ADA American Dental Association®
America's leading advocate for oral health

Fecha de hoy:_____

Información del historial médico y dental del paciente

A nuestros pacientes: tenga en cuenta que podemos formular preguntas de seguimiento para asegurarnos de que tengamos toda la información que necesitamos a fin de poder tratarlo.

INFORMACIÓN DEL PACIENTE

Apellido:	Nombre:	Segundo nombre:
Teléfono particular:	Teléfono celular:	Teléfono laboral:
Dirección de correo electrónico:		
Domicilio postal:	Ciudad:	Estado: Código postal:
Fecha de nacimiento: / /	Sexo:	
Ocupación:		
Contacto de emergencia: Nombre:	Relación:	Teléfono:

Si está completando el formulario en nombre de otra persona, ¿cuál es su nombre y la relación con esa persona? Nombre: _____ Relación: _____
Si firma este formulario en calidad de representante personal del paciente: Declaro y garantizo que tengo pleno derecho y autoridad legal para consentir la realización de cualquier procedimiento a este paciente. Si por alguna razón ya no tengo tal derecho y autoridad legal, lo notificaré de inmediato por escrito al consultorio.

HISTORIAL DENTAL Y SÍNTOMAS

¿Cuál es el motivo de la visita de hoy?

¿Actualmente experimenta algún dolor o malestar dental? ☐ Sí ☐ No Si es así, ¿dónde?

¿Cuándo fue el último examen dental? / / ¿Qué se llevó a cabo en esa cita?

¿Cuándo fue la última vez que le realizaron radiografías dentales?

Marque la casilla con una «X» SOLO si se aplica a usted.

¿Le cuesta abrir la boca? ☐
¿Le duele al masticar, morder o tragar? ☐
¿Le sangran las encías cuando se cepilla o usa hilo dental? ☐
¿Se ha sometido alguna vez a tratamientos periodontales (de encías) como destartraje y alisado radicular? ☐
¿Tiene, o alguna vez ha tenido, llagas o protuberancias en la boca? ☐
¿Aprieta o hace rechinar los dientes? ☐
¿Siente algún chasquido, crujido o dolor en la mandíbula? ☐
¿Tiene dolores de oído o de cuello? ☐
¿El tratamiento dental lo pone nervioso? ☐
¿Alguna vez ha experimentado alguno de estos trastornos respiratorios relacionados con el sueño? ☐
☐ Respiración por boca ☐ Ronquido ☐ Dificultad para respirar durante el sueño

¿Alguna vez ha sufrido una lesión grave en la cabeza o la boca? ☐
Si es así, describa lo ocurrido y cuándo ocurrió: _____

¿Ha tenido problemas con el tratamiento dental en el pasado? ☐
Si es así, describa lo ocurrido: _____

¿Alguna vez ha tenido una reacción o un problema con la anestesia dental? ☐
Si es así, describa lo ocurrido: _____

¿No le gusta su sonrisa? ☐
Si es así, ¿por qué? Marque donde corresponda:
☐ El color de sus dientes ☐ La forma de sus dientes ☐ La posición de sus dientes
☐ Otros. Describa: _____

