

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.

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.

I have received a copy of the Notice of Privacy Practices

Signature _____ **Date:** _____

I refuse to accept the copy of Privacy Practices

Signature _____ **Date:** _____

I hereby grant permission to Dr. James T Cirgin to administer anesthetics and to employ such operative or technical procedures as may be deemed necessary or advisable in the diagnosis or treatment. As a condition of treatment I will pay for all treatment and or costs for the collection of payment including collection fees and attorney fees. I grant my permission for you to call home or work to discuss matters related to this form. I have received a copy of Notice of Privacy Practices and am aware of health information that will be used in regards to treatment and or collection of treatment. A service charge of 1 ½ % monthly (18% per annum) on the unpaid balance will be charged on all accounts. I authorize release of any information relating to treatment.

Signature: _____ **Date:** _____

Relationship to patient _____

I authorize payment be sent to Dr. James T. Cirgin benefits otherwise payable to me from the insurance company. I am aware that the contract with my insurance company is between me and the insurance company and I am responsible for the full cost of treatment.

Signature: _____ **Date:** _____

James T. Cirgin D.D.S.

You may take this copy or leave on clip board thank you.

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 (01/01/2003), 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 \$15.00 for staff time to locate and 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: [Kathy Cirgin](#)

Telephone: 812-829-2261 Fax: 812-829-2263

E-mail: Kathy@drcirgin.com

Address: 51 N. Main St. Spencer IN 47460

Patient Information

Name: _____
 Male Female Married Single Child Other _____
Social Security #: _____ Birth Date: _____
Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____
Address: _____
Street Apartment #

City State Zip Code
Are there any family members currently in our practice? Y/ N If so, please list: _____

Parent or Legal Guardian Information

Name: _____ Date of Birth _____ Social Security # _____
Address: _____
Employer Name: _____ Occupation: _____
Address: _____
Street City State Zip Code Phone

Insurance Information

Primary
Name of Insured: _____ Is insured a patient? Yes No
Last First MI
Insured's Birth Date: _____ ID #: _____ Group #: _____
Insured's Address: _____
Street City State Zip Code
Insured's Employer Name: _____
Address: _____
Street City State Zip Code
Patient's relationship to insured: Self Spouse Child Other _____
Insurance Plan Name and Address: _____

To the best of my knowledge all the information given is true and correct. If I have any changes I will contact Dr. Cirgin without fail.

Signature: _____ *Date:* _____

I hereby grant permission to Dr. James T Cirgin to administer anesthetics and to employ such operative or technical procedures as may be deemed necessary or advisable in the diagnosis or treatment. As a condition of treatment I will pay for all treatment and or costs for the collection of payment including collection fees and attorney fees. I grant my permission for you to call home or work to discuss matters related to this form. I have reviewed a copy of Notice of Privacy Practices and am aware of health information that will be used in regards to treatment and or collection of treatment. A service charge of 1 1/2 % (18%) per annum on the unpaid balance will be charged on all accounts. I authorize release of any information relating to treatment. I am aware that there is a fee for broken or canceled appointments I may incur if I do not notify the office 3-5 days prior to a scheduled appointment.

Signature: _____ *Date:* _____ relationship to patient _____

I authorize payment be sent to Dr. James T. Cirgin benefits otherwise payable to me. I understand my dental insurance is a contract between the insurance carrier and myself, and not between Dr. Cirgin and the insurance carrier. Therefore, I am responsible for all dental fees.

Signature: _____ *Date:* _____

HEALTH HISTORY

Name _____ Date _____

Date of last health care exam: _____ Are you under a doctor's care? _____

Have you been hospitalized in the last 5 years? (Please circle) No Yes

If yes, reason: _____

Are you currently receiving care? No Yes If yes, nature of care: _____

Please list all the names and phone numbers of the physicians who are currently providing you care:

