

PATIENT QUESTIONNAIRE

HIPAA Compliance

1. Please list all family members (and their relationships to you), or other persons, if any, whom we may inform about your appointments, general dental condition, your diagnosis and financial information:

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

NAME (s) PHONE:

3. Please print the address where you would like your billing statements and/or correspondence from our office to be sent.

4. Please print the phone number (s), if any, where you want to receive calls about your appointments, premedication, lab or any other dental or healthcare information:

****** I am aware that cordless phones and cellular phones may not be a secure and private line. ******

5. Can confidential messages (i.e. appointments reminders, lab results, pre-med, reminders, etc.) be left on your home answering machine or other phone numbers provided for our use?

Yes _____ NO _____

6. If I am ever in an unsecured area with the practice, and require privacy, for any reason, I will request to be moved to a private area to complete my needed transactions or correspondence (financial, treatment plan, diagnosis, etc.)

ACKNOWLEDGEMENT FORM

Dr. William B. Langston III, D.D.S.

This form is used to obtain acknowledgement of receipt of our notice of privacy practices or to document our good faith effort to obtain that acknowledgment.

Name of patient (please print)

Signature of patient Date