# HIPAA

NOTICE OF PRIVACY PRACTICES FOR THE OFFICES OF:

Terrence C. O'Keefe, D.D.S., P.C.

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.

If you have any questions about this notice, please contact

Terrence C. O'Keefe, D.D.S., P.C.

Of our office at

11757 Katy Freeway Suite 200
Houston, TX 77079

cheryl@drokeefe.com
281 496 6878
281 496 6581

## WHO WILL FOLLOW THIS NOTICE

This notice describes the information privacy practices followed by our employees, staff and other office personnel. The practices described in this notice will also be followed by health care providers you consult with by telephone (when your regular health care provider from our office is not available) who provide "call coverage" for your health care provider.

## YOUR HEALTH INFORMATION

This notice applies to the information and records we have about your health, health status, and the health care and services you receive at this office. We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.

## HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

### For Treatment

We may use health information about you to provide you with medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, office staff or other personnel who are involved in taking care of you and your health.

For example, your doctor may be treating you for a heart condition and may need to know if you have other health problems that could complicate your treatment. The doctor may use your medical history to decide what treatment is best for you. The doctor may also tell another doctor about your condition so that doctor can help determine the most appropriate care for you.

Different personnel in our office may share information about you and disclose information to people who do not work in our office in order to coordinate your care, such as phoning in prescriptions to your pharmacy, scheduling lab work and ordering x-rays. Family members and other health care providers may be part of your medical care outside this office and may require information about you that we have.

### For Payment

We may use and disclose health information about you so that the treatment and services you receive at this office may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about a service you received here so your health plan will pay us or reimburse you for the service. We may also tell your health plan about a treatment you are going to receive to obtain prior approval, or to determine whether your plan will cover the treatment.

### For Health Care Operations

We may use and disclose health information about you in order to run the office and make sure that you and our other patients receive quality care. For example, we may use your health information to evaluate the performance of our staff in caring for you. We may also use health information about all or many of our patients to help us decide what additional services we should offer, how we can become more efficient, or whether certain new treatments are effective.

### Appointment Reminders

We may contact you as a reminder that you have an appointment for treatment or medical care at the office.

### Treatment Alternatives

We may tell you about or recommend possible treatment options or alternatives that may be of interest to you.

### Health-Related Products and Services

We may tell you about health-related products or services that may be of interest to you.

Please notify us if you do not wish to be contacted for appointment reminders, or if you do not wish to receive communications about treatment alternatives or health-related products and services. If you advise us in writing (at the address listed at the top of this Notice) that you do not wish to receive such communications, we will not use or disclose your information for these purposes.

## SPECIAL SITUATIONS

We may use or disclose health information about you without your permission for the following purposes, subject to all applicable legal requirements and limitations:

### To Avert a Serious Threat to Health or Safety

We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

### Required By Law

We will disclose health information about you when required to do so by federal, state or local law.

### Research

We may use and disclose health information about you for research projects that are subject to a special approval process. We will ask you for your permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the office.

#### Organ and Tissue Donation

If you are an organ donor, we may release health information to organizations that handle organ procurement, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate such donation and transplantation.

**Military, Veterans, National Security and Intelligence**

If you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about you. We may also release information about foreign military personnel to the appropriate foreign military authority.

### Workers' Compensation

We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

### Public Health Risks

We may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.

### Health Oversight Activities

We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.

### Lawsuits and Disputes

If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order.

Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.

### Law Enforcement

We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.

### Coroners, Medical Examiners and Funeral Directors

We may release health information to a coroner or medical examiner.

This may be necessary, for example, to identify a deceased person or determine the cause of death.

### Information Not Personally Identifiable

We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.

### Family and Friends

We may disclose health information about you to your family members or friends if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgment that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse when you bring your spouse with you into the exam room during treatment or while treatment is discussed.

## OTHER USES AND DISCLOSURES OF HEALTH INFORMATION

We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written Authorization. If you give us Authorization to use or disclose health information about you, you may revoke that Authorization, in writing, at any time. If you revoke your Authorization, we will no longer use or disclose information about you for the reasons covered by your written Authorization, but we cannot take back any uses or disclosures already made with your permission.

If we have HIV or substance abuse information about you, we cannot release that information without a special signed, written authorization from you that complies with the law governing HIV or substance abuse records.

## YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the following rights regarding health information we maintain about you:

### Right to Inspect and Copy

You have the right to inspect and copy your health information, such as medical and billing records, that we use to make decisions about your care. You must submit a written request to:

Terrence C. O'Keefe, D.D.S., P.C.

Of our office at

11757 Katy Freeway Suite 200
Houston, TX 77079

cheryl@drokeefe.com
281 496 6878
281 496 6581

in order to inspect and/or copy your health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other associated supplies. We may deny your request to inspect and/or copy in certain limited circumstances. If you

are denied access to your health information, you may ask that the denial be reviewed. If such a review is required by law, we will select a licensed health care professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

### Right to Amend

If you believe health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by this office.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

a) We did not create, unless the person or entity that created the information is no longer available to make the amendment.

b) Is not part of the health information that we keep.

c) You would not be permitted to inspect and copy.

d) Is accurate and complete.

### Right to an Accounting of Disclosures

You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you for purposes other than treatment, payment and health care operations. To obtain this list, you must submit your request in writing to:

Terrence C. O'Keefe, D.D.S., P.C.

Of our office at

11757 Katy Freeway Suite 200
Houston, TX 77079

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It must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper,

electronically). We may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

### Right to Request Restrictions

You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

### We are Not Required to Agree to Your Request

We may not (and are not required to) agree to your restrictions with one exception: If you pay in full (out of pocket) for a service you receive from us, and you request that we not submit the claim for this service to your health insurer or health plan for reimbursement, we must honor that request.

If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

### Right to a Paper Copy of This Notice

You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive it electronically, you are still entitled to a paper copy. To obtain such a copy, contact:

Terrence C. O'Keefe, D.D.S., P.C.

### CHANGES TO THIS NOTICE

We reserve the right to change this notice, and to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a summary of the current notice in the office with its effective date in the top right hand corner. You are entitled to a copy of the notice currently in effect.

To request restrictions, you may complete and submit a Request For Restricting Uses and Disclosures and Confidential Communications Form Information to:

Terrence C. O'Keefe, D.D.S., P.C.

### Right to Request Confidential Communications

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.
To request confidential communications, you may complete and submit the Requests For Restricting Uses and Disclosures and Confidential Communications to:

Terrence C. O'Keefe, D.D.S., P.C.

### COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact:

11757 Katy Freeway Suite 200
Houston, TX 77079

cheryl@drokeefe.com
281 496 6878
281 496 6581

You will not be penalized for filing a complaint.

Signature _____

# GENERAL PATIENT INFORMATION

## Patient Registration

**Patient Information**

Full Name: _____

Date of Birth: _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Sex: ☐ Male ☐ Female

