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| ***WELCOME TO OUR PRACTCE!*** |
| ***Please take a few moments to answer the following questions so we can better assist you with your dental needs.*** |

A close up of a logo

Description automatically generated

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| --- |
| 205A W National Road |
| Vandalia OH, 45377 |
| P: 937-898-8990 F: 937-998-1010 |

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| ***PATIENT INFORMATION*** |

|  |  |  |  |
| --- | --- | --- | --- |
| **Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |  |  |  |
| **Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | |
| **Last First MI** | | | |
| **Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | |
| **Street Address (NO P.O. BOX):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | |
| **City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **State: \_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | |
| **Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | **Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | |
| **Male: \_\_\_\_\_ Female: \_\_\_\_\_ Single: \_\_\_\_\_ Married: \_\_\_\_\_ Widowed: \_\_\_\_\_ Divorced: \_\_\_\_\_** | | | |
| **Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | **Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | |
| **Business Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | **Business Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | |
| **Whom should we thank for referring you: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | |
| **In case of emergency, who should we contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | |
| ***DENTAL INSURANCE*** | | | |
| **Person Responsible for account: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | |
| **Last First MI** | | | |
| **Relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | |
| **Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | |
| **City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **State: \_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | |
| **Responsible Party Employed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | |
| **Business Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | |
| **Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | |
| **Insurance Company Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | |
| **Subscriber ID #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | **Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | |

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| ***DENTAL HISTORY*** | | |
| **Date of Last Dental Visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Last X-Rays: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | |
| **How often do you brush: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How often do you floss: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | |
| **How many high sugar content drinks do you drink per week: \_\_\_\_\_\_\_\_\_** | | |
| **How many high sugar content snacks do you eat per week: \_\_\_\_\_\_\_\_\_\_** | | |
| ***Please check all that apply:*** | | |
| **\_\_\_\_\_ Bad Breath** | **\_\_\_\_\_ Loose Teeth or Broke Fillings** | **\_\_\_\_\_ Sensitivity to Sweets** |
| **\_\_\_\_\_ Bleeding Gums** | **\_\_\_\_\_ Orthodontic Treatment** | **\_\_\_\_\_ Sensitivity When Biting** |
| **\_\_\_\_\_ Blisters on Mouth or Lips** | **\_\_\_\_\_ Periodontal Treatment** | **\_\_\_\_\_ Frequent Headaches** |
| **\_\_\_\_\_ Finger Nail Biting** | **\_\_\_\_\_ Previous Deep Cleaning** | **\_\_\_\_\_ Jaw, Head, or Neck Injuries** |
| **\_\_\_\_\_ Grinding Teeth/ Clenching** | **\_\_\_\_\_ Sensitivity to Cold** | **\_\_\_\_\_ Jaw Clicking, or Pain** |
| **\_\_\_\_\_ Lip or Cheek Biting** | **\_\_\_\_\_ Sensitivity to Heat** | **\_\_\_\_\_ Tooth Pain** |

