Patient Registration

CURRENT DATE: __/__/____

Patient ID: _____ Chart ID: _____ ☐ Mr. ☐ Mrs. ☐ Ms ☐ Dr. *Other:* _____

First Name _____ **Last Name** _____ **Middle Initial** _____

Other Physician Name _____

Responsible Party (If someone other than the patient)

Name _____

Patient Information

Street Address _____

City, State, Zip _____

Home Phone _____ Work Phone _____ Ext. _____ Cell Phone _____

Sex: ☐ Male ☐ Female ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date _____ Soc Sec # _____

E-mail _____ Spouse Name _____

☐ Employed Student Status ☐ Full Time ☐ Part Time Height: Feet ___ Inches ___

INSURANCE INFORMATION

Primary Insurance Information

First Name of Insured _____ Last Name _____ Middle Initial _____

Policy/Group No. _____ Relationship to insured ☐ Self ☐ Spouse

Insurance ID No. _____ ☐ Child ☐ Other

Insured Birth Date _____ Insurance Plan or Program Name _____

Employer _____ Ins. Company _____

Insured Address if different than patient's Street Address _____

Street Address _____

City, State, Zip _____ City, State, Zip _____

Secondary Insurance Information

First Name of Insured _____ Last Name _____ Middle Initial _____

Policy/Group No. _____ Insurance Plan or Program Name _____

Insured Birth Date _____ Sex: Insurance ID No. _____

Employer _____ Ins. Company

Insured Address if different than patient's Street Address

Street Address

City, State, Zip City, State, Zip

Medical History Questionnaire

OFFICE USE
Patient ID: _____

NAME: _____
First *Middle Initial* *Last*

FORM DATE: __/__/____

DATE OF BIRTH: _____

This questionnaire was designed to provide important facts regardng the history of your pain or condition. The information you provide will assist in reaching a diagnosis and determining the source of your problem. Please take your time and answer each question as completely and honestly as possible. Please sign each page.

LIST ANY MEDICATIONS/SUBSTANCES WHICH HAVE CAUSED AN ALLERGIC REACTION:

Y ☐ N ☐	No known allergens	Y ☐ N ☐	Iodine	Y ☐ N ☐	Plastic
Y ☐ N ☐	Antibiotics	Y ☐ N ☐	Latex	Y ☐ N ☐	Sedatives
Y ☐ N ☐	Aspirin	Y ☐ N ☐	Local anesthetics	Y ☐ N ☐	Sleeping pills
Y ☐ N ☐	Barbiturates	Y ☐ N ☐	Metals	Y ☐ N ☐	Sulfa drugs
Y ☐ N ☐	Codeine	Y ☐ N ☐	Penicillin		

Other _____ _____ _____

LIST ANY MEDICATIONS CURRENTLY BEING TAKEN:

Medication name	Dosage/ Frequency	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Other Items: _____ _____

MEDICAL HISTORY: (Please indicate dates on items marked past)

Medical condition	Never	Current	Past	If past, enter date
Acid reflux	☐	☐	☐	_____
Adenoids Removed	☐	☐	☐	_____
Anemia	☐	☐	☐	_____
Arthritis	☐	☐	☐	_____
Asthma	☐	☐	☐	_____
Autoimmune disorder	☐	☐	☐	_____
Arteriosclerosis	☐	☐	☐	_____
Bleeding easily	☐	☐	☐	_____
Blood pressure - High	☐	☐	☐	_____
Blood pressure - Low	☐	☐	☐	_____
Bruising easily	☐	☐	☐	_____
Cancer	☐	☐	☐	_____
Chemotherapy	☐	☐	☐	_____
Chronic cough	☐	☐	☐	_____
Chronic fatigue	☐	☐	☐	_____
Chronic pain	☐	☐	☐	_____
Chronic sinus problems	☐	☐	☐	_____
COPD	☐	☐	☐	_____
Cold hands and feet	☐	☐	☐	_____
CPAP	☐	☐	☐	_____

