

Joseph R. Nemeth, D.D.S.
FARMBROOK MEDICAL BUILDING ONE – SUITE 111
29829 TELEGRAPH ROAD
SOUTHFIELD, MICHIGAN 48034

Practice Limited to Periodontics

TELEPHONE: (248) 357-3100

PLEASE PRINT

REGISTRATION

Date _____

Patient's Name _____ Circle: Dr. - Mr. - Mrs. - Ms.

Residence Address _____

City _____ State _____ Zip Code _____

Telephone: Residence _____ Telephone: Business _____ Email Address _____

Single _____ Married _____ Separated _____ Divorced _____ Widowed _____ Minor _____

Date of Birth _____ Social Security No. _____ Age _____ Height _____ Weight _____

Employed by _____ Occupation _____

Business Address _____

If a Child, Parent's Name _____

Name of Spouse _____

Spouse Employed by _____

Spouse's Date of Birth _____ Spouse's Social Security No. _____ Business Phone No. _____

Referred by _____

Name and Address of General Dentist _____

Phone _____

Nearest Relative Not Living with You _____
(name, address, phone no.)

Person Responsible for Payment of Account _____
(and address if different from above)

Name of Dental Insurance Company _____

Name of Medical Insurance Company _____

Spouse's Dental Insurance Company _____

Spouse's Medical Insurance Company _____

HEALTH QUESTIONNAIRE

Answers to the following questions are for our records and will be considered *confidential*.

- | | |
|--|---|
| <p>1. Are you presently under the care of a physician? Yes No
If so, for what condition are you being treated? _____

Name and address of physician _____

Phone _____</p> <p>2. Is your general health good? Yes No</p> <p>3. Have you ever been hospitalized
or had a serious illness? Yes No
Explain _____</p> <p>4. Have you had abnormal bleeding associated
with previous extractions, surgery, or trauma? Yes No</p> <p>a. Do you bruise easily? Yes No</p> | <p>b. Have you ever required a blood transfusion? Yes No
If so, explain the circumstances. _____
_____</p> <p>5. What drugs are you allergic to or have you reacted
adversely to? _____
_____</p> <p>6. Have you had any trouble with previous
dental work? Yes No
Please explain _____
_____</p> <p>7. Have you ever had a malignant or
non-malignant tumor removed? Yes No</p> <p>8. Do you wear a pacemaker? Yes No</p> <p>9. Are you pregnant? Yes No</p> |
|--|---|

Please Complete Reverse Side

Do you have or have you ever had?

Heart trouble Yes No
 Pain in chest Yes No
 Shortness of breath Yes No
 Swollen ankles Yes No
 Rheumatic fever Yes No
 Heart murmur Yes No
 Mitral valve prolapse (MVP) Yes No
 Fainting or dizziness Yes No
 Stroke Yes No
 High blood pressure Yes No
 Diabetes Yes No
 Bad nose bleeds Yes No
 Rheumatic heart disease Yes No
 Anemia Yes No
 Epilepsy or convulsions Yes No
 Thyroid trouble Yes No

Low blood pressure Yes No
 Multiple sclerosis Yes No
 Lupus Yes No
 Asthma Yes No
 Tuberculosis Yes No
 Kidney or liver trouble Yes No
 Neurosis or
 psychological problems Yes No
 Hepatitis A, B or C Yes No
 Prolonged bleeding Yes No
 Stomach trouble Yes No
 Venereal disease:
 Herpes Yes No
 HIV, AIDS Yes No
 Arthritis Yes No
 Cancer Yes No

Do you take on a regular basis?