MEDICACIONES Y OTROS PRODUCTOS/OTRAS SUSTANCIAS

Marque las respuestas a las siguientes preguntas con una «X». **Sí No ?**

¿Toma algún **anticoagulante** (como warfarina [Coumadin®], rivaroxabán [Xarelto®], dabigatrán [Pradaxa®], clopidogrel [Plavix®], heparina o aspirina)? ☐ ☐ ☐
Si es así, ¿qué medicación toma? _____
¿Toma alguna medicación para tratar la **osteoporosis** o la enfermedad de Paget? ☐ ☐ ☐
Algunos medicamentos que se recetan comúnmente incluyen alendronato (Fosamax®), risedronato (Actonel®), ibandronato (Boniva®), zolendronato (Reclast®) y denosumab (Prolia®).
Si es así, ¿qué medicación toma? _____
¿Usa, o tiene previsto usar, **medicación intravenosa (IV)** para tratar el dolor de huesos, la hipercalcemia o las complicaciones óseas derivadas de la enfermedad de Paget, el mieloma múltiple o el cáncer metastásico? ☐ ☐ ☐
Algunos medicamentos que se recetan comúnmente incluyen denosumab (Xgeva®), pamidronato (Aredia®) o zolendronato (Zometa®).
Si es así, ¿qué medicación toma? _____ ¿Hace cuántos años que la toma? _____
¿Recibe **terapia de sustitución hormonal**? ☐ ☐ ☐
¿Consume algún tipo de **tabaco o productos de nicotina** (cigarrillo, cigarro, rapé, tabaco para mascar, bidi)? ☐ ☐ ☐
¿Utiliza **productos de vapeo**? ☐ ☐ ☐
¿Cuántas **bebidas alcohólicas** consume por semana? _____
¿Consume **sustancias controladas** (drogas), incluida la marihuana, por motivos medicinales o recreativos? ☐ ☐ ☐
Si es así, ¿qué sustancias? _____ Si es así, ¿con qué frecuencia? ☐ A diario ☐ Varias veces por semana ☐ Todas las semanas ☐ A veces
¿La sustancia fue recetada por un médico? ☐ Sí ☐ No Si es así, ¿por qué razones? _____
¿Toma algún otro **medicamento recetado o de venta libre, vitaminas, hierbas o suplementos?** ☐ ☐ ☐
Si es así, enumérelos aquí e incluya información sobre la cantidad y la frecuencia de uso de cada uno _____

SOLO PARA MUJERES:

¿Toma **píldoras anticonceptivas**? ☐ ☐ ☐
¿Está embarazada? Si es así, incluya la cantidad de semanas: _____ ☐ ☐ ☐
¿Está en el periodo de lactancia? Si es así, incluya la cantidad de semanas: _____ ☐ ☐ ☐

ALERGIAS Marque las respuestas a las siguientes preguntas con una «X».

Es alérgico o ha tenido una reacción alérgica a:	Sí	No	?
Aspirina	☐	☐	☐
Barbitúricos, sedantes o píldoras para dormir	☐	☐	☐
Codeína u otros narcóticos	☐	☐	☐
Fiebre del heno/alergias estacionales	☐	☐	☐
Yodo	☐	☐	☐
Látex (caucho)	☐	☐	☐
Anestésicos locales	☐	☐	☐
Metales	☐	☐	☐
Penicilina u otros antibióticos	☐	☐	☐

	Sí	No	?
Sulfamidas como el sulfametoxazol-trimetoprima (Septra, Bactrim), eritromicina-sulfisoxazol, sulfasalazina (Azulfidine), eritromicina-sulfisoxazol (Erizole, Pediazole) gluburida (Diabeta, Glynase PresTabs), dapsona, sumatriptán (Imitrex), celecoxib (Celebrex), hidroclorotiazida (Microzide) y furosemida (Lasix)	☐	☐	☐
Otros	☐	☐	☐

Explique las respuestas afirmativas e incluya información sobre su experiencia.

_____

HISTORIAL MÉDICO Y QUIRÚRGICO

Fecha del último examen físico: / /

¿Cuál es su presión arterial normal (sistólica, diastólica)?

Nombre del médico:

Teléfono:

Marque las respuestas a las siguientes preguntas con una «X».

	Sí	No	?
¿Tiene buena salud física?	☐	☐	☐
¿Actualmente está siendo atendido o tratado por un médico?	☐	☐	☐
¿Le ha recomendado un médico o un dentista anterior que tome **antibióticos** antes de hacerse un tratamiento dental?	☐	☐	☐
¿Ha tenido alguna **enfermedad grave, alguna operación o ha sido hospitalizado** en los últimos 5 años?	☐	☐	☐
¿Se ha sometido a algún tipo de cirugía (ya sea total o parcial) de **reemplazo articular** (por ejemplo, de cadera, rodilla, hombro, codo, dedo, etc.)?	☐	☐	☐
¿Se ha sometido a un **reemplazo de válvula cardíaca o a una cirugía cardíaca**?	☐	☐	☐
¿Se ha sometido a algún **trasplante de órgano o de médula ósea/células madre**?	☐	☐	☐
¿Ha viajado al extranjero en los últimos 30 días?	☐	☐	☐
¿Ha tenido fiebre (38 °C [100.4 °F] o más) en las últimas 72 horas?	☐	☐	☐

Si ha respondido «sí» a alguna de las preguntas anteriores, explique: _____

HISTORIAL MÉDICO ESPECÍFICO Marque las respuestas a las siguientes preguntas con una «X».

