Family Dental Care

Dr. Himanand Akkannappa and Dr. Darshan Singh along with their staff wish you a Warm Welcome and Thank You!...

If you have any questions, please do not hesitate to ask. Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

ABOUT YOU

Today's Date: ____________________

Name: ____
Last First Middle

Birthday: ______/______/______ Age: ____________

S/S #:_____ - ____ - ______ DL #: ____________

Home Address: ________________________________
Apt. / Condo #

____
City State Zip

❑ Single ❑ Married ❑ Partnered ❑ Divorced / Separated ❑ Widowed
❑ Male ❑ Female

Home # (___) ____________ Cell / Other # (___) ____________

Work # (___) ____________ Ext ____________

Employer: ________________________________

E-Mail Address: ________________________________

How did you hear about our office? ____________________

Other family members seen by us: ____________________

Previous / Present Dentist: ____________________
(Please Circle)

Person Responsible for Account: ____________________

SPOUSE INFORMATION

His / Her Name: ________________________________

Employer: ________________________________

Work #: (___) __________ Ext: _____ S/S #: _____ - ____ - ______

Birthday: ___ /___ /_____ DL #: ____________

Relative or Friend not living with you.

His / Her Name: ____________________ Relation: ________

Work #: (___) ____________ Home # (____) ____________

NOTICE OF PRIVACY

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patient's consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient, we want you to know that we respect the privacy of your personal dental records and will do all we can to secure and protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about your treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal dental records. We may have indirect treatment relationships with you (such as laboratories that only interact with doctors and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities most often not required to obtain patient consent.

You may refuse to consent to the use of disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat if you choose to refuse to disclose your Personal Health Information (PHI). You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions, and revoke consent in writing after you have reviewed our privacy notice.

Person Giving Consent

I have the opportunity to read and consider the consents of this form and notice of Privacy Practices. I understand that by signing this consent form I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations. I Also acknowledge that I received a copy of the notice of Privacy Practices.

Patient Signature: ________________________________
(If Minor Legal Guardian)