Medical condition	Never	Current	Past	If past, enter date
Insomnia	☐	☐	☐	_____
Intestinal disorders	☐	☐	☐	_____
Irregular heartbeat	☐	☐	☐	_____
Jaw joint surgery	☐	☐	☐	_____
Kidney problems	☐	☐	☐	_____
Liver disease	☐	☐	☐	_____
Low energy	☐	☐	☐	_____
Meniere's disease	☐	☐	☐	_____
Menstrual cramps	☐	☐	☐	_____
Mitral valve prolapse	☐	☐	☐	_____
Multiple sclerosis	☐	☐	☐	_____
Muscle aches	☐	☐	☐	_____
Muscle shaking (tremors)	☐	☐	☐	_____
Muscle spasms or cramps	☐	☐	☐	_____
Muscular dystrophy	☐	☐	☐	_____
Nasal allergies	☐	☐	☐	_____
Needing extra pillows to help breathing at night	☐	☐	☐	_____
Nervous system irritability	☐	☐	☐	_____
Nervousness	☐	☐	☐	_____

Patient Signature _____ Date _____

Medical condition	Never	Current	Past	If past, enter date
Current pregnancy	☐	☐	☐	_____
Depression	☐	☐	☐	_____
Diabetes	☐	☐	☐	_____
Difficulty concentrating	☐	☐	☐	_____
Difficulty sleeping	☐	☐	☐	_____
Dizziness/Vertigo	☐	☐	☐	_____
Emphysema	☐	☐	☐	_____
Epilepsy	☐	☐	☐	_____
Excessive thirst	☐	☐	☐	_____
Fibromyalgia	☐	☐	☐	_____
Fluid retention	☐	☐	☐	_____
Frequent cough	☐	☐	☐	_____
Frequent illnesses	☐	☐	☐	_____
Frequent stressful situations	☐	☐	☐	_____
Gastrointestinal Reflux Disease (GERD)	☐	☐	☐	_____
General anesthesia	☐	☐	☐	_____
Glaucoma	☐	☐	☐	_____
Gout	☐	☐	☐	_____
Hay fever	☐	☐	☐	_____
Hearing impaired	☐	☐	☐	_____
Heart attack	☐	☐	☐	_____
Heart disorder	☐	☐	☐	_____
Heart murmur	☐	☐	☐	_____
Heart pacemaker	☐	☐	☐	_____
Heart palpitations	☐	☐	☐	_____
Heart valve replacement	☐	☐	☐	_____
Hemophilia	☐	☐	☐	_____
Hepatitis	☐	☐	☐	_____
Hypertension	☐	☐	☐	_____
Hypoglycemia	☐	☐	☐	_____
Immune system disorder	☐	☐	☐	_____
Injury to face	☐	☐	☐	_____
Injury to mouth	☐	☐	☐	_____
Injury to neck	☐	☐	☐	_____
Injury to teeth	☐	☐	☐	_____