¿Padece o se le ha diagnosticado alguna de las siguientes afecciones?

	Sí	No	?
Salud del corazón (cardíaca)			
Marcapasos/desfibrilador implantable	☐	☐	☐
Válvula cardíaca (protésica) artificial	☐	☐	☐
Endocarditis infecciosa anterior	☐	☐	☐
Cardiopatía congénita (CPC)	☐	☐	☐
CPC cianótica no reparada	☐	☐	☐
Reparada (por completo) en los últimos 6 meses	☐	☐	☐
CPC reparada con defectos residuales	☐	☐	☐
Arteriosclerosis	☐	☐	☐
Enfermedad de las arterias coronarias	☐	☐	☐
Insuficiencia cardíaca congestiva	☐	☐	☐
Válvulas cardíacas dañadas	☐	☐	☐
Ataque al corazón	☐	☐	☐
Soplo/trastorno del ritmo cardíaco	☐	☐	☐
Enfermedad cardíaca reumática	☐	☐	☐
Accidente cerebrovascular	☐	☐	☐
Salud de la respiración (respiratoria)			
Asma (EPOC)	☐	☐	☐
Bronquitis	☐	☐	☐
Enfisema	☐	☐	☐
Sinusitis	☐	☐	☐
Tuberculosis	☐	☐	☐

	Sí	No	?
Cáncer	☐	☐	☐
Tipo: _____			
Fecha de diagnóstico: _____			
Quimioterapia: _____			
Radioterapia: _____			
Salud de la sangre (circulatoria)			
Anemia	☐	☐	☐
Transfusión de sangre	☐	☐	☐
Si es así, ¿qué fecha? _____			
Hemofilia	☐	☐	☐
Presión arterial alta o baja	☐	☐	☐
Salud del cerebro (neurológica)/mental			
Ansiedad	☐	☐	☐
Depresión	☐	☐	☐
Epilepsia	☐	☐	☐
Trastornos de salud mental	☐	☐	☐
Trastornos neurológicos	☐	☐	☐
Trastorno por estrés postraumático	☐	☐	☐
Lesión cerebral traumática o conmoción cerebral	☐	☐	☐
Enfermedad autoinmune			
Sida o infección por VIH	☐	☐	☐
Lupus	☐	☐	☐

	Sí	No	?
Salud digestiva			
Enfermedad gastrointestinal	☐	☐	☐
Reflujo gastroesofágico/acidez estomacal persistente (ERGE)	☐	☐	☐
Úlceras estomacales	☐	☐	☐
Salud de los ojos (visual)			
Glaucoma	☐	☐	☐
Otros			
Artritis	☐	☐	☐
Dolor crónico	☐	☐	☐
Diabetes (tipo 1 o 2)	☐	☐	☐
Trastorno alimenticio	☐	☐	☐
Infecciones frecuentes	☐	☐	☐
Tipo de infección: _____			
Hepatitis, ictericia o enfermedad hepática	☐	☐	☐
Inmunodeficiencia	☐	☐	☐
Problemas renales	☐	☐	☐
Desnutrición	☐	☐	☐
Osteoporosis	☐	☐	☐
Artritis reumatoide	☐	☐	☐
Infección de transmisión sexual (ITS)	☐	☐	☐
Problemas de tiroides	☐	☐	☐

¿Tiene alguna enfermedad, afección o problema que no figure en esta lista? Si es así, explique. _____

SÍNTOMAS MÉDICOS/GENERAL Marque las respuestas a las siguientes preguntas con una «X».

