Glenn M. Kidder, DDS
12036 Justice Ave.
Baton Rouge, LA 70816
(225) 292-4158
(225) 292-9967 Fax
drglennkidder@aol.com

PATIENT

First Name: _____ Address: _____

Last Name: _____ Address 2: _____

Name you prefer to be called: _____ City, State, Zip: _____
(Nickname, etc.)

Date of Birth: _____ Age: _____ Home Phone: _____

Social Security Number: _____ Cell Phone: _____

Driver's License Number: _____ Work Phone: _____

Sex: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Email Address: _____

☐ I would like to be contacted by text message regarding appointment notifications.

☐ I would like to be contacted by email regarding appointment notifications.

Employer: _____ Spouse's Employer: _____

Occupation: _____ Occupation: _____

RESPONSIBLE PARTY

Relationship to Patient:

☐ Self (Same info as above)

☐ Spouse

☐ Other _____

Driver's License Number: _____

Address: _____

Address 2: _____

City, State, Zip: _____

First Name: _____

Last Name: _____ Home Phone: _____

Social Security Number: _____ Cell Phone: _____

Date of Birth: _____ Age: _____ Work Phone: _____

Is another member of your family or relative a patient at our office? ☐ Yes ☐ No

Name: _____ Relationship: _____

Who can we thank for referring you to our office? _____

1. Physician's Name: _____ Phone Number: _____

2. Have you taken any medications or drugs during the past 2 years? ☐ Yes ☐ No
If so, please list below:

3. Are you taking any medications, drugs or pills at the present? ☐ Yes ☐ No
If so, please list below:

4. Are you aware of having an allergic (or adverse reaction) to any medication or substance? If so, please list: ☐ Yes ☐ No

5. Please check any of the following that you have had, or have at the present:

☐ Heart (Surgery, Disease, Attack)	☐ Ulcers	☐ Hepatitis A (infections) B (Serum)
☐ Chest Pain	☐ Diabetes	☐ Venereal Disease
☐ Congenital Heart Disease	☐ Thyroid Problems	☐ A.I.D.S
☐ Heart Murmur	☐ Glaucoma	☐ H.I.V. Positive
☐ High Blood Pressure	☐ Contact Lenses	☐ Cold Sores/Fever Blisters
☐ Mitral Valve Prolapse	☐ Emphysema	☐ Blood Transfusion
☐ Artificial Heart Valve	☐ Chronic Cough	☐ Hemophilia
☐ Heart Pacemaker	☐ Tuberculosis	☐ Sickle Cell Disease
☐ Rheumatic Fever	☐ Asthma	☐ Bruise Easily
☐ Arthritis/Rheumatism	☐ Hay Fever	☐ Liver Disease
☐ Cortisone Medicine	☐ Latex Sensitivity	☐ Yellow Jaundice
☐ Swollen Ankles	☐ Allergies or Hives	☐ Neurological Disorders
☐ Stroke	☐ Sinus Trouble	☐ Epilepsy or Seizures
☐ Diet (Special/Restricted)	☐ Radiation Therapy	☐ Fainting or Dizzy Spells
☐ Artificial Joints (hip, knee, etc)	☐ Chemotherapy	☐ Nervous/ Anxious
☐ Kidney Trouble	☐ Tumors	☐ Psychiatric/Psychological Care
☐ Sleep Apnea/Airway Issues	☐ GI/Reflux	

6. Do you use more than two pillows to sleep? ☐ Yes ☐ No

7. Have you lost or gained more than 10 pounds in the past year? ☐ Yes ☐ No

8. Do you have or have you had any disease, condition, or problem not listed? If yes please list: ☐ Yes ☐ No

9. **Women**: Are you pregnant? ☐ Yes, ____ Months ☐ No Are you nursing? ☐ Yes ☐ No
Are you taking Birth Control? ☐ Yes ☐ No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient/Guardian Signature: _____ **Date** _____

PAYMENT TERMS
I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event that payment in full is not made at the time of service, I understand that payment shall be due within 30 days from the date of invoice. Should I fail to pay the full amount of the invoice within said time period, I agree to pay interest at the rate of 1% per month on the balance until paid in full.

