PITTSBURGH DENTAL ASSOCIATES

PERSONAL INFORMATION

Name: _____ Date: _____
Street address: _____
City: _____ State: _____ Zip: _____
Home phone: _____ Business phone: _____ Cell phone:_____
Date of Birth: _____ Sex: _____ Height: _____ Weight: _____
Place of employment: _____ Occupation: _____
Social security number: _____ Email address: _____
Marital Status: _____ Emergency contact:_____
Phone number: _____Relationship: _____

DENTAL INSURANCE INFORMATION

Company: _____ Subscriber name & Birth date: _____
ID#:_____ Group #:_____

HEALTH INFORMATION

1. Are you in good health? _____ 2. Are you now under the care of a physician? _____
3. If yes, for what reason?_____
4. Have you been hospitalized or seriously ill within the past five years? _____
   If yes, for what reason? _____
5. Please circle any of the following health conditions that pertain to you:

high blood pressure	heart disease	heart murmur	lung disease
asthma	epilepsy	diabetes	joint replacement - list joint
hepatitis/liver disease	glaucoma	cancer – list cancer	heart valve
arthritis	blood disorders	osteoporosis	renal disease

6. Do you have any medical condition requiring pre-medications prior to dental appointments? _____
7. Do you have any disease or health condition that we should know about? _____
   _____
8. Please list any drugs or medications you are taking at this time: _____
   _____
9. Are you taking blood thinners or aspirin? _____
10. Are you taking any drugs for bone density or osteoporosis (i.e. Fosamax or Actonel?)_____
11. Are you taking Viagra (Sildenafil Citrate) or any drugs of this type?_____
12. Please list any allergies you have: _____
13. Do you smoke or use tobacco products? _____

WOMEN

14. Are you pregnant? _____
15. Are you taking oral contraceptives or hormonal therapy? _____

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Notice of Privacy Practices
SUMMARY

At Dr. Joshua Culver's office, we are committed to protecting the privacy of your medical/dental information, as federal and state laws require. When we say "Information" we mean health, treatment or payment information that identifies you. THIS SUMMARY IS NOT A COMPLETE LISTING OF HOW WE USE AND SHARE YOUR HEALTH INFORMATION. Pittsburgh Dental Associates has the right to change this Summary without first notifying you.

HOW DR. ANDROS MAY USE AND SHARE YOUR HEALTH INFORMATION

Without your consent, Dr. Culver can use and share your health information to:

- Provide you with dental treatment and other services
- Receive payment from you, an insurance company or someone else for services we provide you
- Operate Dr. Culver's office, which includes such things as giving you appointment reminders, telling you about other treatment options and contacting you for certain marketing activities.
- Comply with the law
- Meet special situations such as public health, safety and research.

Exception: <u>This does not include behavioral health, drug and alcohol and AIDS/HIV information.</u>

With your verbal agreement, Dr. Culver can:

- Share your dental information with the family and friends you agree can have this information.

ALL OTHER USES AND SHARING OF YOUR DENTAL INFORMATION WILL BE DONE ONLY WITH YOUR SPECIFIC WRITTEN PERMISSION OR AS REQUIRED BY LAW.

YOUR LEGAL RIGHTS ABOUT YOUR HEALTH INFORMATION

- RIGHT to ask to see and copy your dental record
- RIGHT to ask that incorrect or complete information in your dental record be corrected
- RIGHT to ask for a list of all parties with whom we have shared your health information. This does not include dental information we shared, 1) if we had your written permission to share the information and 2) to carry out treatment, payment and health care operations.
- RIGHT to ask Dr. Culver to limit how we use and share your dental information without your consent. Dr. Culver is not required to agree to your request.
- RIGHT to ask for confidential communications.
- RIGHT to ask for a paper copy of the Notice of Privacy Practices

VIOLATION OF PRIVACY RIGHTS
If you believe your privacy rights have been violated, you have a right to file a complaint.

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ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I acknowledge that I have received the attached Privacy Notice.

Patient name printed: _____

_____ _____

Patient or Personal Representative Signature Date

If Personal Representative's signature appears above, please describe Personal Representative's relationship to the patient:

_____