Medical condition	Never	Current	Past	If past, enter date
Neuralgia	☐	☐	☐	_____
Numbness of fingers	☐	☐	☐	_____
Osteoarthritis	☐	☐	☐	_____
Osteoporosis	☐	☐	☐	_____
Ovarian cysts	☐	☐	☐	_____
Parkinson's disease	☐	☐	☐	_____
Poor circulation	☐	☐	☐	_____
Prior orthodontic treatment	☐	☐	☐	_____
Psychiatric care	☐	☐	☐	_____
Radiation treatment	☐	☐	☐	_____
Restless leg syndrome	☐	☐	☐	_____
Rheumatic fever	☐	☐	☐	_____
Rheumatoid arthritis	☐	☐	☐	_____
Scarlet fever	☐	☐	☐	_____
Scoliosis	☐	☐	☐	_____
Shortness of breath	☐	☐	☐	_____
Sinus problems	☐	☐	☐	_____
Skin disorder	☐	☐	☐	_____
Sleep apnea	☐	☐	☐	_____
Slow healing sores	☐	☐	☐	_____
Speech difficulties	☐	☐	☐	_____
Stroke	☐	☐	☐	_____
Swelling in ankles or feet	☐	☐	☐	_____
Swollen, stiff or painful joints	☐	☐	☐	_____
Tendency for frequent colds	☐	☐	☐	_____
Tendency for ear infections	☐	☐	☐	_____
Tendency for sore throats	☐	☐	☐	_____
Thyroid disorder	☐	☐	☐	_____
Tinnitis/Ringing in the ears	☐	☐	☐	_____
Tired muscles	☐	☐	☐	_____
Tonsils Removed	☐	☐	☐	_____
Tuberculosis	☐	☐	☐	_____
Tumors	☐	☐	☐	_____
Urinary disorders	☐	☐	☐	_____
Wisdom teeth extracted	☐	☐	☐	_____
Vertigo	☐	☐	☐	_____

Other	Current	Past	If past, enter date
_____	☐	☐	_____
_____	☐	☐	_____
_____	☐	☐	_____

	Current	Past	If past, enter date
_____	☐	☐	_____
_____	☐	☐	_____
_____	☐	☐	_____

ADDITIONAL MEDICAL HISTORY ITEMS:

	Never	Current	Past	If past, enter date
Recreational drugs	☐	☐	☐	_____

	Never	Current	Past	If past, enter date
HIV/AIDS	☐	☐	☐	_____

Patient Signature _____ Date _____

LIST ANY SURGICAL OPERATIONS YOU HAVE HAD:

Y ☐ N ☐ Appendectomy	Y ☐ N ☐ Heart	Y ☐ N ☐ Thyroid
Y ☐ N ☐ Back	Y ☐ N ☐ Hernia repair	Y ☐ N ☐ Tonsillectomy
Y ☐ N ☐ Ear	Y ☐ N ☐ Lung	Y ☐ N ☐ Uvulectomy
Y ☐ N ☐ Gallbladder	Y ☐ N ☐ Nasal	Y ☐ N ☐ Periodontal
Other _____	_____	_____
_____	_____	_____

FAMILY HISTORY Has any member of you family had (parent, sibling or grandparent):

__Yes __No Cancer	__Yes __No Obesity
__Yes __No Heart disease	__Yes __No Thyroid disorder
__Yes __No Diabetes	__Yes __No Father snores
__Yes __No High blood pressure	__Yes __No Mother snores
__Yes __No Stroke	__Yes __No Father has sleep apnea
__Yes __No Sleep disorder	__Yes __No Mother has sleep apnea

SOCIAL HISTORY:

Patient's Occupation _____ Employer _____

Tobacco Use: Cigarettes ☐ Never smoked ☐ Current smoker # packs per day ____ # of years ____ ☐ Quit When did you quit? _____

Other tobacco: ☐ Pipe ☐ Snuff ☐ Cigar ☐ Chew

Alcohol Use: Do you drink alcohol? ☐ Yes ☐ No If yes, # of drinks per week: ____

Caffeine Intake: ☐ None ☐ Coffee/Tea/Soda # cups per day: ____

Additional:

__Yes __No Regular exercise _____ Number of children:

I authorize the release of a full report of examination findings, diagnosis, treatment program etc., to any referring or treating dentist or physician. I additionally authorize the release of any medical information to insurance companies or for legal documentation to process claims. I understand that I am responsible for all charges for treatment to me regardless of insurance coverage.

Patient Signature _____ Date _____

I certify that the medical history information is complete and accurate.