I further understand that failure to pay the indebtedness in full within 30 days of the date of the invoice will render me in default. In the event that it becomes necessary to employ an attorney for collection, I agree to pay reasonable attorney fees of 33% of the indebtedness owed, and all collection and court costs incurred.
I have read and understand the payment terms stated above. _____ (initial)

Patient: _____ **Date** _____

TEMPOROMANDIBULAR JOINT QUESTIONNAIRE

Name: _____ Age: _____ Date: _____

DIRECTIONS: Check next to the appropriate answer. Provide additional information where necessary

1. Do you have or have you had any clicking, popping or grating noise in your right jaw joint? ◯ Yes ◯ No
   your left jaw joint? ◯ Yes ◯ No
2. When did you first notice the noise?
3. Has the noise recently become more pronounced? ◯ Yes ◯ No
   When? _____
4. Do you have pain in or around the right joint? ◯ Yes ◯ No
   Do you have pain in or around the left joint? ◯ Yes ◯ No
5. When did you first notice the pain? _____
6. Has the pain recently become more pronounced? ◯ Yes ◯ No
   When? _____
7. Is the pain worse: ☐ Mornings _____ ☐ At meals _____
   ☐ Evenings _____ ☐ No specific time _____
8. Is the pain: ☐ Dull _____ ☐ Continuous _____
   ☐ Stabbing _____ ☐ Intermittent _____
   ☐ Throbbing _____ ☐ Other _____
9. Does the pain sometimes feel like it is in your ear? ◯ Yes ◯ No
10. Do you think this problem has affected your hearing? ◯ Yes ◯ No
11. Does your jaw problem interfere with your normal activities? ◯ Yes ◯ No
12. Are you taking or have you taken medication for this problem? ◯ Yes ◯ No
    Explain:

    _____

    _____
13. Did anything occur which might be related to the onset of this problem? ◯ Yes ◯ No
    Explain:

    _____

    _____
14. Do you have frequent headaches or neckaches? ◯ Yes ◯ No
    What area? _____
    How frequent? _____
15. Have you ever had a severe blow or trauma to the head, neck, or jaw? ◯ Yes ◯ No
    What area? _____
    Explain:

    _____

    _____
16. a. What makes the pain worse?

    _____

    _____

    b.What makes the pain better?

    _____

    _____

17. Do you have difficulty chewing? ◯ Yes ◯ No
because of: ☐ Pain in joint ☐ Limited opening
☐ Pain in teeth ☐ Missing teeth
☐ Clicking ☐ Other

18. Has your mouth ever locked open so you were unable to close it? ◯ Yes ◯ No
Explain:

_____

_____

19. Have you had problems opening your mouth wide? ◯ Yes ◯ No
Explain:

_____

_____

20. Please indicate the time sequence in which you became aware of the following problems (1st, 2nd, 3rd,etc.) Number only those problems which apply to you.
Pain: _____ Noise: _____ Limited opening: _____ Locking: _____ Other: _____

21. Which aspects of your problem concern you the most? What is your chief concern? Please be specific.

_____

_____

22. Are you aware of clenching your teeth? ◯ Yes ◯ No

23. Do you grind your teeth? ◯ Yes ◯ No
When? _____

24. Has there been a recent change in your lifestyle such as a change in marital status, childbirth, change of employment, death in immediate family or other stressful events? ◯ Yes ◯ No
Explain:

_____

_____

25. Do you think nervous tension seems to affect this problem? ◯ Yes ◯ No
Explain:

_____

_____

26. Have you had this problem with other joints? ◯ Yes ◯ No
Explain: _____

27. Have you had orthodontic treatment? ◯ Yes ◯ No
When? _____ Where? _____

28. Have you had recent dental treatment? ◯ Yes ◯ No
When? _____ Where? _____
Explain: _____

29. Have you had x-rays taken for this problem? ◯ Yes ◯ No
When? _____ Where? _____

30. Have you received previous treatment for this problem? ◯ Yes ◯ No
When? _____ Where? _____

31. Do you have trouble sleeping? Do you snore, have sleep apnea or airway issues? ◯ Yes ◯ No
Please explain: _____

32. Do you wish to add to the above information? ◯ Yes ◯ No

_____

_____

TREATMENT HISTORY

PLEASE LIST ALONG WITH REQUESTED INFORMATION <u>ANY AND ALL</u> DOCTORS AND/OR THERAPISTS SEEN FOR THIS <u>AND/OR ANY RELATED PROBLEM(S)</u>. IF YOU HAVE BEEN IN AN AUTOMOBILE ACCIDENT, LIST ALL DOCTORS AND/OR THERAPISTS SEEN AND TREATMENT RENDERED.

