

Please assist us in providing you the highest quality dental care by completing this confidential questionnaire.

Your Name: _____ Birth Date: _____

Home Address: _____ City: _____ Zip: _____

Married? _____ SS Number (for ins.): _____ Home Phone: _____

Parent or Spouse: _____ Phone: _____

Who to notify in case of emergency: _____ Phone: _____

Your Employer: _____ Address: _____

Occupation: _____ How Long?: _____ Work City: _____ Zip: _____

Daytime Phone: _____ Doctor or person who referred you: _____

E-mail: _____

Personal Health History

Please circle "yes" or "no" and explain as necessary

Yes No Are you in good health? _____ If taking medicine (include birth control pills), what? _____

Yes No Are you under the care of a physician? If so, with whom and for what?: _____

Yes No Have you had any serious illnesses or been hospitalized in the past five years? _____

Yes No Are you allergic to any drugs or medicines? If so, which ones? _____

Yes No (Females) Are you pregnant or is it possible you may be pregnant? How long? _____

Please Circle Any Illnesses Which You Have Had:

AIDS/HIV Infection	Blood Pressure	Glaucoma	Kidney or Liver	Rheumatic Fever
Alcoholism	Cancer	Head/Neck Injury	Mental/Psychiatric	Sinusitis
Allergies	Diabetes	Heart Trouble	Migraine	Tuberculosis
Anemia	Drug/Narcotic Dependency	Hepatitis	Pacemaker/Implant	Ulcers
Asthma	Epilepsy	Herpes	Respiratory	Venereal Disease

Yes No Do you have any disease, condition or problem not listed which we should know about? _____

**To avoid misunderstandings the following is given for your information.
Please feel free to discuss treatment and fees with us at any time.**

Please initial beside each statement below:

_____ I understand that I will be presented with an Informed Consent Form if endodontic treatment is recommended for me.

_____ I am personally responsible for payment of dental services charged to my account. It is the usual policy of this office that I pay the full fee on or before completion of treatment.

_____ Fees vary with the difficulty of treatment and once quoted remain the same except:

1. When broken appointments prolong treatment or 2. When surgery becomes necessary

_____ I have Dental Insurance and have read and understand the Insurance Policy for this office.

_____ The permanent restoration (fillings, crown, etc.) will usually be done by my regular dentist, not here.

My signature below indicates I have read and understand what is written above.

Signed _____ Dated _____

Notice of Privacy Practices Acknowledgment

Richard J. Pockat, DDS, PA
425 S. Sharon Amity, Suite B
Charlotte, NC 28211
704-364-3422

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

Office Use Only

I attempted to obtain the patient's signature in acknowledgment on this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

Date	Initials	Reason