1. _____
2. _____
3. _____
4. _____

Please list **all medications** that you are taking at this time. _____

Heart Murmur (mitral valve prolapse)	No	Yes	Psychosis	No	Yes
Anemia	No	Yes	Sore/Enlarged Lymph Nodes	No	Yes
Diabetes	No	Yes	Previous Biopsies	No	Yes
Epilepsy	No	Yes	Slow-Healing Mouth Sores	No	Yes
Hepatitis, Any Form	No	Yes	Other Infections	No	Yes
Rheumatic Fever	No	Yes	Recurrent Illnesses	No	Yes
Asthma	No	Yes	Joint Replacement	No	Yes
HIV Positive or AIDS Related Complex	No	Yes	Glaucoma	No	Yes
Emphysema or other Respiratory Illnesses	No	Yes	Abnormal Bleeding from a cut	No	Yes
Abnormal Heart Condition	No	Yes	Liver Disease (including Jaundice)	No	Yes
Kidney Disease	No	Yes	Unintentional Weight Loss/Gain	No	Yes
Heart (Surgery, Disease, Attack)	No	Yes	Latex Sensitivity	No	Yes
Venereal Disease	No	Yes		No	Yes

Are you required to **Pre-Medicate** before dental treatment? No Yes

Women: Are you pregnant? No Yes

If no, are you planning a pregnancy in the near future? No Yes

Are you a nursing mother? No Yes

Are you taking birth control pills? No Yes

Abnormal Blood Pressure? (Please circle) No Yes

If yes, what is it usually: S /D

Are you **allergic** or have you had a reaction to:

a. **Local anesthetics** No Yes

b. **Penicillin or other antibiotics** No Yes

c. **Aspirin** No Yes

d. **Codeine, valium or other sedatives**..... No Yes

e. **Please list any allergy** _____

f. Are you a smoker? _____ How many a day? _____

DENTAL HISTORY

Date of your last visit to a dentist?
Reason for your last visit (or series of visits)?
Do you have any of your X-rays or dental records?
IN RESPECT TO ANY PREVIOUS DENTAL TREATMENT HAVE YOU:
Ever fainted?
Had an allergic reaction?
<i>If yes, describe</i>
Had abnormal bleeding?
<i>If yes, describe</i>
Any other complications during or following dental treatment?
<i>If yes, describe</i>
Do your gums bleed on brushing or eating?
Does food catch between your teeth?
Have your teeth shifted?
Are there spaces between your teeth now where there were none?
Are your teeth flaring, or are some of your teeth becoming loose?
<i>If yes, describe</i>
Are any of your teeth sensitive to heat, cold or pressure?
Do you grind your teeth or clench your jaws?
Do you have pain or clicking in the jaw joint around your ear?
Have your jaw muscles ever been sore?
Are there any sores or growth in your mouth?
<i>If yes, describe</i>
Do any of your teeth ache?
<i>If yes, describe</i>
Do you have any other dental complaint?
If there was a simple and inexpensive way to whiten your teeth, would you be interested?
If you could wave a magic wand and change one thing about your smile, what would it be?
Why did you leave your last dentist?
Who can we thank for sending you to our office?

NOTE: A *change* in your health status should be reported to the office at the earliest possible time. .

Signature: _____ **Date:** _____

Dr. James T. Cirgin Update

Patient's Name: _____ **Birth date:** _____
Address: _____ **City:** _____ **Zip** _____
State: _____ **Phone:** _____
Cell: _____ **e-mail** _____
Insurance Company? _____ **Employer** _____

Please give Kathy or Carla your insurance card and driver's license to copy for your records.

Please List **any medical** condition you may have or have been treated for..

Heart (Surgery, Disease, Attack)	No	Yes	Hepatitis, Any Form	No	Yes
Heart Murmur (mitral valve prolapse)	No	Yes	Rheumatic Fever	No	Yes
Joint Replacement	No	Yes	H.I.V. Infection/AIDS	No	Yes
Cancer treatment	No	Yes	Surgery in the last year	No	Yes

Are you under a physician's care at this time? Yes No Please explain and give medical doctor's name.

Are you taking any medication? Please list:

- | | |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

Do you have any allergies? No Yes please list:

- | | |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

I understand the information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I grant my permission for you to call home or work to discuss matters related to this form. I will notify the doctor of change in my health and medication. As a condition of treatment I will pay for all treatment and or costs for the collection of payment including collection fees and attorney fees. A service charge of 1 1/2% (18%) per annum of the unpaid balance will be charged on all accounts. I authorize release of any information relating to treatment. I authorize payment be sent to Dr. James T. Cirgin benefits otherwise payable to me. I understand my dental insurance is a contract between the insurance carrier and myself, and not between Dr. Cirgin and the insurance carrier. Therefore, I am responsible for all fees.

Print Name	Signature	Date