DOCTOR	APPROXIMATE DATE	TEST(S) RUN OR TREATMENT RENDERED	RESULTS

Clinician Name _____

Address _____

TMJ SCALE ™

ADA PROFESSIONALLY RECOGNIZED American Dental Association

PAIN RESOURCE CENTER

This questionnaire is designed to help your doctor evaluate your problem. Please answer all questions as honestly as possible. Mark answers clearly, filling in the bubble for your selection completely and erasing completely any changes. Make no marks outside answer spaces. **Do not skip any questions**, even if you are not absolutely sure.

Initials:_____ Last Six Numbers of Social Security No. _____

Today's Date: _____ Age:_____ Sex (Mark one) ① Male ② Female

Marital Status: (Mark one) ① Single ② Married ③ Separated ④ Divorced ⑤ Widowed ⑥ Remarried

Ethnic/ Racial Group (Mark one) ① Black ② Hispanic ③ Asian ④ White ⑤ Other

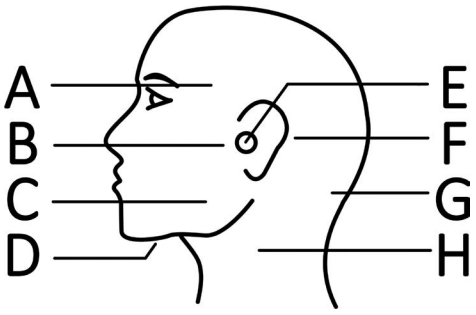
Number of School Years (mark one) ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ ⑪ ⑫ ⑬ ⑭ ⑮ ⑯ ⑰ ⑱ ⑲ ⑳

Problem Length (Mark One) ① None ② Less Than 1 Month ③ 1-5 Months ④ 6-11 Months ⑤ 1-2 Years ⑥ 3-5 Years ⑦ 6-10 Years ⑧ 10+ Years

1. This question should only be answered if you have upper and lower front teeth or are wearing a replacement for them. Open your mouth as wide as possible and position your hand as shown in the diagram below. Place as many fingers as possible between your upper and lower front teeth. Now **mark one number** below indicating the **number of fingers**.

Less than 1 finger	⓪
At least 1 finger	①
At least 2 fingers	②
At least 3 fingers	③
At least 4 fingers	④

For questions #2-8 below, locate each area on your face (except F) using the lettered diagram. Press each area firmly on both sides of your face. **Mark the number** that indicates the **maximum amount of pain** you feel.



No pain 0
Slight pain 1
Moderate pain 2
Quite a bit of pain 3
Extreme pain 4

2.	Pressing my temples (A on diagram)	⓪ ① ② ③ ④
3.	Pressing my jaw joints (B on diagram)	⓪ ① ② ③ ④
4.	Pressing my jaw muscles (C on diagram)	⓪ ① ② ③ ④
5.	Pressing the muscles under the sides of my jaw (D on diagram)	⓪ ① ② ③ ④
6.	Pressing in my ears (E on diagram)	⓪ ① ② ③ ④
7.	Pressing the back of my neck (G on diagram)	⓪ ① ② ③ ④
8.	Pressing the sides of my neck (H on diagram)	⓪ ① ② ③ ④

Mark the number which best describes **how much of the time** each statement below applies to you, using the following key:

None of the time 0
A little of the time 1
A moderate amount of the time 2
Quite a bit of the time 3
All of the time 4

