Patient Registration

PLEASE PRINT Date: _____________

First MI Last

Patient Name:____

Street Address: ____

City/State: ____Zip Code:________________

Cell Phone: (_____)_____________Home (_____)_____________Work (_____)____________

May we contact you by Text Message? Yes_______ No _______

Date of Birth: _____/_____/_____ SS#: ________________________________

Employer:______________________Address:__________________________________

Referred by:____

Patient Email:____

Person Responsible for Account (if different than above)

Name: ____

Street Address: ____

City/State:____ Zip Code:________________

Cell Phone: (_____)______________Home (_____)_____________Work (_____)___________

Employer: _________________________________Relation to patient: ____________________

SS#: __________________________ Drivers License #: _________________________

MEDICAL HISTORY

1. Your current physical health is (circle one): GOOD FAIR POOR

2. Are you currently under the care of a physician? YES NO
   IF YES, please explain:____

3. Are you taking any prescription or over-the-counter drugs? YES NO
   IF YES, please list each one:____
   ____

4. Please circle any of the following if you currently have or ever had in the past:

Rheumatic Fever	Endocarditis	Total Joint Replacement (e.g. artificial knee or hip)	Hepatitis	Anemia
Kidney Disease	Diabetes	Liver Disease	High Blood Pressure	Sinusitis
Glaucoma	Blood Disease	Epilepsy	AIDS/HIV positive	Artificial heart valves
Heart Transplant	Heart Disease	Other:		

5. Have you ever had, or do you currently have Osteoporosis? YES NO
   IF YES, please list any drugs you have ever taken in the past ***or*** are currently taking for Osteoporosis:
   ____

6. Have you received any donor organs, artificial heart valves, or joint implants? YES NO

7. Have you ever had trouble with prolonged bleeding after surgery? YES NO

8. Are you ***allergic to*** any of the following (if yes, please circle)?

Latex	Aspirin	Ibuprofen	Tylenol	Codeine	Dental Anesthetics	Penicillin	Clindamycin

9. Please list any other drugs or materials that you are allergic to:______________________________

10. Is there any other information that should be known about your health or about previous dental visits?
    ____

11. FOR WOMEN: Are you pregnant? YES NO Week #:______
    Are you nursing? YES NO

PATIENT NAME (please print):_________________________________**DATE:**______________

PATIENT SIGNATURE: _______________________________________

Jeffrey C. Kotz, D.M.D., P.A.

Practice Limited to Endodontics

To Our Patients:

Some patients may be apprehensive and anxious about root canal treatment. In order to avoid any misunderstanding and better inform you, the following information and office policies are provided for your benefit.

1. Endodontics, or root canal therapy, is that specialty of dentistry devoted to the saving of teeth where the pulp (nerve) is affected. It is true that it is easier to extract a tooth than to save it, but the value of a natural tooth is irreplaceable. In addition, extraction and replacement is usually more costly.

2. No tooth will be undertaken for treatment unless there is a chance for success. While there is no absolute certainty concerning the healing of body tissues, we expect it to occur in approximately 90% of the cases. Should the success rate for saving your tooth be estimated to be below this average, you will be so informed.

3. Complete treatment averages two visits. First, a small opening is made in the biting surface of the tooth, then the pulp tissue is removed and the canal or canals are cleaned out, shaped, and medicated. The tooth is closed with a white temporary filling material. At the time of the final visit, the canal or canals are sealed with a rubber-like material called gutta percha and again the opening is filled with temporary filling material.

4. Root canal therapy assumes certain risks, including but not limited to: fracture of the tooth or an existing porcelain restoration ("cap"), tooth perforation, and instrument separation. While the incidence of these complications is low, their occurrence may require additional procedures.

5. Generally you can expect treatments to be fairly simple…similar to having a filling done. The manipulation of the tooth during treatment may produce some minor irritation and you may have some tenderness for one or two days following appointments. Medication taken for a headache, or that prescribed by our office, should control this minor discomfort. In some rare instances, a tooth that was comfortable before the beginning of treatment can manifest severe pain and swelling after a treatment session known as a "flare up". (If you experience a flare up, please call us.)

6. Between treatments there will be a temporary filling in the tooth. *Do not chew on that side of your mouth.* This will allow for faster healing, less discomfort, and prevent accidental breakage of the temporary filling. Please maintain normal hygiene.

7. When root canal treatment is completed, your tooth will require a final restoration, either a filling or a crown (to be decided by your referring dentist). OUR FEE DOES NOT INCLUDE THIS PROCEDURE. Your referring dentist will render this service which is essential for the preservation of your tooth. Please schedule an appointment with him or her as soon as possible after your last appointment with us.

INFORMED CONSENT

I have read and understand the above information letter "To Our Patients" and hereby give consent to treatment:

PATIENT NAME (please print): ____

PATIENT SIGNATURE: ____________________________________DATE:______________

Jeffrey C. Kotz, D.M.D., P.A.

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 4-14-2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. 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 provider performance, conducting training programs, accreditation, 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. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use 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.

(CONTINUED ON NEXT PAGE)

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 you 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 for medical records other than worker's compensation cases, such reasonable costs shall not exceed twenty dollars ($20.00) for medical records up to forty (40) pages or less in length. Each page copied after the first forty (40) pages will be charged at $0.25 per page. If you want copies mailed to you postage will be additional.
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 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 Web site or by electronic mail (e-mail), 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 us or with the U.S. Department of Health and Human Services.

Contact Officer: Jeffrey C. Kotz, D.M.D., P.A. Telephone:
843-225-9002 Fax 843-225-6995
E-mail: kotzoffice@yahoo.com
Address: 742 Saint Andrews Boulevard, Charleston, SC 29407

Privacy Practices Acknowledgement

I have reviewed and/or received a copy of this office's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. 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 below 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 that you are not required to agree to my requested restrictions. However, if you do agree, then you are bound to abide by such restrictions. I further understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: ____

Signature: ____

Relationship to Patient: ____

Date: ____

Do we have your permission to:

Leave a message on your voice mail at home or on your cell phone relating to an appointment or account? ( ) Yes ( ) No

Call or leave a message at your place of employment? ( ) Yes ( ) No

***Discuss your medical/dental condition/treatment with any members of your household?** ( ) Yes ( ) No

***If yes, with whom:** ______________________ **Relationship** ______________*

Jeffrey C. Kotz, D.M.D., P.A.
742 St. Andrews Blvd
Charleston, SC 29407