MORA
FAMILY DENTISTRY

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PATIENT HIPAA QUESTIONNAIRE

I. Please list the family members or other persons, if any, whom we may inform about your general dental & medical condition (including treatment, payment and health care operations).

_____

_____

II. Please list the family members or significant others, if any, whom we may inform about your medical condition **ONLY IN AN EMERGENCY**:

_____

_____

III. Please print the address of where you would like your reminder postcards and/or correspondence from our office to be sent **IF OTHER THAN YOUR HOME**.

_____

street **city** **zip code**

IV. Please indicate if you want all correspondence from our office sent in a sealed envelope marked **"CONFIDENTIAL"**: **YES** _____ **NO** _____

V. Please print the telephone number, if any, where you want to receive calls about your appointments or other health care information IF OTHER THAN YOUR HOME

PHONE NUMBER: (____)_____.

VI. Can confidential messages (ie. Appointment reminders) be left on your telephone answering machine or voicemail? **YES** _____ **NO** _____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE

This document acknowledges that you have received a copy of the Notice of Privacy Practices. This document will remain in your records.

I, _____, acknowledge that I have received a copy of the Notice of Privacy Practices.

_____ _____ _____

PATIENT NAME [PRINT] PATIENT/GUARDIAN* SIGNATURE DATE

*If the patient is a minor (under 18 years of age) or under the care of another individual, a parent/guardian/caregiver must sign for the patient.