SSN/ID: _____

Email Address: _____

Home Phone Number: _____

Cell Phone Number: _____

**Drivers License**

State: _____

Number: _____

**Home Address:**

Address: _____

City, State and ZIP: _____

**Billing Address:**

Address: _____

City, State and ZIP: _____

**Work Information**

Employer: _____

Occupation: _____

Work Phone Number: _____

**Method of Contact:** ☐ Phone ☐ Email ☐ Text Message ☐ Any of the previous ones

**Emergency Contact:**

Full Name: _____

Phone Number: _____

Relation: _____

**How did you hear about our office?**

| |
|---|
| |

**Who may we thank for referring you?** _____

# GENERAL PATIENT INFORMATION

## Financial Information

**Patient's Payment Details – Guarantor (Person responsible for paying the bill)**

Guarantor Name: _____

SSN/ID: _____

Relation to Patient: _____

**Patient's Student Status**

Student Status: _____

College: _____

College Address: _____

**Primary Dental Insurance Company – Subscriber and Insurance Company Details**

Subscriber Name: _____

Date of Birth: _____

SSN/ID: _____

Employer: _____

Policy Number: _____

Group Number: _____

Coverage Type: ☐ Individual ☐ Family ☐ Prepaid / Capitation

Insurance Company: _____

Company Phone Number: _____

Company City, State, ZIP: _____

**Secondary Dental Insurance Company – Subscriber and Insurance Company Details**

Subscriber Name: _____

Date of Birth: _____

SSN/ID: _____

Employer: _____

Policy Number: _____

Group Number: _____

Coverage Type: ☐ Individual ☐ Family ☐ Prepaid / Capitation

Insurance Company: _____

Company Phone Number: _____

Company City, State, ZIP: _____

**Pharmacy Information**

Name: _____

Address: _____

Pharmacy Phone Number: _____

**Medicaid Number:** _____

I authorize the dentist to release any information, including diagnosis, treatment plans/records and radiographs to third party payers and/or health practitioners. I authorize and request that my insurance company (if applicable) pay directly to the dental group or dentist benefits that are, otherwise, payable to me. I understand that my dental insurance may pay less than the actual bill for service or may not cover certain treatment.

I hereby certify that the foregoing information is accurate and complete and that in consideration of treatment and services rendered to me or my dependents by this dental office, I accept responsibility and agree to be obligated to pay the office in accordance with its payment and credit terms and policies.

Signature: _____

# PATIENT MEDICAL HISTORY

## Patient's Medical History

**Physician Information**

Physician's Full Name: _____

Address: _____

City, State and ZIP: _____

Are you currently under a physician's Care? ☐Yes ☐No

If Yes, for what?

Are you taking any medication, drugs or pills? ☐Yes ☐No

If so, please list the names and dosages of each:

Have you been hospitalized in the last two years? ☐Yes ☐No

If Yes, for what?

Do you Smoke? ☐Yes ☐No How Much? _____

**Women Only**

Are you pregnant? ☐Yes ☐No What is your due date? _____

Are you nursing? ☐Yes ☐No Are you taking birth control pills? ☐Yes ☐No

Are you on Hormone Therapy? ☐Yes ☐No

## Patient's Current or Previous Conditions

Select any of the following if you presently have or have had the condition in the past:

**Medical Alerts**

| YES | NO | |
|---|---|---|
| ☐ | ☐ | Allergic to Penicillin |
| ☐ | ☐ | Allergic to Tetracycline |
| ☐ | ☐ | Allergic to Aspirin |
| ☐ | ☐ | Other |
| ☐ | ☐ | Allergic to Codeine |
| ☐ | ☐ | Allergic to 'Novocaine' |
| ☐ | ☐ | Allergic to Latex Rubber |
| ☐ | ☐ | Pre-Medication required |
| ☐ | ☐ | Mitral Valve Prolaspe |
| ☐ | ☐ | Heart Problems |
| ☐ | ☐ | Pacemaker |
| ☐ | ☐ | HIV Positive |
| ☐ | ☐ | Prior Hepatitis |

**Medical Conditions**

| YES | NO | | YES | NO | | YES | NO | | YES | NO | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | Heart Attack | ☐ | ☐ | Osteoporosis | ☐ | ☐ | Chemotherapy | ☐ | ☐ | Excessive Bleeding when Cut |
| ☐ | ☐ | Heart Murmur | ☐ | ☐ | Sickle Cell Disease | ☐ | ☐ | Ulcers | ☐ | ☐ | Swelling of Feet/Ankles |
| ☐ | ☐ | Chest Pain | ☐ | ☐ | Glaucoma | ☐ | ☐ | Gastrointestinal Upset | ☐ | ☐ | Artificial Joint Replacement |
| ☐ | ☐ | Congenital Heart Problem | ☐ | ☐ | Diabetes | ☐ | ☐ | Acid Reflux | ☐ | ☐ | Psychiatric Care |
| ☐ | ☐ | Artificial Heart Valve | ☐ | ☐ | Excessive Thirst | ☐ | ☐ | Lung Disease | ☐ | ☐ | Epilepsy or Seizures |
| ☐ | ☐ | Heart Surgery | ☐ | ☐ | Scarlet Fever | ☐ | ☐ | Tuberculosis | ☐ | ☐ | Extreme Nervousness |
| ☐ | ☐ | High/Low Blood Pressure | ☐ | ☐ | Thyroid Disease | ☐ | ☐ | Shortness of Breath | ☐ | ☐ | Fainting or Dizziness |
| ☐ | ☐ | Rheumatic Fever | ☐ | ☐ | Parathyroid Disease | ☐ | ☐ | Emphysema | ☐ | ☐ | Hypoglycemia |
| ☐ | ☐ | Anemia | ☐ | ☐ | Kidney Disease | ☐ | ☐ | Asthma | ☐ | ☐ | Hives |
| ☐ | ☐ | Blood Disease | ☐ | ☐ | Liver Disease | ☐ | ☐ | Sinus Trouble | ☐ | ☐ | Cold Sores/Fever Blisters |
| ☐ | ☐ | Blood Transfusion | ☐ | ☐ | Hepatitis A or B | ☐ | ☐ | Hay Fever | ☐ | ☐ | Venereal Disease |
| ☐ | ☐ | Stroke | ☐ | ☐ | Yellow Jaundice | ☐ | ☐ | Frequent Cough | ☐ | ☐ | Herpes |
| ☐ | ☐ | Deep Vein Clot | ☐ | ☐ | Cancer | ☐ | ☐ | Rheumatism | ☐ | ☐ | HPV(Human Papillomavirus) |
| ☐ | ☐ | Hemophilia | ☐ | ☐ | X-Ray or Cobalt Treatment | ☐ | ☐ | Arthritis/Gout | ☐ | ☐ | Cortisone Treatment |
| | | | | | | | | | ☐ | ☐ | Chemical Dependency |