9.	Just a light touch on my face causes shock-like pain	⓪ ① ② ③ ④
10.	My jaw must click or pop before I can open it wide	⓪ ① ② ③ ④
11.	My jaw opens all the way without any sideways movements	⓪ ① ② ③ ④
12.	My jaw locks open	⓪ ① ② ③ ④
13.	I have headaches which begin after seeing flashes of light or dark spots	⓪ ① ② ③ ④
14.	My jaw moves easily	⓪ ① ② ③ ④
15.	I have health problems which haven't responded to treatment	⓪ ① ② ③ ④
16.	I have pain in my jaw joint(s) (B on diagram)	⓪ ① ② ③ ④
17.	My jaw tires easily when chewing	⓪ ① ② ③ ④
18.	I have headaches which are made worse by bright light	⓪ ① ② ③ ④
19.	It hurts my teeth when I bite	⓪ ① ② ③ ④
20.	I have muscle or joint pain in areas other than my head or neck	⓪ ① ② ③ ④
21.	I can move my jaw more to one side than to the other	⓪ ① ② ③ ④
22.	I feel tense and worried	⓪ ① ② ③ ④
23.	I have drainage from my ear(s)	⓪ ① ② ③ ④
24.	I feel sad and depressed	⓪ ① ② ③ ④
25.	I clench my teeth	⓪ ① ② ③ ④
26.	My bite feels comfortable	⓪ ① ② ③ ④
27.	I have jaw pain which gets worse the more I move my jaw	⓪ ① ② ③ ④
28.	It is difficult to find a comfortable position for my jaw	⓪ ① ② ③ ④
29.	I have pain in my ear(s) (E on diagram)	⓪ ① ② ③ ④
30.	I have sinus problems	⓪ ① ② ③ ④
31.	When I bite down normally, my front teeth touch	⓪ ① ② ③ ④
32.	During my life, I've had many different painful disorders	⓪ ① ② ③ ④
33.	I have facial pain which comes on suddenly like electric shocks	⓪ ① ② ③ ④
34.	I can open my mouth as far as possible without pain	⓪ ① ② ③ ④
35.	I have pain in or behind my eye(s)	⓪ ① ② ③ ④
36.	My jaw makes a grating or grinding noise when it opens and closes	⓪ ① ② ③ ④
37.	I think my bite is off	⓪ ① ② ③ ④
38.	I have pain which gets worse with stress or tension	⓪ ① ② ③ ④

Mark the number which best describes **how much of the time** each statement below applies to you, using the following key:

None of the time 0
A little of the time 1
A moderate amount of the time 2
Quite a bit of the time 3
All of the time 4

39.	My jaw clicks or pops when I chew	⓪ ① ② ③ ④
40.	I can bite down hard without pain in my jaw	⓪ ① ② ③ ④
41.	One painful problem is followed by another	⓪ ① ② ③ ④
42.	I have jaw pain which makes me feel sick and feverish	⓪ ① ② ③ ④
43.	l grind my teeth during the day	⓪ ① ② ③ ④
44.	I have numb areas on my face	⓪ ① ② ③ ④
45.	I use nerve pills, sleeping pills, or alcohol for relief	⓪ ① ② ③ ④
46.	I can move my jaw smoothly	⓪ ① ② ③ ④
47.	l can chew without bumping my teeth unexpectedly	⓪ ① ② ③ ④
48.	I have a feeling of pins and needles on my face	⓪ ① ② ③ ④
49.	l have pain in my jaw muscles (C on diagram)	⓪ ① ② ③ ④
50.	I have pain in the back of my neck (G on diagram)	⓪ ① ② ③ ④
51.	Over the years, I've been under a lot of stress	⓪ ① ② ③ ④
52.	My jaw twitches or jerks uncontrollably	⓪ ① ② ③ ④
53.	When l bite down norrnally, my back teeth touch	⓪ ① ② ③ ④
54.	The way my front teeth fit seems to be changing	⓪ ① ② ③ ④
55.	A light touch on one side of my face causes shock-like pain on the other	⓪ ① ② ③ ④
56.	l have ringing in my ear(s)	⓪ ① ② ③ ④
57.	I have pain which gets worse with certain people or situations	⓪ ① ② ③ ④
58.	l have pain in the side(s) of my neck (H on diagram)	⓪ ① ② ③ ④
59.	I have a steady pain across my forehead	⓪ ① ② ③ ④
60.	I have many changing pains	⓪ ① ② ③ ④
61.	I feel angry	⓪ ① ② ③ ④
62.	Other people notice noise from my jaw when I chew	⓪ ① ② ③ ④
63.	I can chew food as well as I used to	⓪ ① ② ③ ④
64.	I have health problems which seem to be getting worse	⓪ ① ② ③ ④
65.	I have pain in the muscles under my jaw (D on diagram)	⓪ ① ② ③ ④
66.	I have pain in my temple(s) (A on diagram)	⓪ ① ② ③ ④
67.	l feel anxious	⓪ ① ② ③ ④
68.	I can open my mouth as wide as I used to	⓪ ① ② ③ ④

