RALPH W. NIEMANN, D.D.S., M.S.

REGISTRATION

DATE:_______________________

NAME:____

DATE OF BIRTH:____

HOME PHONE NO:____

CELL NO:____

HOME ADDRESS:____

____

EMAIL ADDRESS:____

PERSON RESPONSIBLE FOR ACCOUNT:______________________________
(IF OVER AGE OF 18 IT WOULD BE YOURSELF)

RELATIONSHIP TO PATIENT:____

PERSON AUTHORIZED TO DISCUSS YOUR
ACCOUNT:____

PLEASE DO NOT FORGET THE BACKSIDE OF THIS FORM

MEDICAL HISTORY

1) ARE YOU IN GOOD HEALTH? YES NO

2) ARE YOU UNDER A PHYSICIANS CARE NOW? YES NO
IF SO, PLEASE GIVE REASON:__________________________________

3) ARE YOU TAKING ANY KIND OF MEDICATION(S)? YES NO
IF SO, PLEASE LIST:____

4) PLEASE CIRCLE YES OR NO FOR ALL OF THE FOLLOWING:

ALLERGIES (SEASONAL)	Y/N	EPILEPSY	Y/N
RHEUMATIC FEVER	Y/N	DIABETES	Y/N
HEART TROUBLE	Y/N	GLAUCOMA	Y/N
INFECTIOUS HEPATITIS B OR C	Y/N	ASTHMA	Y/N
TUBERCULOSIS	Y/N	HIV-INFECTION	Y/N
KIDNEY OR LIVER PROBLEMS	Y/N	ANEMIA	Y/N

OTHER:____

5) HAVE YOU EVER HAD TROUBLE WITH PROLONGED BLEEDING AFTER SURGERY? YES NO
IF SO, PLEASE
LIST:____

6) HAVE YOU EVER HAD ANY UNUSUAL REACTION TO AN ANESTHETIC OR DRUG SUCH AS PENICILLIN ETC? YES NO
IF SO, PLEASE LIST:____

7) IS THERE ANY OTHER INFORMATION THAT WE SHOULD KNOW ABOUT YOUR HEALTH? YES NO
IF SO, PLEASE LIST:____

SIGNATURE:____________________________________ DATE:_________

Authorization and Consent

To Send Unencrypted Patient Information by Email and Other Electronic Means

Until I tell you in writing to stop, I authorize the office of Ralph W. Niemann DDS, MS, PA to transmit patient information relating to my treatment by email, without encryption or special security precautions, to me or someone I designate, or to other health care providers, health plans and others involved in my treatment, or Ralph W. Niemann DDS, MS, PA health care operations. The patient information that may be emailed may include my x-rays, diagnosis, and treatment.

I understand that:

- I do not have to sign this form.
- My treatment, payment, enrollment and eligibility for benefits will not be affected by my decision about signing this form.
- If I don’t sign this form, Ralph W. Niemann DDS, MS, PA may use other ways to send my information, such as U.S. Mail, or may ask me to send my information to third parties myself.
- There is some risk that emails and other electronic messages may be improperly acquired by hackers or received by unintended recipients. If that happens, the information may be redisclosed and no longer protected by privacy law.
- Ralph W. Niemann DDS, MS, PA **do not email** such sensitive personal information as Social Security number, credit card number, mental health diagnosis, genetic information, alcohol/substance abuse, or positive HIV status unless the patient insists.

I can tell you in writing to stop emailing my patient information at any time, but if I do so, this will not affect emails that Ralph W. Niemann DDS, MS, PA already sent before receiving my written instructions to stop.

Patient name (please print) ________________________

Signature: ______________________________________ Date: ________________