

Patient Information

Date _____

Patient's Name _____
Last First MI MALE FEMALE

Address _____
Street City State Zip

Home Phone _____ Work Phone _____ Cell Phone _____ Birthdate _____

E-mail _____

Employer _____ Occupation _____ SSN _____

Whom may we thank for referring you to our office? _____

Person responsible for this account? _____
Last First Middle

Relationship to patient _____ Phone _____

Address _____ How long at present address? _____

Spouse or Parent Information

Name _____
Last First MI Relationship

Address _____
Street City State Zip

Home Phone _____ Cell Phone _____ Work Phone _____

SSN _____ Birthdate _____

Employer _____ Occupation _____

Insurance Information

Insured's Name _____ Subscriber's I.D.# _____

Insured's Employer _____

Insurance Company _____ Group No. _____

Insurance Company Phone _____ Insurance Company Address _____

Do you have double coverage? Yes No If yes: _____

Insured's Name _____ Subscriber's I.D.# _____

Insured's Employer _____

Insurance Company _____ Group No. _____

Insurance Company Phone _____ Insurance Company Address _____

Emergency Information

Name of the nearest relative not living with you _____

Complete Address _____

Phone _____

Where appropriate, credit reports may be obtained with patient consent.

Signature _____

FOR OFFICE USE ONLY

Updates (date & initial) _____

*** PLEASE FILL OUT HEALTH QUESTIONNAIRE ON REVERSE SIDE ***

FOR OFFICE USE ONLY

HEALTH INFORMATION UPDATES RMH _____

BLOOD PRESSURE Date _____ Pressure _____

Robert L. Friess, D.M.D. HEALTH QUESTIONNAIRE Raymond A. Youngberg, D.M.D.

MEDICAL

Name of Physician _____ Phone _____ In Salem? Yes [] No []

Have you had a complete physical within the past 5 years? Yes [] No []

General health: Excellent [] Good [] Fair [] Poor []

Are you taking medication? Yes [] No [] What kind? _____

Are you allergic to: Penicillin [] Codeine [] Local anesthetic [] Other medications []

Pregnant? Yes [] No []

Have you ever been treated for drug or alcohol abuse? Yes [] No []

HAVE YOU EVER HAD?

- Heart Disease Yes [] No [] Frequent Headaches Yes [] No []
Heart Valve Problems Yes [] No [] Excess Urination Yes [] No []
Rheumatic Fever Yes [] No [] Jaundice Yes [] No []
Abnormal Blood Pressure Yes [] No [] Asthma Yes [] No []
Chest Pains Yes [] No [] Sinus Trouble Yes [] No []
Fainting or Dizziness Yes [] No [] Hepatitis A, B, or C Yes [] No []
Shortness of Breath Yes [] No [] STD (Sexually Transmitted Disease) Yes [] No []
Do you have any prosthetic joints? Yes [] No [] HIV Positive Yes [] No []
Stints in Vessels Yes [] No [] AIDS Yes [] No []
Shunts Yes [] No [] Arthritis Yes [] No []
Ulcers Yes [] No [] Stroke Yes [] No []
T.B. or Lung Disease Yes [] No [] Glaucoma Yes [] No []
Diabetes Yes [] No [] Osteoporosis Yes [] No []
Epilepsy Yes [] No [] Have you ever been seriously ill or hospitalized? Yes [] No []
Anemia Yes [] No [] If Yes, when and what for? _____
Cancer or Tumor Yes [] No [] Have you had a blood transfusion? Yes [] No []
Psychiatric Therapy Yes [] No [] Do you use tobacco? Type _____ Yes [] No []
Periods of Depression Yes [] No []

What other health conditions should we be aware of? _____

DENTAL

Date of last dental exam _____ Former dentist _____ Phone _____

Has your dental care been: Regular (yearly) [] Intermittent (when necessary) [] Infrequent (when in pain) []

Dental goal _____

Have you had any unfavorable experiences from previous dental treatment? Yes [] No []

If yes, give details _____

[] I give permission for all previous dental records to be released from my former dentist

Patient's Signature: _____ Date _____

Additional comments: _____

ROBERT L. FRIESS, DMD & RAYMOND A. YOUNGBERG, DMD
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 12/29/2003, and will remain in effect until we replace it.

We reserved the right to change our privacy practices and the terms of the 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 and disclose your health information to a dentist, hygienist or other healthcare provider for treatment purposes.

Payment: We may use and disclose your health information to bill for and collect 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 providers, evaluating provider performance, conducting training programs, peer review, 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 may disclose health information about you to your family members or friends if we obtain your verbal authorization to do so if we give you an opportunity to object and you do not object. We also may disclose health information to your family or friends if we can infer from the circumstances, based on our reasonable judgment that you would not object, for example when you bring your spouse with you when treatment is discussed. We may use our professional judgment to infer that it is in your best interest to allow another person to pick-up filled prescriptions, medical supplies, x-rays or recommend that they take you to your physician or emergency room.

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, or your general condition. 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.

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 federal, state or local law or legal process, for example, subpoena, court order, administrative order, warrant, or summons; and pursuant to workers' compensation laws.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we have reason to 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.

Governmental Officials and Law Enforcement: We may disclose to authorize governmental officials health information required for lawful investigation, military authorities, the health information of Armed Forces personnel, and a correctional institution or law enforcement officials having lawful custody of health information of an inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as postcards, voicemail messages, or letters) or information about oral health care and related benefits and services.

PATIENTS RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You must request access by sending us a letter to the address at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies, postage and staff time. If you request an alternative format that we can practicably provide, 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 December 29, 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.

Restrictions: You have the right to request in writing that we place additional restrictions on our use of 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 explanations 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 by electron 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 of 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. You will not be penalized in any way if you choose to file a complaint with us or the U.S. Department of Health and Human Services.

Patients Rights Information and/or Complaints:

Robert L. Friess, DMD
Raymond A. Youngberg, DMD
3295 Triangle Dr. SE, Suite 242
Salem, OR 97302
(503) 585-0101