En los últimos 30 días, ha:	Sí	No	?
tenido dolor u opresión en el pecho?	☐	☐	☐
tosido sangre o ha tenido tos por más de 3 semanas?	☐	☐	☐
estado expuesto a alguien con tuberculosis?	☐	☐	☐
tenido un latido rápido o irregular?	☐	☐	☐
tenido dificultades para recuperar el aliento?	☐	☐	☐
tenido fiebre alta (más de 38.6 °C [101.5 °F]) sin motivo alguno?	☐	☐	☐
notado un cambio en la visión?	☐	☐	☐
sufrido algún desmayo sin motivo alguno?	☐	☐	☐
tenido vómitos, diarrea, escalofríos, sudor nocturno o sangrado?	☐	☐	☐
tenido migrañas o dolores de cabeza fuertes?	☐	☐	☐

NOTA: Es importante que tanto el médico como el paciente hablen con honestidad sobre la salud del paciente antes de iniciar el tratamiento dental.

He respondido a las preguntas anteriores de manera completa y precisa, y con mi mayor capacidad.

Firma del paciente/tutor legal: _____ Fecha: _____

PARA SER COMPLETADO POR EL DENTISTA

Comentarios: _____

Solo para uso oficial: ☐ Alerta médica ☐ Premedicación ☐ Alergias ☐ Anestesia

Revisado por: _____ Fecha: _____

Formulario S50121 Para volver a pedirlo, llame al 800.947.4746 o visite ADAcatalog.org.

NEW HORIZONS FAMILY DENTAL

GENERAL DENTISTRY INFORMED CONSENT FORM

1. **EXAMINATION AND X-RAYS**

   I understand that the initial visit may require radiographs in order to complete the examination, diagnosis, and treatment plan.

2. **DRUGS, MEDICATION, AND SEDATION**

   I have been informed and understand that antibiotic, analgesics, and other medications can cause allergic reactions causing redness, swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). They may cause drowsiness and lack of awareness and coordination, which can be increased by the use of alcohol or other drugs. I understand and fully agree not to operate any vehicle or hazardous device for at least 12 hours or until fully recovered from the effects of the anesthetic medication and drugs that may have been given me in the office for my treatment. I understand that failure to take medications prescribed for me in the manner prescribed may offer risks of continued or aggravated infection, pain, and potential resistance to effect treatment of my condition. I understand that antibiotics can reduce the effectiveness of oral contraceptives.

3. **CHANGES IN TREATMENT PLAN**

   I understand that during treatment, it may be necessary to change or add procedures because of conditions found while working on teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any or all changes and additions as necessary.

4. **TEMPOROMANDIBULAR JOINT DYSFUNCTIONS (TMJ)**

   I understand that symptoms of popping, clicking, locking and pain can intensify or develop in the joint of the lower (near the ear) subsequent to routine dental treatment wherein the mouth is held in the open position. However, symptoms of TMJ associated with dental treatment are usually transitory in nature and well tolerated by most patients. I understand that should the need for treatment arise, then I will be referred to a specialist for treatment, and the cost of which is my responsibility.

5. **FILLINGS**

   I understand that care must be exercised in chewing on filling during the first 24 hours to avoid breakage, and tooth sensitivity is common after-effect of a newly placed filling.

6. **REMOVAL OF TEETH (EXTRACTION)**

   Alternative to removal has been explained to me (root canal therapy, crowns, periodontal surgery, etc.) and I authorize the Dentist to remove the tooth and any others necessary for the reasons in paragraph #3. I understand removing teeth does not always remove all infection if present and it may be necessary to have further treatment. I understand the risks involved is having teeth removed, some of which are pain, swelling, and spread of infection, dry socket, loss of feeling in my teeth, lips, tongue, and surrounding tissue (paresthesia) that can last for an indefinite period of time or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility.

7. **CROWNS, BRIDGES, VENEERS AND BONDING**

I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realized that the final opportunity to make changes in my new crowns, bridge or cap (including shape, fit, size, placement, and color) will be done before cementation. It has been explained to me that, in very few cases, cosmetic procedures may result in the need for future root canal treatment, which cannot always be predicted or anticipated. I understand that cosmetic procedures may affect tooth surfaces and may require modification of daily cleaning procedures.

8. **DENTURES – COMPLETE OR PARTIAL**

I realize that full or partial dentures are artificial, constructed of plastic, metal and or porcelain. The problems of wearing those appliances have been explained to me including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new denture (including shape, fit, size, placement, and color) will be "teeth in wax" try-in visit. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not the initial denture fee.