Mark the number which best describes **how much of the time** each statement below applies to you, using the following key:

None of the time 0
A little of the time 1
A moderate amount of the time 2
Quite a bit of the time 3
All of the time 4

69.	The way my back teeth fit seems to be changing	⓪ ① ② ③ ④
70.	I sleep well	⓪ ① ② ③ ④
71.	I have head or facial pain which gets worse when I bend over	⓪ ① ② ③ ④
72.	When I touch one side of my face, the other side gets numb	⓪ ① ② ③ ④
73.	My jaw gets stuck and won't open all the way	⓪ ① ② ③ ④
74.	The only real problems in my life are problems with my physical health	⓪ ① ② ③ ④
75.	I've had conflicting doctors' opinions about health problems	⓪ ① ② ③ ④
76.	I can move my jaw in any direction without pain	⓪ ① ② ③ ④
77.	I have facial pain which gets worse in cold weather	⓪ ① ② ③ ④
78.	I feel frustrated	⓪ ① ② ③ ④
79.	I have a stuffy nose	⓪ ① ② ③ ④
80.	Recently I've been under a lot of stress	⓪ ① ② ③ ④
81.	I have headaches which make me feel sick to my stomach	⓪ ① ② ③ ④
82.	I can take big bites of things like apples	⓪ ① ② ③ ④
83.	I have work or family pressures	⓪ ① ② ③ ④
84.	I have pain and stiffness in my finger joints	⓪ ① ② ③ ④
85.	My back teeth feel like they fit properly	⓪ ① ② ③ ④
86.	I believe I have an incurable problem in spite of reassurance by doctors	⓪ ① ② ③ ④
87.	In the morning my teeth are sore **and** my jaw is tired	⓪ ① ② ③ ④
88.	My ears feel blocked or stopped up	⓪ ① ② ③ ④
89.	I have many health problems	⓪ ① ② ③ ④
90.	My jaw moves just as far forward as it used to	⓪ ① ② ③ ④
91.	I have difficulty swallowing	⓪ ① ② ③ ④
92.	I have pain behind my ear(s) (F on diagram)	⓪ ① ② ③ ④
93.	I have facial pain when other joints are also sore	⓪ ① ② ③ ④
94.	I have nervous problems	⓪ ① ② ③ ④
95.	I have throbbing headaches	⓪ ① ② ③ ④
96.	I feel dizzy	⓪ ① ② ③ ④
97.	I consider myself to be a sickly person	⓪ ① ② ③ ④

INSURANCE INFORMATION

Please complete the information below so that we may help determine if you have any benefits available. Thank you!

DENTAL INSURANCE

Insurance Company:_____ Phone:_____

Insurance Company's Address:_____

lnsured's Name:_____ lnsured's ID#:_____

Group #:_____ Insured's SS#:_____

lnsured's Date Of Birth:_____ Employer Name:_____

lnsured's Address:_____

DENTAL INSURANCE

Insurance Company:_____ Phone:_____

Insurance Company's Address:_____

lnsured's Name:_____ lnsured's ID#:_____

Group #:_____ Insured's SS#:_____

lnsured's Date Of Birth:_____ Employer Name:_____

lnsured's Address:_____

3rd PARTY INFORMATION (Worker's Comp., MVA, etc.)

