

Patient Dental & Medical Health History Information

To our patients: Please know that we may ask follow-up questions to make sure we have all of the information we need in order to treat you.

PATIENT INFORMATION

Last Name:	First Name:	Middle Name:
Home Phone:	Cell Phone:	Work Phone:
Email Address:		
Mailing Address:	City:	State: Zip:
Date of Birth: / /	Gender:	
Occupation:		
Emergency Contact: Name:	Relationship:	Phone:

If you are completing this form for another person, what is your name and relationship to that person? Name: _____ Relationship: _____
 If executing this form as the patient's personal representative, I represent and warrant that I have full legal right and authority to consent to the performance of any procedure(s) on this patient. If for any reason I no longer have such legal right and authority, I will immediately notify the practice in writing.

DENTAL HISTORY & SYMPTOMS

What is the reason for your visit today? _____

Are you currently experiencing any dental pain or discomfort? ☐ Yes ☐ No If yes, where? _____

When was your last dental exam? / / What was done at that appointment? _____

When was the last time you had dental x-rays taken? _____

Please mark an "X" in the box ONLY if this applies to you.

Is it hard to open your mouth?	<input type="checkbox"/>	Have you ever had a serious injury to your head or mouth?	<input type="checkbox"/>
Does it hurt to chew, bite or swallow?	<input type="checkbox"/>	If yes, please describe what happened and when it happened: _____	
Do your gums bleed when you brush or floss your teeth?	<input type="checkbox"/>	Have you ever had problems with dental treatment in the past?	<input type="checkbox"/>
Have you ever had periodontal (gum) treatments like scaling and root planing?	<input type="checkbox"/>	If yes, please describe what happened: _____	
Do you have, or have you ever had, any sores or growths in your mouth?	<input type="checkbox"/>	Have you ever had a reaction to, or problem with, dental anesthesia?	<input type="checkbox"/>
Do you clench or grind your teeth?	<input type="checkbox"/>	If yes, please describe what happened: _____	
Does your jaw click, pop or hurt?	<input type="checkbox"/>	Are you unhappy with your smile?	<input type="checkbox"/>
Do you have earaches or neck pains?	<input type="checkbox"/>	If yes, why? Please mark all that apply:	
Does dental treatment make you nervous?	<input type="checkbox"/>	<input type="checkbox"/> The color of your teeth <input type="checkbox"/> The shape of your teeth <input type="checkbox"/> The position of your teeth	
Have you ever experienced any of these sleep-related breathing disorders?	<input type="checkbox"/>	<input type="checkbox"/> Other. Please describe: _____	
<input type="checkbox"/> Mouth breathing <input type="checkbox"/> Snoring <input type="checkbox"/> Trouble breathing during sleep			

MEDICATIONS & OTHER PRODUCTS/SUBSTANCES

Please use an "X" to mark your answers to the following questions. Yes No ?

Are you taking any **blood thinners** (such as Coumadin, Warfarin, rivaroxaban (Xarelto®), dabigatran (Pradaxa®), clopidogrel (Plavix®), heparin or aspirin)? ☐ ☐ ☐

If yes, what medication are you taking? _____

Are you taking any medication to treat **osteoporosis** or Paget's disease? ☐ ☐ ☐

Some commonly-prescribed drugs include alendronate (Fosamax®), risedronate (Actonel®), ibandronate (Boniva®), zoledronate (Reclast®), and denosumab (Prolia®).

If yes, what medication are you taking? _____

Are you taking, or scheduled to take, an **IV medication** to treat bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? ☐ ☐ ☐

Some commonly-prescribed drugs include denosumab (Xgeva®), pamidronate (Aredia®) or zoledronate (Zometa®).

If yes, what medication are you taking? _____ How many years have you been taking it? _____

Are you taking **hormonal replacements**? ☐ ☐ ☐

Do you use any form of **tobacco or nicotine products** (cigarettes, cigars, snuff, chew, bidis)? ☐ ☐ ☐

Do you use **vaping products**? ☐ ☐ ☐

How many **alcoholic beverages** do you have per week? _____

Do you use **controlled substances** (drugs), including marijuana, for either medicinal or recreational reasons? ☐ ☐ ☐

If yes, what substances? _____ If yes, how often is your use? ☐ Daily ☐ Several times per week ☐ Weekly ☐ Occasionally

Was the substance prescribed by a doctor? ☐ Yes ☐ No If yes, for what reason(s)? _____

Do you take any other **prescriptions and/or over-the-counter medicine(s), vitamins, herbs and/or supplements**? ☐ ☐ ☐

If yes, please list them here and include information about how much and how often you use each one. _____

WOMEN ONLY: Are you:

Taking **birth control pills**? ☐ ☐ ☐

Pregnant? If yes, number of weeks: ☐ ☐ ☐

Nursing? If yes, number of weeks: ☐ ☐ ☐

ALLERGIES Please use an "X" to mark your answers to the following questions.