# PATIENT DENTAL HISTORY

## Patient's Dental History

**What is your primary reason for seeking dental care?**

_____

**Previous Dentist Information**

Dentist's Full Name: _____

City, State and ZIP: _____

Month and Year of Last Visit: _____

What was done at your last visit? _____

Date of Last full mouth x-rays: _____

Reason for leaving previous dentist: _____

How often do you visit the dentist? ☐ Annual Check Up ☐ Twice a Year Check Up

☐ Only when I have a problem ☐ Other

**Please choose the appropriate answer**

Are you nervous about receiving dental treatment? ☐ Yes ☐ No

Do you gag easily? ☐ Yes ☐ No

Have you had previous problems with dental care? ☐ Yes ☐ No

If so, please explain?

Are your teeth sensitive to hot, cold, pressure or sweets? ☐ Yes ☐ No

Do you have problems with teeth/fillings breaking? ☐ Yes ☐ No

Are you aware of an uncomfortable bite? ☐ Yes ☐ No

Do your gums feel tender and/or bleed? ☐ Yes ☐ No

Does food catch between your teeth? ☐ Yes ☐ No

Have you had periodontal (gum) treatments? ☐ Yes ☐ No

Do you get sores in or around your mouth? ☐ Yes ☐ No

Do you have regular headaches, earaches or neck pains? ☐ Yes ☐ No

Do you grind or clench your teeth? ☐ Yes ☐ No

Do you hear a "clicking" sound when you open/close your mouth? ☐ Yes ☐ No

Does your jaw ever get "stuck?" ☐ Yes ☐ No

Do you have a Temporomandibular (TMJ) jaw disorder? ☐ Yes ☐ No

Are you missing teeth that have not been replaced? ☐ Yes ☐ No

Have you had excessive bleeding after an extraction? ☐ Yes ☐ No

Do you take any Bisphosphonate medication such as Fosamax, Boniva, Actonel, Aredia or Zometa? ☐ Yes ☐ No

Have you had mouth sores that take long to heal? ☐ Yes ☐ No

Do you have any dental implants? ☐ Yes ☐ No

Do you wear dentures (partials or full)? ☐ Yes ☐ No

Do you have any crowns (caps) or bridges? ☐ Yes ☐ No

Do you chew tobacco? ☐ Yes ☐ No

Do you have a dry mouth? ☐ Yes ☐ No

Are you unhappy with the appearance of your teeth? ☐ Yes ☐ No

Would you like your smile to look better? ☐ Yes ☐ No

Would you like whiter teeth? ☐ Yes ☐ No

Would you like straighter teeth? ☐ Yes ☐ No

Do you regularly use dental floss? ☐ Yes ☐ No

Do you brush at least once daily? ☐ Yes ☐ No

Is there anything else that you would like us to know?

I authorize the use of my radiographs [x-rays] and/or photographs for educational and promotional use in seminars, publications and the dental office web site. ☐ Yes ☐ No

I hereby certify that the foregoing information is accurate and complete and that I will notify the office of any changes in a timely manner. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in completion of this form.

Signature: _____