Wallace C. Price, D.M.D.

Cell phone #_____

(Please Print)

Patient Name _____ Age ____ Referred By _____

Street Address _____ Phone (H) _____

City, State and Zip _____ Sex M____ F ____

Employer _____ How Long Employed? _____ Phone (W) _____

Bus. Address _____ Marital Status _____ Birth Date _____

Spouse/Parent Name _____ Occupation (Spouse) _____

Former Dentist _____ Physician _____

Last Physical Exam _____ Findings _____ D.L. # _____

Responsible for account _____ Do you have dental insurance? _____

* Please present your Insurance I.D. card to office

Policy No. _____ Company _____ S.S. # _____

Present Dental Complaints _____ Emergency Phone _____

Have you ever had:	Yes	No
Hepatitis		
Epilepsy		
Rheumatic Fever		
Kidney Disease		
Diabetes		
Liver Disease		
Tuberculosis		
Heart Trouble		
Heart Murmur		
High Blood Pressure		
Shortness of Breath		
Chest Pains		
Allergies		
Medical Treatment by X-Ray		
Radiation or Chemo Therapy		
Surgery		
Glaucoma		
Prostate Trouble		
Contact Lenses		
Drug Reaction		
Any Serious Illness Not listed		

Are You:	Yes	No
Presently Under the Care of a Physician?		
Taking Any Medication Now or Within Past Year		
Allergic to Dental Anesthetic		
Aware of Recent Weight Change		
Subject to Frequent Urination		
Often Thirsty		
Often Exhausted or Fatigued		
Subject to Frequent Headaches		
A Nervous Person		
Often Unhappy or Depressed		
In Good Health Now		
Allergic to any Medication		
AIDS or Immuno Suppressive Disorders		
Nervous or Psychiatric Disorders		

Other _____

_____

_____

	Yes	No
Do you have prolonged bleeding after injury or tooth extraction?		
If female, are you now:		
Pregnant		
Taking Anti-pregnancy Drug		
Presently in Menopause		
Post Menopause		
Have you ever had Orthodontic treatment?		
Do you ever have sore teeth?		
Have you ever been told you had gum trouble?		
Have you ever had trench mouth?		
Have you ever been treated for Periodontal disease (Pyorrhea)?		
Do you fear dental treatment?		
Are you aware of grinding or clenching your teeth day or night?		
Do you ever have sore or popping joints?		
Do you smoke/chew/dip?		

APPOINTMENTS

So that we may assure you and other patients of uninterrupted treatment, it is necessary for all patients to accept and adhere to a definite arrangement of appointment and fees. Once an appointment is made, please remember that this time is reserved for you; AT LEAST 24 HOURS NOTICE MUST BE GIVEN IF CANCELLATION IS ABSOLUTELY NECESSARY, OTHERWISE A CANCELLATION CHARGE WILL BE MADE.

INSURANCE

To avoid misunderstandings regarding dental insurance, we wish our patients to know that ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED DIRECTLY TO THE PATIENT and that PATIENTS ARE PERSONALLY RESPONSIBLE FOR PAYMENT OF FEES. We will prepare necessary forms or reports to help you obtain your benefits from insurance companies. We do not render our services on the basis that insurance companies will pay all our fees. Each fee is individual for the patient.

_____ _____

Signature Date

This is a summary. The complete policy is posted in our lobby for your review.

Wallace C. Price, D.M.D., P.C. ("Practice")

EFFECTIVE DATE April 1, 2003

Notice of Privacy Practices

Summary

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU. The following categories describe different ways that we use and disclose medical information.

For Payment We may use and disclose medical information about you so that the treatment and services you receive at the practice may be billed to and payment may be collected from you, an insurance company or a third party. For example: we may disclose your record to an insurance company, so that we can get paid for treating you.

For Treatment We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you at the practice or the hospital. For example, we may disclose medical information about you to people outside the practice who may be involved in your medical care, such as family members, clergy or others persons that are part of your care.

For Health Care Operations. We may use and disclose medical information about you for health care operations. These uses and disclosures are necessary to run the practice and ensure that all of our patients receive quality care. We may also disclose information to doctors, nurses, technicians, medical students, and other practice personnel for review and learning purposes. For example, we may review your record to assist our quality improvement efforts.

POLICY REGARDING THE PROTECTION OF PERSONAL INFORMATION. We create a record of the care and services you receive at the practice. We need this record in order to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by the practice, whether made by practice personnel or by your personal doctor. The law requires us to make sure that medical information that identifies you is kept private; give you this notice of our legal duties and privacy practices with respect to medical information about you; and to follow the terms of the notice that is currently in effect. Other ways we may use or disclose your protected healthcare information include: appointment reminders, as required by law; for health related benefits and services; to individuals involved in your care or payment for your care; research; to avert a serious threat to health or safety; and for treatment alternatives. Other uses and disclosures of your personal information could include disclosure to, or for: coroners, medical examiners and funeral directors; health oversight activities; inmates; law enforcement; lawsuits and disputes; military and veterans; national security and intelligence activities; organ and tissue donation; protective services for the President and others; public health risks; and worker's compensation.

NOTICE OF INDIVIDUAL RIGHTS

You have the following rights regarding medical information we maintain about you:

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures."

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by, or for, the practice.

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care.

Right to a Paper Copy of this Notice. You have a right to a paper copy of this notice.

Right to Request Confidential Communications. You have a right to request that we communicate with you about medical matters in a certain way or at a certain location.

Right to Request Restrictions. You have a right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend.

COMPLAINTS. If you believe your privacy rights have been violated, you may file a complaint with the practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the practice, contact our **Administrator/Privacy Officer at 256-238-1121.** All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

OTHER USES OF MEDICAL INFORMATION. Other uses and disclosures of medical information not covered by this notice or the laws that apply to use will be made only with your written authorization. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time.

If you have any questions about this notice or would like to receive a more detailed explanation, please contact our Privacy officer.

I acknowledge by signing below that I have received the Notice of Privacy Practices and Notice of Individual Rights.

_____ _____

Patient or Patient's Personal Representative **Date**

_____

Print Name