Insurance Company:_____ Claim #/ID#:_____

Contact person:_____ Phone#:_____

Fax #:_____

Attorney's Name:_____ Phone#:_____

Address:_____

INFORMED CONSENT FOR DIAGNOSIS AND TREATMENT OF TEMPOROMANDIBULAR DISORDER PATIENTS AT THE OFFICE OF DR. GLENN M. KIDDER

OVERVIEW

Orofacial pain disorders, including temporomandibular disorders, can involve a number of different conditions affecting jaws, teeth, jaw joints, muscles, and/or related structures of the head, face and mouth. Disorders of the temporomandibular joint can mimic other dental and medical problems. Because diagnosis and treatment of these conditions are usually complex and multifaceted, a great deal of information is required in order to properly identify the precise problem. The following will outline and discuss the steps that may be necessary to diagnose and treat your specific condition(s):

I. Initial Diagnosis

The first step requires information gathering in an attempt to properly diagnose, and if necessary, properly treat your problem. In order to make that determination, we usually undertake the following:

- Obtain a detailed medical, dental, and present illness history;
- Perform a comprehensive head, neck, and oral physical exam;
- Obtain diagnostic x-rays and/or soft tissue images (MRI) of the temporomandibular joints;
- Administer psychometric testings (TMJ SCALE);
- For most conditions, mounted study casts of your teeth and jaw relation may be necessary.

II. Initial Symptomatic Care and Further Diagnostic Procedures

The next step involves a combination of treatment modalities which are designed to attempt to relieve your symptoms and more precisely diagnose your problem. Normally, conservative methods will be attempted first, and more invasive procedures will be utilized only if necessary. The number of different procedures that may be necessary to diagnose or treat your problem demonstrate that conditions are usually complex and that each person's response to treatment may be different. Treatment can be lengthy and frustrating. Your cooperation and best efforts will be necessary during the diagnostic process. Further evaluations may include pain management interviews and psychological testing and consultations with medical or other dental specialists.

III. Treatment including the Orthopedic appliance (occlusal Splint, orthotic)

Treatment may include patient education, medications, stress management including relaxation techniques and biofeedback, physical therapy including home exercises and postural training, orthopedic appliance therapy, occlusal adjustment, and/or surgery.

In many cases an orthopedic appliance (a plastic mouthpiece) will be used as a device to treat your problem. The purpose of the device includes the following:

- To protect the teeth from the effects of clenching, grinding, and other habits which may be
- contributing to your problem
- To help your muscles relax and your jaw adapt to a stabilized position
- To reduce joint and muscle symptoms and improve limited jaw motion
- To redistribute occlusal forces
- The splint also acts as a diagnostic aid

Sometimes your symptoms may get worse initially with the use of the orthopedic appliance. If the appliance is broken, it may cause teeth to shift, or may cause cuts or abrasions in your mouth. Inform your doctor immediately of breakage. The splint may warp or distort if it is dried out or is heated. Clean the splint by brushing it with tooth paste or dental cleaner. Do NOT use this splint without supervision by your doctor.

Your bite may change as your muscles relax and your jaw realigns. This usually requires adjustment of the splint. Some of your symptoms may be relieved while other may not. The amount of time you will be required to use the splint varies (full time or nights only) depending on the type and severity of the disorder.

IV. Complications and Risks of Treatment

Each patient's response to treatment can be different. The following conditions are known to have happened during the above mentioned treatment procedures, although most of them are rare:

- Additional changes in the temporomandibular joints causing pain, noise (clicking, popping and crepitus) or locking.
- Muscle pain and increased muscle activity in the head, face, neck, shoulder and back. Change in the way your teeth meet requiring additional dental treatment to reestablish a comfortable bite including occlusal adjustment, orthodontic therapy, restorations (fillings, crowns and bridges) and/ or surgery.
- Painful, decayed, broken or loosened teeth or dental restorations requiring dental treatment.
- Periodontal problems resulting in bone loss and/or lost teeth requiring appropriate treatment.
- Additional medical and dental risks that have not been mentioned may occur

The best therapeutic improvement is a result of good patient-clinician communication. Please call our office anytime there is a problem or question about treatment.

I acknowledge that I have read, reviewed, and understand this form. I further acknowledge that I have asked questions about any item which I do not understand and all my questions have been answered. I understand that no warranties or guarantees have been made concerning my treatment or the results of the treatment.

Signature of Patient	Date
Signature of Witness, If Utilized	Date
Signature of Doctor	Date

Glenn M. Kidder, DDS
12036 Justice Ave.
Baton Rouge, LA 70816
(225) 292-4158

PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the *Health Insurance Portability and Accountability Act of 1996* (HIPPA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPP A. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and healthcare operations, but that you are not required to agree to these requests restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this _____ day of _____ , 20 ___ .

Relationship to Patient: _____

Signature: _____