Ecotrin, Motrin, Aspirin,
 Aleve, Ibuprofen Yes No
 Anticoagulants Yes No
 Antibiotics Yes No
 (If yes, name) _____
 Antihistamines Yes No
 Drugs for high blood
 pressure Yes No
 Insulin Yes No
 Vitamin E Yes No
 Ginkgo biloba Yes No
 St. John's Wort Yes No
 Bilbery Yes No
 Melatonin Yes No
 Echinacea Yes No
 Ginseng Yes No

What medications are you taking? _____

Do you have any condition, problem, or disease not mentioned above? _____

Please explain _____

Is there anything else about your health or health history that might affect your dental care? _____

THE FOLLOWING IMPORTANT HISTORY IS NECESSARY FOR YOUR PERIODONTAL DIAGNOSIS AND TREATMENT PLANNING

Why are you here? _____

Who is your general dentist? _____ When were your teeth last cleaned? _____

Are you currently experiencing pain
 from your mouth? Yes No
 Explain _____

Have you ever had periodontal treatment? Yes No

Have you completed any recent dental procedures?
 What? _____

Do you fear dental treatment? Yes No

Can you chew satisfactorily? Yes No

Are you embarrassed by bad breath? Yes No

Have you noticed any bad oral odors or taste? Yes No

Have you ever had a tooth or gum abscess? Yes No

Are your teeth sensitive to hot or cold drinks,
 sweets, chewing, or touch? Yes No

Have you noticed bleeding during brushing,
 flossing, or eating? Yes No

Do you have any loose teeth? Yes No

Are your gums receding? Yes No

Do you ever awaken with "tightness" or
 pain in the jaw joints? Yes No

Do your jaw joints pop or click? Yes No

Do you clench or grind your teeth at night or
 during the day? Yes No

Have you noticed your bite changing or
 any teeth moving? Yes No

Do you smoke? Yes No

Are your teeth affecting your
 general health in any way? Yes No

Patient's Signature _____ **Date** _____

JOSEPH R. NEMETH, D.D.S., P.C.
Practice Limited to Periodontics
29829 Telegraph Road, Suite 111 • Southfield, MI 48034
Phone: (248) 357-3100 Fax: (248) 357-1626

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 October 14, 2002, 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 in 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 to the health or safety of others.

JOSEPH R. NEMETH, D.D.S., P.C.

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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 institutions or law enforcement officials 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 a flat rate of \$65.00 to cover the cost of copies, 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: After April 14, 2003, 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. 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: Jodi S. Alcock
Telephone: (248) 357-3100
Fax: (248) 357-1626
E-mail: jodi@drnemeth.com
Address: 29829 Telegraph Road, Suite 111
Southfield, MI 48034

Patient Acknowledgement and Consent Form

Effective April 14, 2003, the new federal law known as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that our office comply with certain rules regarding the maintenance of the privacy of your information that we have collected and will collect in the future.

To comply with one of HIPAA's requirements, we are giving you a copy of our Notice of Privacy Practices. This notice of Privacy Practices contains the information that HIPAA requires us to disclose regarding our privacy practices.

Existing Michigan Law requires (in addition to our attempt to obtain written acknowledgement, discussed above) us to first obtain your written consent prior to disclosing any of your information except for our disclosures in connection with: a defense to a claim challenging our professional competence; a review entity's functions; a claim for payment of fees; a third party payer's examination of our records; a court order as part of a criminal investigation; an identification of a dead body; a licensure investigation; or a child abuse/neglect investigation.

From time to time it may be necessary for us to make disclosures of your information in connection with your treatment. For example, we may make a referral to or consult with another dentist or other health care professional, provide a specimen to a laboratory for testing or otherwise make disclosures of your information in connection with providing or coordinating your treatment.

Patient Acknowledgement

** You May Refuse to Sign This Acknowledgement **

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

Please Print
Name _____ **Signature** _____ **Date** _____

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:

- Patient or Guardian refused to sign
- Communications barriers prohibited obtaining the Acknowledgement
- An emergency situation prevented us from obtaining Acknowledgement
- Other (Please Specify) _____

Signature of Staff Member _____ **Date** _____

Patient Consent

Please sign this form below under the heading "Consent" to consent to our disclosure of your information that we deem necessary in order to provide you with proper treatment.

I consent to your disclosures of my information, which you deem are necessary in connection with my treatment. I understand that such disclosures may not be of the type listed above.

Please Print
Name _____ **Signature** _____ **Date** _____