Patient Signature _____ Date _____

Version: SLPQV2

Sleep Consultation

OFFICE USE
Patient ID: _____

NAME: _____ CURRENT DATE: __/__/____
First *Middle Initial* *Last*

DATE OF BIRTH: _____ ☐MALE ☐FEMALE

Referring Physician: _____

Number
#1 = the most severe symptom

____ CPAP intolerance
____ Difficulty falling asleep
____ Fatigue
____ Frequent heavy snoring
____ Frequent heavy snoring which affects the sleep of others

____ _____
____ _____
____ _____

Continued...

____ Gasping when waking up
____ Nighttime choking spells
____ Significant daytime drowsiness
____ Sleepiness while driving
____ Witnessed apneic events

____ _____
____ _____
____ _____

THE EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situatons?

✓ **Check one in each row:**	**0 No chance of dozing**	**1 Slight chance of dozing**	**2 Moderate chance of dozing**	**3 High chance of dozing**
Sitting and reading	☐	☐	☐	☐
Watching TV	☐	☐	☐	☐
Sitting inactive in a public place (i.e. a theater or a meeting)	☐	☐	☐	☐
As a passenger in a car for an hour without a break	☐	☐	☐	☐
Lying down to rest in the afternoon when circumstances permit	☐	☐	☐	☐
Sitting and talking to someone	☐	☐	☐	☐
Sitting quitely after a lunch without alcohol	☐	☐	☐	☐
In a car, while stopping for a few minutes in traffic	☐	☐	☐	☐

Total Score: _____ *(Add columns 0-3)*

FATIGUE SCALE

During the past week:	No << 1	2	3	4	5	6	7 >> Yes
I felt fatigued and had less motivation	☐	☐	☐	☐	☐	☐	☐
I felt fatigued and did not desire to exercise	☐	☐	☐	☐	☐	☐	☐
I felt fatigued often	☐	☐	☐	☐	☐	☐	☐
I felt fatigue that interfered with my physical functioning	☐	☐	☐	☐	☐	☐	☐
I felt fatigued which caused me frequent problems	☐	☐	☐	☐	☐	☐	☐
I felt fatigued which prevented sustained physical functioning	☐	☐	☐	☐	☐	☐	☐
I felt fatigued and couldn't carry out certain duties and responsibilities	☐	☐	☐	☐	☐	☐	☐
Fatigue was among my three most disabling symptoms	☐	☐	☐	☐	☐	☐	☐
Fatigue interfered with my work, family or social life	☐	☐	☐	☐	☐	☐	☐

Total Score: ____

Berlin Questionnaire Sleep Evaluation

category 1

1. Complete the following:

   Height ___ ft ___ in

   Weight ____ Age ____

2. Do you snore?
   - ☐ yes
   - ☐ no
   - ☐ don't know

If you snore: *(Answer questions 3-6)*

3. Your snoring is?
   - ☐ slightly louder than breathing
   - ☐ as loud as talking
   - ☐ louder than talking
   - ☐ very loud. Can be heard in adjacent rooms

4. How often do you snore?
   - ☐ nearly every day
   - ☐ 3-4 times a week
   - ☐ 1-2 times a week
   - ☐ 1-2 times a month
   - ☐ never or nearly never

5. Has your snoring ever bothered other people?
   - ☐ yes
   - ☐ no

6. Has anyone noticed that you quit breathing during your sleep?
   - ☐ nearly every day
   - ☐ 3-4 times a week
   - ☐ 1-2 times a week
   - ☐ 1-2 times a month
   - ☐ never or nearly never

category 2

7. How often do you feel tired or fatigued after your sleep?
   - ☐ nearly every day
   - ☐ 3-4 times a week
   - ☐ 1-2 times a week
   - ☐ 1-2 times a month
   - ☐ never or nearly never

8. During your waketime, do you feel tired, fatigued or not up to par?
   - ☐ nearly every day
   - ☐ 3-4 times a week
   - ☐ 1-2 times a week
   - ☐ 1-2 times a month
   - ☐ never or nearly never