9. **ENDODONTIC TREATMENT (ROOT CANAL)**

I realize there is no guarantee that root canal treatment will save my tooth and those complications can occur from the treatment and that occasionally metal objects are cemented in the tooth, or extend through the root, which does not necessarily affect the success of the treatment. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy).

10. **PERIODONTAL TREATMENT**

I understand that I have a serious condition causing gum inflammation and/or bone loss and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including non-surgical cleaning, gum surgery and/or extractions. I understand the success of a treatment depends in part on my efforts to brush and floss daily, receive regular cleaning as directed, following a healthy diet, avoid tobacco products and follow other recommendations.

CONSENT: *I understand that dentistry is not an exact science, therefore: reputable parishioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I understand that each Dentist is an individual practitioner and is individually responsible for the dental care rendered to me. I also understand that no other Dentist other than the treating Dentist is responsible for my dental treatment.*

Patient signature: _____Date: _____

Patient Name (Print): _____

NEW HORIZONS
FAMILY DENTAL

OFFICE POLICIES

Dental Insurance: Submission of insurance claims is a COURTESY that our office provides but not an obligation. We can only ESTIMATE what the insurance will cover based on what they tell us. Each insurance company has their policies for benefits and exclusions. It is the patient's responsibility to familiarize themselves with the type of coverage and limitations of their insurance policy. Co-payments are due at the time that services are rendered unless other financial arrangements have been made. Therefore, it is the patient's responsibility for the difference in payments. We will not be held responsible for charges incurred after the maximum has been exceeded, waiting periods, clauses and/or benefit termination.

Recall/Hygiene Appointments: Our office adheres to ADA recommendations in regards to x-rays and dental cleanings which are: full mouth x-rays or panoramic once every 3 to 5 years; bitewing x-rays every 6 to 12 months and dental cleanings twice per year (every 6 months) MINIMUM. Please keep in mind that two cleanings per year is the minimum. Each individual has different needs based on the health of their mouth.

Refusal of Treatment, Exams and X-rays: There is a standard of care that our office must adhere to. It is impossible for us to make a proper diagnosis and treatment plan without current x-rays and a dental examination. It is our OBLIGATION to inform you of existing problems in your mouth, therefore, all patients who refuse exams and appropriate x-rays should seek help elsewhere as our office would not be able to provide you with the quality of care that we believe in. All patients are welcome to seek a second opinion elsewhere. For those who refuse treatment, it is certainly your right, and therefore we would kindly ask you to sign a LETTER of REFUSAL for treatment which states that our office has informed you of the need of treatment and the possible consequence if left untreated and that you are fully aware of the consequence and would take full responsibility of it.

Broken Appointment: We have a STRICT cancellation policy. We do not overbook patients in anticipation of no-shows or last minute cancellations therefore it is important that you keep scheduled appointment. We understand that last minute changes in your schedule may be unavoidable and we will try to accommodate those changes if possible. However, when appointments are scheduled our dentist`s and/or hygienist`s time is reserved for you and it is unavailable to other patients who need to schedule an appointment.
We strive to see patients on time for scheduled appointments; however there are times when our schedule is delayed in order to accommodate an emergency or complication in a scheduled procedure. Please accept our apology should this occur during your appointment.
Follow our standard policy for broken appointments:
Broken/Missed Appointments: There is a **$50** broken appointment **fee** for missed appointments or cancelled with less than **48 hours notice**. Please note that if you need to cancel appointments that are scheduled on a Monday, our office needs to be **notified by Thursday at noon time as our office is closed on the weekends. If 2 broken appointments occur, our office reserves the right to not schedule any subsequent appointments for you.**

Reminder of Appointments: Reminder of appointments is a COURTESY that our office provides not an OBLIGATION. We suggest that you call our office if you are unsure of the time and/or date of your appointment because there WIL BE a broken appointment charge if you do not show up.

I have read and fully understand and agree with the broken appointment policy of Vibhi Vellanki ,Inc.

