Existing Patient Update:

Name: ____

Address: ____

Home #:__________________ **Cell #:** ___________________ **Work #:** ___________________

E-mail address: ____

Dental Insurance Carrier: ______________________________________

Health changes: ____

Date of last visit with physician: __________________________________

Signature: ____ **Date:** ___________

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LIST OF CURRENT MEDICATIONS:

List all tablets, patches, drops, ointments, injections, etc. Include prescription, over-the-counter, herbal, vitamin, and diet supplement products. Also list any medicine you take only on occasion (like Viagra, albuterol, nitroglycerin).

Medication (Brand and Generic Name)	Dose	How Often Do You Take the Medication	Reason for taking medication	Prescriber

Known Allergies:

List any reaction you have experienced from medicines that have had bad side effects. Also include any allergy to dye, food, etc.

Signature: **Date:**

HIPAA Consent To Leave A Message

Patient Name: ____ Date: ___________________
(print)

I wish to be called at: (fill all that apply)

Home: ______________________________________

Cell: ____

Other: _______________________________________

Regarding my care and follow-up.

- ❑ I do
- ❑ I do not

Give permission to leave relevant medical information on my answering machine or voice mail. These might include: treatment plans, pre-medication reminders, and general Protected Health Information.

- ❑ I do
- ❑ I do not

Want relevant medical information to be shared with the person who may answer the telephone. The name(s) of the individual(s) with whom you may leave Protected Health Information are:

1. ____
2. ____
3. ____

____ _________________

Patient Signature Date

Acknowledgement of Receipt of Notice of Privacy Practices

* You May Refuse to Sign This Acknowledgment*

I have received/ been offered a copy of this office's Notice of Privacy Practices.

Print Name: ________________________________

Signature: __________________________________ Date: ______________________

I give permission to leave health information and/ or appointment information on my answering system at: (Please check all that apply)

Home______ Work________ Cell______ __________ (Initial)

I give permission to discuss health care information with:

Name/Relationship_______________________________________ **Contact #**________________________

Name/Relationship_______________________________________ **Contact #**________________________

__________ (Initial)

May we have your permission to show our appreciation and send a thank you to the person who referred you to our practice? (Please circle one) Yes or No

__________ (Initial)

Right to Revoke:

I have the right at any time to revoke this Acknowledgement for any reason.

Signature: ______________________________________Date:______________________________

E-mail Statement and Acknowledgment:

It is our office's goal to keep your information confidential and secure. Being that most E-mail systems are unencrypted, there are inherent risks with E-mail (e.g. interception, alteration). If you understand the risks associated with E-mail and would still like to be communicated with in that way, please acknowledge below.

__________ (Initial)

For Office Use Only

____

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement

Other (Please Specify)