9. Have you ever nodded off or fallen asleep while driving a vehicle?
   - ☐ yes
   - ☐ no

   If yes, how often does it occur?
   - ☐ nearly every day
   - ☐ 3-4 times a week
   - ☐ 1-2 times a week
   - ☐ 1-2 times a month
   - ☐ never or nearly never

category 3

10. Do you have high blood pressure?
    - ☐ yes
    - ☐ no
    - ☐ don't know

(For office use)

Scoring Questions: Any answer within the box is a positive response

Scoring categories

- ☐ Category 1 is positive with 2 or more positive responses to questions 2-6
- ☐ Category 2 is positive with 2 or more positive responses to questions 7-9
- ☐ Category 3 is positive with 1 positive response and/or a BMI > 30

Score: ___

(BMI = Body Mass Index)

Final Result: 2 or more possible categories indicates a high likelihood of sleep disordered breathing.

Patient Signature _____ Date _____

SLEEP STUDIES

Have you ever had an evaluation at a Sleep Center? ☐ Yes ☐ No

☐ Home Sleep Study ☐ Polysomnographic evaluation performed at sleep disorder center

Sleep Center Name _____

Sleep Study Date _____

FOR OFFICE USE ONLY

The evaluation confirmed a diagnosis of
[ ] moderate obstructive sleep apnea
[ ] severe obstructive sleep apnea
[ ] mild obstructive sleep apnea

The evaluation showed

		during REM	*Supine*	*Side*
an RDI of	____	____	____	____
an AHI of	____	____	____	____

a nadir SpO2 of ____ T90 ____ ODI (Oxygen Desaturation Index)

Slow Wave Sleep ☐ Decreased ☐ None
REM Sleep ☐ Decreased ☐ None

CPAP Intolerance (Continuous Positive Airway Pressure device)

If you have attempted treatment with a CPAP device, but could not tolerate it please fill in this section:

__Yes __No Mask leaks
__Yes __No Inability to get the mask to fit properly
__Yes __No Discomfort from headgear
__Yes __No Disturbed or interrupted sleep
__Yes __No Noise disturbing sleep and/or bed partner's sleep
__Yes __No CPAP restricted movements during sleep
__Yes __No CPAP does not seem to be effective
__Yes __No Pressure on the upper lip causing tooth related problems
__Yes __No Latex allergy
__Yes __No Claustrophobic associations
__Yes __No An unconscious need to remove the CPAP
__Yes __No Does not resolve symptoms
__Yes __No Noisy
__Yes __No Cumbersome

Other _____ _____ _____

OTHER THERAPY ATTEMPTS

What other therapies have you had for breathing disorders?

__Yes __No Dieting
__Yes __No Weight loss
__Yes __No Surgery (Uvuloplasty)
__Yes __No Surgery (Uvulectomy)
__Yes __No Pillar procedure
__Yes __No Smoking cessation
__Yes __No CPAP
__Yes __No BiPap
__Yes __No Uvulectomy (but continues to have symptoms)
__Yes __No Uvuloplasty (but continues to have symptoms)

Other _____
_____

Patient Signature _____ Date _____

SLEEP HISTORY

Previous Diagnosis

☐ Yes ☐ No Have you been previously diagnosed with Obstructive Sleep Apnea?

If Yes, how long ago was it? _____ ☐ Years ago ☐ Months ago ☐ Days ago
number

Sleep:

How long does it take you to fall asleep? ____ minutes

Normally goes to bed at ___ ☐ AM ☐ PM

Hours of sleep per night ___ hours

Sleep aid ☐ Yes ☐ No

If yes, name that medication _____

__Yes __No Bruxism
__Yes __No Dry mouth
__Yes __No Excessive movements
__Yes __No Gasping
_____ Getting up <number of times> per night
__Yes __No Hypnagogic Hallucinations
__Yes __No Restless legs
__Yes __No Waking up and having difficulty returning to sleep
__Yes __No Dreaming
_____ Frequency of nocturnal urination (# of times)

