5510 Abrams Road, Suite 102, Dallas Texas 75214 214 691-2969

PF-2000 Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures

Treatment
Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment
Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations
Your health information may be used as necessary to support the day-to-day activities and management of [Name of Practice]. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement
Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting
Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization
Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

PF-2000 Notice of Privacy Practices (cont'd)

Additional Uses of Information

Appointment reminders
Your health information will be used by our staff to send you appointment reminders.

Complaints and Contact Person
The name and address of the person you can contact for further information concerning our privacy practices is:

The U. S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257 (877) 696-6775

Effective Date
This notice is effective on or after **October 16, 2003**

5510 Abrams Road, Suite 102, Dallas Texas 75214 214 691-2969

PF2000 Acknowledgment of Receipt of Notice of Privacy Practices

Dr. Paletti reserves the right to modify practices outlined in the notice.

Signature
I have received a copy of the **Notice of Privacy Practices** for **Dr. Paletti.**

Patient Name: _____

Patient Signature: _____

Date: _____

_____
Signature of patient Representative
(Required if the patient is a minor or an adult who is unable to sign this form.)

_____
Relationship of Patient Representative

5510 Abrams Road, Suite 102, Dallas Texas 75214 214 691-2969

PATIENT REGISTRATION FORM

GENERAL INFORMATION (Please print)

Name: _____ ☐S ☐M ☐W ☐D ☐C

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Mobile: _____

Work Phone: _____ Sex: ☐ M ☐ F

Date of Birth: _____ Occupation: _____

Employer: _____

Social Security Number: _____

Physician's Name: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Insurance Information

Name of Insurance Carrier: _____

Address: _____

Phone: _____ Policy Holder Name: _____

ID #: _____ Group #: _____

AUTHORIZATION FOR RELEASE OF INFORMATION ASSIGNMENT BENEFITS

I HEREBY AUTHORIZE DR. PALETTI TO RELEASE ANY MEDICAL INFORMATION ACQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT NECESSARY TO PROCESS MY INSURANCE CLAIMS, AND AUTHORIZE PAYMENT DIRECTLY TO DR. PALETTI. I UNDERSTAND, THAT I AM FINANCIALLY RESPONSIBLE FOR ANY FEES NOT COVERED BY MY INSURANCE COMPANY. I UNDERSTAND THAT THIS IS MY RESPONSIBILITY TO PROVIDE CORRECTED AND UPDATED INFORMATION REGARDING MY INSURANCE COMPANY.

Signature: _____ Date:_____

5510 Abrams Road, Suite 102, Dallas Texas 75214 214 691-2969

Health History

1. Patient Name: _____ Birth Date: _____

2. Name of Physician: _____ Phone #: _____

3. Date of Last Medical Checkup: _____

4 Are You being treated by a physician currently? ☐Yes ☐No If Yes, list nature of treatment.

_____

5. Current Prescribed Medications: _____

_____

6. Are You taking any vitamins or supplements not prescribed by your physician? ☐Yes ☐No

If yes, please list: _____

7. Approximate date of last Dental appointment: _____

Nature of treatment: _____

8. Reason for scheduling today's appointment: _____

Are you in pain? ☐Yes ☐No Do you have a specific concern? ☐Yes ☐No

Is today's appointment for a routine checkup? ☐Yes ☐No

9. Allergies to Medications? ☐Yes ☐No If Yes, please list: _____

Penicillin allergies? ☐Yes ☐No Anesthesia? ☐Yes ☐No If Yes, please list:

_____

10. Have you been told by your Physician that you need antibiotic pre-medicatation for a heart problem (rheumatic fever, heart valve defect or mitral valve prolapse)?

☐Yes ☐No Or, joint replacement? ☐Yes ☐No If Yes, list nature of problem:

_____

Health History (Cont'd)

Prosthetic heart valve? ☐Yes ☐No

11. Have you had a heart attack? ☐Yes ☐No Heart Surgery ☐Yes ☐No If Yes, list nature of surgery and date:

_____

12. Do you have a pacemaker? ☐Yes ☐No

13. High Blood Pressure? ☐Yes ☐No If Yes, please list medications: _____

14. Have you had a stroke? ☐Yes ☐No Date: _____ Family History?_____

_____

15. Have you had radiation treatments? ☐Yes ☐No If Yes, date of treatment: _____

16. Have you been diagnosed with Hepatitis? ☐Yes ☐No If Yes, list date: _____

17. Do you have Diabetes? ☐Yes ☐No If Yes, please list medications: _____

18. Are you being treated for Osteoporosis? ☐Yes ☐No If Yes, please list medications:

_____

19. Surgeries of any kind? ☐Yes ☐No If Yes, list nature of surgery and date:

_____

20. AIDS or HIV positive? ☐Yes ☐No If Yes, list date of diagnosis: _____

21. Do you smoke? ☐Yes ☐No If Yes, how long? _____

22. Do you have any lung or other upper respiratory problems? ☐Yes ☐No If Yes, please list:

_____

23. Do you have any upper or lower gastric (digestive) problems? ☐Yes ☐No If Yes, please list:

_____

24. Are you or might you be pregnant? ☐Yes ☐No Are you taking birth control pills? ☐Yes ☐No

25. Are there ANY medical problems not listed? ☐Yes ☐No If Yes, please list: (use back if needed)

_____

_____

_____

Patient Signature: _____ **Date:** _____

5510 Abrams Road, Suite 102, Dallas Texas 75214 214 691-2969

AUTHORIZATION FOR RELEASE OF INFORMATION ASSIGNMENT BENEFITS

I HEREBY AUTHORIZE DR. PALETTI TO RELEASE ANY MEDICAL INFORMATION ACQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT NECESSARY TO PROCESS MY INSURANCE CLAIMS, AND AUTHORIZE PAYMENT DIRECTLY TO DR. PALETTI. I UNDERSTAND, THAT I AM FINANCIALLY RESPONSIBLE FOR ANY FEES NOT COVERED BY MY INSURANCE COMPANY. I UNDERSTAND THAT THIS IS MY RESPONSIBILITY TO PROVIDE CORRECTED AND UPDATED INFORMATION REGARDING MY INSURANCE COMPANY.

Patient Signature: _____ **Date:** _____