



We would like to get to know you better!

Name: _____ Male Female Date: _____
 Residence: _____ Zip Code: _____
 If child, Parent name: _____
 Phone: _____ Occupation: _____ Employer: _____
 Employer Address: _____ Employer Phone: _____
 Date of Birth: _____ Age: _____ Spouse's Name: _____
 Spouse's Occupation: _____ Spouse's Employer: _____
 Employer Address: _____ Employer Phone: _____
 Who referred you to our office? _____
 Person responsible for dental investment: _____

For Insurance Purposes

Name of Carrier: _____
 Social Security Number: _____ Group Number: _____
 Are you covered by another plan? _____ If so, Name of Carrier: _____
 Social Security Number: _____ Group Number: _____

Are your teeth sensitive to:	Yes No	When was your last dental appointment? _____	
Heat?	Yes No	Do you have any general health problems?	Yes No
Cold?	Yes No	If so, please specify: _____	
Sweets?	Yes No	_____	
Biting Pressure?	Yes No	_____	
Does food catch between your teeth?	Yes No	Have you had surgery?	Yes No
Do your gums bleed when brushing?	Yes No	If so, please specify: _____	
Have you noticed any gum swelling around your teeth?	Yes No	_____	
Do you have an unpleasant taste or odor in your mouth?	Yes No	Are you currently under a physician's care?	Yes No
Problems of the Jaw:		Reason: _____	
Clicking of the jaw	Yes No	Any Medications? _____	
Pain (joints, ear, side of face)	Yes No	To the best of your knowledge, are you or have you ever	
Difficulty opening or closing	Yes No	been affiliated with:	
Difficulty chewing	Yes No	Heart Ailment	Yes No
Do you ever avoid any part of the mouth while brushing?	Yes No	Diabetes	Yes No
Have you had a reaction to a local anesthetic?	Yes No	Rheumatic Fever	Yes No
Are you dissatisfied with your teeth & their appearance?	Yes No	Epilepsy	Yes No
Are you deeply concerned about the finances required to		High Blood Pressure	Yes No
return your teeth to excellent dental health?	Yes No	Respiratory Disease	Yes No
Do you get frustrated because you always have something		Hepatitis	Yes No
to be treated or repaired when you visit a dentist?	Yes No	HIV Positive	Yes No
Do you smoke?	Yes No	Prolonged Bleeding	Yes No
Have you ever had any teeth removed?	Yes No	Healing Complications	Yes No
How long have these teeth been missing? _____		Allergy to any Drug	Yes No
Do you feel you will eventually wear artificial dentures?	Yes No	Are you pregnant?	Yes No
Do you have any fears?	Yes No	Why did you leave your last dentist? _____	

		What is your present dental problem? _____	

Signature: _____

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 _____ and will remain in effect until we replace it.

We reserve the right to change our privacy practices and applicable law permits the terms of this Notice at any time, provided such changes. 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 provide performance, conducting training programs, accreditation, and 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 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 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 your 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 \$0-50 for each page. \$25.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format if you prefer we will prepare a summary or an explanation of your health information for a fee. Contact us using the information sheet 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 on 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 website or by electronic mail (email), 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 the U.S. Department of Health and Human Services or us.

Contact Officer: Kimberly Willets

Telephone: (313) 388-2400 Fax: (313) 386-9550

E-mail: paulpolyviou@wowway.com

Address: 3784 Dix Toledo Road Lincoln Park, MI 48146

American Dental Association

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ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE

Paul Polyviou, DDS, P.C & Associates

PLEASE SIGN THE FORM BELOW UNDER THE HEADING "CONSENT" TO CONSENT TO OUR DISCLOSURES OF YOUR INFORMATION THAT WE DEEM NECESSARY IN ORDER TO PROVIDE YOU WITH PROPER TREATMENT.

PART ONE: Acknowledgement of Receipt of Privacy Notices

I, _____, acknowledge that I have received a Notice of Privacy Practices from the above named practice.

Signature: _____ **Date:** _____

If a personal representative signs this authorization on behalf of the individual please complete the following.

Personal Representative's Name: _____

Relationship to Individual: _____

FOR OFFICE USE ONLY:

PART TWO: Good faith effort to obtain acknowledgement of Receipt

Patient refused to sign:

Describe your good faith effort to obtain the individual's signature on the form: _____

Describe the reason why the individual would not sign the form: _____

PATIENT CONSENT

I attest that the above information is correct.

Patient Signature: _____ Date: _____