Witnessed apneas are:

__Yes __No Worse during supine sleep
__Yes __No Worse following alcohol late at night

Wake

Sleepiness while driving ☐ Yes ☐ No

└ Risks discussed ☐ Yes ☐ No

The patient:

__Yes __No Awakens unrefreshed
__Yes __No Has morning headaches

_____ Naps
_____ (Choose ONE from below)
_____ naps daily
never napping
occasionally naps

Snoring is reported as:

_____ Frequency
_____ (Choose ONE from below)
_____ seldom
_____ never
daily
often

_____ Severity
_____ (Choose ONE from below)
_____ light
moderate
loud

__Yes __No Worse during supine sleep
__Yes __No Worse following alcohol late at night

I authorize the release of a full report of examination findings, diagnosis, treatment program etc., to any referring or treating dentist or physician. I additionally authorize the release of any medical information to insurance companies or for legal documentation to process claims. I understand that I am responsible for all charges for treatment to me regardless of insurance coverage.

Patient Signature _____ Date _____

I certify that the medical history information is complete and accurate.

Patient Signature _____ Date _____

Notice of Privacy Practices

Purpose: This form, Notice of Privacy Practices, presents the information that federal law requires us to give our patients regarding our privacy practices. {Note: this form may need to be changed to reflect the dental practice's particular privacy policies and/or stricter state laws.}

We must provide this Notice to each patient beginning no later than the date of our first service delivery to the patient, including service delivered electronically, after April 14, 2003. We must make a good-faith attempt to obtain written acknowledgement of receipt of the Notice from the patient. We must also have the Notice available at the office for patients to request to take with them. We must post the Notice in our office in a clear and prominent location where it is reasonable to expect any patients seeking service from us to be able to read the Notice. Whenever the Notice is revised, we must make the Notice available upon request on or after the effective date of the revision in a manner consistent with the above instructions. Thereafter, we must distribute the Notice to each new patient at the time of service delivery and to any person requesting a Notice. We must also post the revised Notice in our office as discussed above.

{NAME OF PRACTICE}

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 01 / 01 / 15, 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.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We 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 or with payment for 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 of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

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

Abuse or Neglect: We may disclose your health information to appropriate authorities if we 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. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0. 25c for each page, $15.00 per hour for staff time to copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional 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 location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

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

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. 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 Health and Human Services.

Contact Officer: Mark W. Langberg

Telephone: 248 356-8790 Fax: 248 356-8793

E-mail: drlangberg@drlangberg.com

Address: 26206 W. 12 Mile Rd. Ste 303, Southfield M148034

MARK W LANGBERG DDS, MAGD, PC
26206 W. 12 MILE RD, STE 303
SOUTHFIELD, MI 48034
(248)356-8790

We are grateful you have chosen us. Please help us learn more about our web presence.

How did you hear about us?_____

If you found us on the internet, how did you search?_____

Google_____ Yahoo_____ Bing_____ Angie's List_____ Other_____

What specific search words did you use?_____

What about our website attracted you?_____

Acknowledgement of Receipt of this Practices Privacy Notice

I acknowledge that I have been given the choice of reviewing the Notice of Privacy Practices of this office. I am aware that I may receive a paper copy of this notice if I request it. In addition, I acknowledge that the Notice of Privacy Practice is kept in each treatment room of the office where I can review it if desired.

_____ _____

Patient or Patient Representative or Parent **Date**
(If patient representative signs above, please include relationship to patient)

The patient presented for treatment on this date and was provided with the Practice Privacy Notice. A good faith effort was made to obtain written acknowledgement of receipt. A written acknowledgement was not obtained because:

_____ Patient refused to sign, with the reason_____

_____ Patient is unable to sign due to_____

_____ There was a medical emergency preventing timely signature, and an attempt will be made to obtain acknowledgement later.

_____ Other_____

Employee Signature_____ Date_____