Are you allergic to or have you had an allergic reaction to:

	Yes	No	?
Aspirin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Barbiturates, sedatives or sleeping pills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Codeine or other narcotics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hay fever/seasonal allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Iodine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Latex (rubber)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Local anesthetics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Metals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin or other antibiotics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Sulfa drugs such as sulfamethoxazole-trimethoprim (Septra, Bactrim), erythromycin-sulfisoxazole, sulfasalazine (Azulfidine), erythromycin-sulfisoxazole (Eryzole, Pediazole) glyburide (Diabeta, Glynase PresTabs), dapsone, sumatriptan (Imitrex), celecoxib (Celebrex), hydrochlorothiazide (Microzide) and furosemide (Lasix).....☐☐☐

Other☐☐☐

Please describe any "Yes" answers and include information about your experience.

MEDICAL & SURGICAL HISTORY

Date of last physical exam: / /

What is your normal blood pressure (systolic, diastolic)?

Doctor's Name:

Phone:

Please use an "X" to mark your answers to the following questions.

	Yes	No	?
Are you in good physical health?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you currently being seen or treated by a physician?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has a physician or previous dentist recommended that you take antibiotics before having dental work done?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had a serious illness, operation or been hospitalized in the past 5 years?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any type (either total or partial) of joint replacement surgery (such as for a hip, knee, shoulder, elbow, finger, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had a heart valve replacement or heart surgery ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had an organ or bone marrow/stem cell transplant ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you traveled internationally within the last 30 days	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had a fever (100.4°F or above) in the last 72 hours?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you answered yes to any of the above, please explain:

MEDICAL HISTORY SPECIFIC Please use an "X" to mark your answers to the following questions.

Do you have, or have you been diagnosed with, any of the following conditions?

	Yes	No	?
Heart (Cardiac) Health			
Pacemaker/implanted defibrillator	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Artificial (prosthetic) heart valve	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Previous infective endocarditis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Congenital heart disease (CHD)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unrepaired, cyanotic CHD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Repaired (completely) in last 6 months	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Repaired CHD with residual defects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arteriosclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coronary artery disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Congestive heart failure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Damaged heart valves	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur/rhythm disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breathing (Respiratory) Health			
Asthma (COPD)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sinus trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Type:			
Date of diagnosis:			
Chemotherapy:			
Radiation treatment:			
Blood (Circulatory) Health			
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood transfusion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, date:			
Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High or low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brain (Neurological)/Mental Health			
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental health disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neurological disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Post-traumatic stress disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Traumatic brain injury or concussion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Autoimmune Disease			
AIDS or HIV Infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Digestive Health			
Gastrointestinal disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G.E. reflux/persistent heartburn (GERD)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stomach ulcers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye (Vision) Health			
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other			
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes (type I or II)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frequent infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Type of infection:			
Hepatitis, jaundice or liver disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Immune deficiency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Malnutrition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexually transmitted infection (STI)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do you have any disease, condition, or problem that's not listed here? If so, please explain.

MEDICAL SYMPTOMS/GENERAL Please use an "X" to mark your answers to the following questions.

In the past 30 days, have you:	Yes	No	?		Yes	No	?		Yes	No	?
had pain or tightness in the chest?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	found it hard to catch your breath?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	experienced vomiting, diarrhea, chills, night sweats or bleeding?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
coughed up blood or had a cough that lasted longer than 3 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	had a high fever (greater than 101.5°F) for no reason?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	had migraines or severe headaches?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
been exposed to anyone with tuberculosis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	noticed a change in your vision?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
had a rapid or irregular heart beat?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	fainted for no reason?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

NOTE: It's important for both the doctor and patient to talk honestly about the patient's health before dental treatment starts.

I have answered the above questions completely, accurately and to the best of my ability.

