HIPPA PATIENT QUESTIONAIRE

1. Please List the family members or other person(s), if any whom we may inform about your general medical/dental condition and your diagnosis (including treatment, payment and health care information):

Name: _____Phone Number: _____

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

Name: _____Phone Number: _____

2. Please list the family members or others, if any we may inform about your dental /medical conditions **ONLY IN A EMERGENCY**

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

3. Please print the address of where you would like your billing statements and /or correspondence from our office to be sent .

Name: _____ Address: _____

4. Please indicate if you want all correspondence from us sent in a sealed envelope marked "Confidential". YES ___ NO ___

5. Please print the telephone number or e-mail where you want to receive calls about your appointments, lab and x-ray results or other health care information.

Number : _____ E-Mail :_____

6. Can confidential messages (ie., appointment reminders) be left on your telephone answering machine or voicemail? Yes ____ No ___

7. I understand the Privacy Protection Act and have been offered a copy of the Organization's Notice of Privacy Practices updated for the HITECH Omnibus Rule 2013.

Patient Name : _____ (guardian if under 18 years)

Patient/ Guardian Signature _____ Date : _____