Richard J. Pockat, D.D.S., P.A. **Endodontics**

Please assist us in providing you the highest quality dental care by completing this confidential questionnaire.

Your Name: ______________________ Birth Date: ______________

Home Address: ______________________ City: ______________ Zip: ________

Married? _____ SS Number : ______________Home Phone: ______________

Parent or Spouse or Partner:______________________ Phone: ______________

Who to notify in case of emergency: ______________ Phone: ______________

Your Employer: ______________ Address: ______________________

Occupation: __________ How Long?: _____ Work City: __________ Zip: _______

Daytime/Cell Phone: ______________ Driver's License Number ______________

E-mail: ______________ Doctor or person who referred you ______________

Personal Health History *Please circle "yes" or "no" and explain as necessary*

Yes No Are taking medicines (such as blood pressure medicines, bone building drugs)? Please List:__________

Yes No Are you under the care of a physician? If so, with whom and for what?: ______________

Yes No Have you had any serious illnesses or been hospitalized in the past five years?______________

Yes No Are you allergic to LATEX or any drugs or medicines? If so, which ones? ______________

Yes No (Females) Are you pregnant or is it possible you may be pregnant? How long? ______________

Please Circle Any Illnesses Which You Have Had:

AIDS/HIV Infection	Blood Pressure	Glaucoma	Kidney or Liver	Rheumatic Fever
Alcoholism	Cancer, Chemo, Radiation	Head/Neck Injury	Mental/Psychiatric	Sinusitis
Allergies	Diabetes	Heart Trouble	Migraine	Tuberculosis
Anemia	Drug/Narcotic Dependency	Hepatitis	Pacemaker/Implant	Ulcers
Asthma	Epilepsy	Herpes	Respiratory	Venereal Disease

Yes No Do you have any disease, condition or problem not listed which we should know about? ______________

To avoid misunderstandings the following is given for your information.
Please feel free to discuss treatment and fees with us at any time.

Please initial beside each statement below:

_____ I understand that I will be presented with an Informed Consent Form if endodontic treatment is recommended for me.
_____ I am personally responsible for payment of dental services charged to my account. It is the usual policy of this office that I pay the full fee on or before completion of treatment.
_____ Fees vary with the difficulty of treatment and once quoted remain the same except:
1. When broken appointments prolong treatment or 2. When surgery becomes necessary
_____ I have Dental Insurance and have read and understand the Insurance Policy for this office.
_____ The permanent restoration (fillings, crown, etc.) will usually be done by my regular dentist, not here.

My signature below indicates I have read and understand what is written above.

Signed ______________________ Dated ______________

Notice of Privacy Practices Acknowledgment

Richard J. Pockat, DDS, PA
425 S. Sharon Amity, Suite B
Charlotte, NC 28211
704-364-3422

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. 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 above to obtain a current copy of the *Notice of Privacy Practices.*

Dr. Pockat or his representatives have my permission to discuss my appointment information, health information, or financial issues with the following persons:

*1.*____

2.____

_________Messages may be left at my home or on voice mail.
Initials

I understand that I have the right to restrict information that may be released and that this restriction must be in writing.

_________No Restrictions

_________With Restrictions (list):____

Patient Name: _________________________

Relationship to Patient: _________________________

Signature: _________________________

Date: _____________

Office Use Only

I attempted to obtain the patient's signature in acknowledgment on this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

Date	Initials	Reason