelled beforehand within a reasonable time frame.

ADMINISTRATIVE FEES (If applicable)

*Returned checks are subject to a \$30.00 fee.

* If collection and/or legal services are required to obtain payment, I further agree to pay for all legal fees and costs incurred.

I understand and agree that, regardless of my insurance (if applicable), I am ultimately responsible for the balance on my account for all charges and services rendered. I have read all the information on this sheet.

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 _5/01/2018_, 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 (i.e.; to insurance companies)

HEALTHCARE OPERATIONS: We may use and disclose your health information for treatment, payment or 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, 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 (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your locations, 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 judgement disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgement 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 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: 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. By signing the correlating form you are giving Main Street Dental Center permission to send your records to you directly via email, mail or otherwise, as well permission to give your health information to other healthcare providers.

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.

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 locations, 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 must 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, you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information regarding 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 method or locations, you may submit a complaint 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 Human Services.

Contact Officer: Kristie Eason Office #: 830-798-0844 Email: mainstdentalmf@gmail.com