Privacy Practices Acknowledgement (HIPPA): I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

_____ _____ _____

Signature of Patient, Parent, Guardian Name of Patient, Parent, Guardian DATE

NEW HORIZONS
FAMILY DENTAL

Financial Responsibility for account:
Who is responsible for this account: _____
Relationship to patient: _____

Dental Insurance Assignment & Release:

I certify that I, and/or my dependent(s), have insurance coverage with _____
And assign directly to the dentists at New Horizons Family Dental and/or Vibhi Vellanki Inc all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____
Name of Patient, Parent, Guardian or Personal Representative

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____ _____
Relationship to Patient Date

NOTICE OF PRIVACY PRACTICES*

We Care About Your Privacy

1. Our Pledge Regarding Medical Information

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

2. Our Legal Duty

Law Requires Us to:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the current notice.

We Have the Right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices:

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

3. Use and Disclosure of Your Medical Information

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

For Treatment:

We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

For Payment:

We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your medical information.

For Health Care Operations:

We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

Additional Uses and Disclosures:

In addition to using and disclosing your medical information for treatment, payment, and health care operations, we may use and disclose medical information for the following purposes.

Facility Directory:

Unless you notify us that you object, the following medical information about you will be placed in our facility directories: your name; your location in our facility; your condition described in general terms; your religious affiliation, if any. We may disclose this information to members of the clergy or, except for your religious affiliation, to others who contact us and ask for information about you by name.

Notification:

We may use and disclose medical information to notify or help notify: a family member, your personal representative or another person responsible for your care. We will share information about your location, general condition, or death. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray or medical information for you.

Disaster Relief:

We may share medical information with a public or private organization or person who can legally assist in disaster relief efforts.

Fundraising:

We may provide medical information to one of our affiliated fundraising foundations to contact you for fundraising purposes. We will limit our use and sharing to information that describes you in general, not personal, terms and the dates of your health care. In any fundraising materials, we will provide you a description of how you may choose not to receive future fundraising communications.

Research in Limited Circumstances:

We may use medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information.

Funeral Director, Coroner, Medical Examiner:

To help them carry out their duties, we may share the med-

ical information of a person who has died with a coroner, medical examiner, funeral director, or an organ procurement organization.

Specialized Government Functions:
Subject to certain requirements, we may disclose or use health information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

Court Orders and Judicial and Administrative Proceedings:
We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may share your medical information with law enforcement officials. We may share limited information with a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim or missing person. We may share the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

Public Health Activities:
As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purposes of reporting adverse events associated with product defects or problems, to enable product recalls, repairs or replacements, to track products, or to conduct activities required by the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

Victims of Abuse, Neglect, or Domestic Violence:
We may use and disclose medical 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 share your medical information if it is necessary to prevent a serious threat to your health or safety or the health or safety of others. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.

Workers Compensation:
We may disclose health information when authorized or necessary to comply with laws relating to workers compensation or other similar programs.

Health Oversight Activities:
We may disclose medical information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations or proceedings, inspections, licensure or disciplinary actions, or other authorized activities.

Law Enforcement:
Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding suspected victims of crimes at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.

Appointment Reminders:
We may use and disclose medical information for purposes of sending you appointment postcards or otherwise reminding you of your appointments.

Alternative and Additional Medical Services:
We may use and disclose medical information to furnish you with information about health-related benefits and services that may be of interest to you, and to describe or recommend treatment alternatives.

4. Your Individual Rights

You Have the Right to:

1. Look at or get copies of certain parts of your medical information. You may request that we provide copies in a format other than photo copies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. You may ask the receptionist for the form needed to request access. There may be charges for copying and for postage if you want the copies mailed to you. Ask the receptionist about our fee structure.
2. Receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment, and health care operations and other specified exceptions.
3. Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).
4. Request that we communicate with you about your medical information by different means or to different locations. Your request that we communicate your medical information to you by different means or at different locations must be made in writing to our Privacy Officer.
5. Request that we change certain parts of your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you with a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.
6. If you wish to receive a paper copy of this privacy notice, then you have the right to obtain a paper copy by making a request in writing to our Privacy Officer.

Questions and Complaints

If you have any questions about this notice, please ask the receptionist to speak to our Privacy Officer.

If you think that we may have violated your privacy rights, you may speak to our Privacy Officer and submit a written complaint. To take either action, please inform the receptionist that you wish to contact the Privacy Officer or request a complaint form. You 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. We will not retaliate in any way if you choose to file a complaint.

*These privacy practices are currently in effect and will remain in effect until further notice.