Signature of Patient/Legal Guardian:

Date:

FOR COMPLETION BY DENTIST

Comments:

Office Use Only: ☐ Medical Alert ☐ Premedication ☐ Allergies ☐ Anesthesia

Reviewed by:

Date:

PATIENT INFORMATION

Date _____ Patients Full Name _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Birthday _____ Social Security # _____

If patient is a minor, give parent's or guardian's name _____

How did you find us? ☐ Referral _____ ☐ Yellow pages ☐ Internet ☐ Newspaper

Person to contact in case of Emergency _____ Phone # _____

Nearest relative not living with you _____ Phone # _____

ACCOUNT INFO PERSON RESPONSIBLE FOR ACCOUNT

Name _____ Relation _____ Home# _____

Work # _____ Mobile # _____ Birthdate _____

Billing Address _____ City _____ State _____ Zip _____

Email _____ Employer _____ Employer Address _____

_____ City _____ State _____ Zip _____

INSURANCE INFORMATION

Provider Name _____ Provider Address _____

City _____ State _____ Zip _____ Group # _____

Insured's Name _____ Relation _____ Insured's Birth Date _____

Insured's SSN # _____ Insured's Employer _____ Insured's Phone # _____

SECONDARY INSURANCE

Provider Name _____ Provider Address _____

City _____ State _____ Zip _____ Group # _____

Insured's Name _____ Relation _____ Insured's Birth Date _____

Insured's SSN # _____ Insured's Employer _____ Insured's Phone # _____

Katrina Eglian, D.M.D.



Family and Cosmetic Dentistry

20921 Walnut Street
Red Bluff, CA 96080
Office (530) 527-7951
Fax (530) 527-7955

NO SHOW POLICY

We would like to take this opportunity to inform you of our NO SHOW POLICY.

An appointment is considered to be a "No-show" if the patient does not come to the scheduled appointment and when the appointment is canceled or rescheduled within two hours of the scheduled appointment.

Our No Show Policy is as follows:

When you schedule an appointment we look forward to being a part of your dental journey, and when you miss an appointment we miss you. We understand that things come up, but it is our mission to make sure your dental needs are met. After a missed appointment we will make every good faith effort to contact you. We may call you directly, leave a phone message, and/or send a letter asking you to contact us.

Please note: If a patient does not come to 3 scheduled visits in a 12 month period, or if a patient has excessive rescheduling or canceling of appointments, the patient may be discharged from our office.

When you sign this paper, you certify that you have read and understand the above information regarding our No Show, Cancellation, and Reschedule Policy, and understand that if you are unable to attend a scheduled appointment or bring your child to a scheduled appointment, it is your responsibility to contact us 24 hours in advance.

NAME OF PATIENT

PATIENTS DATE OF BIRTH

SIGNATURE OF PATIENT / RESPONSIBLE PARTY

DATE

Katrina Eglian, D.M.D.

20921 Walnut Street
Red Bluff, CA 96080
530-527-7951

In compliance with the HIPAA regulations and law, we are not able to speak w/ anyone other than you the patient regarding any medical information. If you have someone that you authorize us to leave information with or speak with regarding your medical care please list them below. Thank you.

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

Patient Signature

Date

Katrina Eglian, D.M.D.

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 (MM/DD/YY), 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 \$0._ for each page, \$_ per hour for staff time to 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 circumstance.

Electronic Notice: If you receive this Notice on our Website 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: Katrina Eglan, D.M.D.

Telephone: 530.527.7951 _____ **Fax:** 530.527.7955 _____

E-mail: _____

Address: 20921 Walnut Street, Red Bluff, CA 96080 _____

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Reproduction and use of this form by dentists and their staff is permitted. Any other use, duplication or distribution of this form by any other party requires the prior written approval of the American Dental Association.

We require 3 signatures please...

Practice Acknowledgments

Katrina Eglian, D.M.D.

Dental Materials Fact Sheet

I, _____, received and read the Dental Materials Fact Sheet Summary from Dr. Eglian. I am aware that a full disclosure is available at the front desk.

X _____ X _____
Signature Date

Financial Guideline

I fully understand the Financial Guidelines for the office of Katrina Eglian, D.M.D.
I acknowledge that I am responsible for the payment of services regardless of insurance decision.
I understand that payments are due at the time of services, unless otherwise arranged.

X _____ X _____
Signature Date

Acknowledge of Receipt of Notice of Privacy Practices

I, _____, have received a copy of this office's Notice of Privacy Practices. You may refuse to sign this acknowledgment.

X _____ X _____
Signature Date

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- ___ Individual refused to sign
- ___ Communication barriers prohibited obtaining acknowledgment
- ___ An emergency situation prevented us from obtaining acknowledgment
- ___ Other