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| ***MEDICAL HISTORY*** | | | | | | | | | | |
| **Physician’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Last Visit \_\_\_\_\_\_\_\_\_\_\_\_Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | |
| **Cardiologist Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Last Visit \_\_\_\_\_\_\_\_\_\_\_\_Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | |
| **Current Medical Treatment. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | |
| **Have you ever been hospitalized or had a major operation? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | |
| **Do you require a pre-medication before any dental treatment? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | |
| **Have you ever taken bisphosphonates, currently or in the past (Fosamax)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | |
| **Please list all medications, pills, and vitamins, and the conditions for which you are receiving them.** | | | | | | | | | | |
| **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | |
| **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | |
| **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | |
| **Preferred Pharmacy\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_Fax Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | |
| **YES** | **NO** |  | |  | | **Are you allergic to any of the following?** | | | | |
| **\_\_\_\_\_** | **\_\_\_\_\_** | **Do you smoke or use tobacco products?** | | | | **YES** | **NO** | |  |  |
| **\_\_\_\_\_** | **\_\_\_\_\_** | **Do you use, or have you used any controlled substances in the past?** | | | | **\_\_\_\_\_** | **\_\_\_\_\_** | | **Local Anesthetics** | |
| **\_\_\_\_\_** | **\_\_\_\_\_** | **Are you currently taking any blood thinners?** | | | | **\_\_\_\_\_** | **\_\_\_\_\_** | | **Penicillin** | |
| **\_\_\_\_\_** | **\_\_\_\_\_** | **Are you currently taking antidepressants?** | | | | **\_\_\_\_\_** | **\_\_\_\_\_** | | **Sulfa Drugs** | |
| **\_\_\_\_\_** | **\_\_\_\_\_** | **Are you under the care of a dermatologist?** | | | | **\_\_\_\_\_** | **\_\_\_\_\_** | | **Sedatives** | |
| **\_\_\_\_\_** | **\_\_\_\_\_** | **Have you ever considered Botox and/or dermal fillers such as Juvederm?** | | | | **\_\_\_\_\_** | **\_\_\_\_\_** | | **Iodine** | |
| **Women, are you:** | | | | | | **\_\_\_\_\_** | **\_\_\_\_\_** | | **Aspirin** | |
| **YES** | **NO** |  | |  | | **\_\_\_\_\_** | **\_\_\_\_\_** | | **Latex** | |
| **\_\_\_\_\_** | **\_\_\_\_\_** | **Pregnant** | | | | **\_\_\_\_\_** | **\_\_\_\_\_** | | **Metal** | |
| **\_\_\_\_\_** | **\_\_\_\_\_** | **Nursing** | | | | **Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | |
| **\_\_\_\_\_** | **\_\_\_\_\_** | **Taking birth control pills** | | | |  | | | | |
| **Please check all that apply:** | | | | | | | | | | |
| **\_\_\_\_\_ AIDS/HIV Positive** | | | **\_\_\_\_\_ Circulatory Problems** | | **\_\_\_\_\_ High Cholesterol** | | | **\_\_\_\_\_ Rheumatic Fever** | | |
| **\_\_\_\_\_ Alzheimer’s Disease** | | | **\_\_\_\_\_ Cold Sores/ Blisters** | | **\_\_\_\_\_ Hypoglycemia** | | | **\_\_\_\_\_ Scarlet Fever** | | |
| **\_\_\_\_\_ Anaphylaxis** | | | **\_\_\_\_\_ Cortisone Treatments** | | **\_\_\_\_\_ Jaundice** | | | **\_\_\_\_\_ Shingles** | | |
| **\_\_\_\_\_ Anemia** | | | **\_\_\_\_\_ Diabetes** | | **\_\_\_\_\_ Jaw Pain** | | | **\_\_\_\_\_ Sickle Cell Disease** | | |
| **\_\_\_\_\_ Arthritis/ Rheumatism** | | | **\_\_\_\_\_ Emphysema** | | **\_\_\_\_\_ Kidney Disease** | | | **\_\_\_\_\_ Sinus Trouble** | | |
| **\_\_\_\_\_ Artificial Joints** | | | **\_\_\_\_\_ Epilepsy or Seizures** | | **\_\_\_\_\_ Latex Sensitivity** | | | **\_\_\_\_\_ Stroke** | | |
| **\_\_\_\_\_ Asthma** | | | **\_\_\_\_\_ Excessive Bleeding** | | **\_\_\_\_\_ Liver Disease** | | | **\_\_\_\_\_ Swelling of limbs** | | |
| **\_\_\_\_\_ Back problems** | | | **\_\_\_\_\_ Fainting or Dizziness** | | **\_\_\_\_\_ Low Blood Pressure** | | | **\_\_\_\_\_ Swollen Neck Glands** | | |
| **\_\_\_\_\_ Blood Disease** | | | **\_\_\_\_\_ Glaucoma** | | **\_\_\_\_\_ Mitral Valve Problems** | | | **\_\_\_\_\_ Thyroid Problems** | | |
| **\_\_\_\_\_ Blood Thinners** | | | **\_\_\_\_\_ Headaches** | | **\_\_\_\_\_ Nervous Problems** | | | **\_\_\_\_\_ Tonsillitis** | | |
| **\_\_\_\_\_ Blood Transfusion** | | | **\_\_\_\_\_ Heart Murmur** | | **\_\_\_\_\_ Osteoporosis** | | | **\_\_\_\_\_ Tuberculosis** | | |
| **\_\_\_\_\_ Cancer** | | | **\_\_\_\_\_ Heart Problems** | | **\_\_\_\_\_ Pacemaker** | | | **\_\_\_\_\_ Tumors or growths** | | |
| **\_\_\_\_\_ Chemical Dependency** | | | **\_\_\_\_\_ Hepatitis- Type \_\_\_\_** | | **\_\_\_\_\_ Psychiatric Care** | | | **\_\_\_\_\_ Ulcers** | | |
| **\_\_\_\_\_ Chemotherapy** | | | **\_\_\_\_\_ Herpes** | | **\_\_\_\_\_ Radiation Treatment** | | | **\_\_\_\_\_ Venereal Disease** | | |
| **\_\_\_\_\_ Chronic Fatigue** | | | **\_\_\_\_\_ High Blood Pressure** | | **\_\_\_\_\_ Renal Dialysis** | | |  | | |
| **AUTHORIZATION** | | | | | | | | | | |

**I hereby authorize payment directly to Thomas C. Volck, D.D.S for all insurance benefits otherwise payable to me for services rendered. I understand that the office of Thomas C. Volck, D.D.S. is not under contract with any dental insurance plans, and that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents. I agree to pay co-payments, or self-payments at time of service.**

**I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.**

**Signature of Responsible Party \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Printed Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Witness \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Thomas C. Volck, D.D.S

OFFICE POLICY

1. **The office of Thomas C. Volck, D.D.S is NOT under contract with any dental insurance plan.** Dental insurance is a contract agreement between the patient and insurance carrier (your employer has selected your plan and is ultimately responsible for how your contract is designed). Therefore, the patient is responsible for all dental fees. As a courtesy to you, our office will file insurance claims for you. (*DELTA and SUPERIOR DENTAL Insured/Patients have the option to have claims submitted from our office. However, full payment is due at time of service- insurance reimburses the Insured/Patient*). A Pre-Authorization can be sent to the insurance, per patient’s request, to get a better estimate of insurance coverage on treatment.

The patient’s portion (estimated co-pay, deductible or self-pay) is due at the time of service. We accept cash, check, American Express, Visa, MasterCard and Discover Card. Our office only accepts payment plans through CareCredit (1-800-365-8295 or at carecredit.com) or LendingClub (1-800-630-1663 or at lendingclub.com/dental). ALL discounts will be voided on the portion paid with CareCredit or LendingClub.

Initial (\_\_\_\_\_\_\_) I am responsible for the estimated payment due at time of service.

Initial (\_\_\_\_\_\_\_) I am responsible for all charges that are not paid by Insurance.

1. Please inform our office, prior to being seen at each dental visit, of any insurance changes such as carrier name, address, policy, or telephone numbers.
2. If you are 18 years of age or older, and covered under dental insurance through a parent/ legal guardian, appointments must be authorized by the parent/ legal guardian. All balances are due and payable by the Insured/ Person responsible for the account.
3. Bitewing x-rays are taken once a year. *Please notify us if you may be pregnant.*
4. In consideration of others, we request that you arrive on time for appointments. If you cannot make an appointment, please give us 24 hours’ notice so that another patient may be scheduled. Habitual violation of this policy will alter your choices for your next appointment. The entire staff thanks you for your consideration.

Initial (\_\_\_\_\_\_\_) I acknowledge that the office of Thomas C. Volck, D.D.S, may limit appointments if I violate the no show/no call policy.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature Date**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Parent/ Legal Guardian Date**

Thomas C. Volck, D.D.S

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

**Section A: PATIENT GIVING CONSENT**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Section B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY**

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters regarding your protected health information. A copy of our Notice accompanies this consent. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revision of our notice at any time.

**Section C: SIGNATURE**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If this consent is signed by a personal representative on behalf of the patient, please complete the following:

Personal representative’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Right to revoke: You have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the Doctor listed above. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or to continue treating you. If you revoke (refuse to sign) this consent.**

Thomas C. Volck, D.D.S

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ have received a copy of the office of Thomas C. Volck, D.D.S. Notice of Privacy Practices. In addition, I acknowledge the notice is posted in the office.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please Print Name**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date**

|  |
| --- |
| **For Office Use Only** |

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

* Individual refused to sign
* Communication barriers prohibited obtaining the acknowledgement
* An emergency situation prevented us from obtaining acknowledgement
* Other (Please Specify)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_