

**PATIENT REGISTRATION**

ID: \_\_\_\_\_

Chart ID: \_\_\_\_\_

First Name: \_\_\_\_\_

Last Name: \_\_\_\_\_

Middle Initial: \_\_\_\_\_

Patient Is:  Policy Holder

Responsible Party

Preferred Name: \_\_\_\_\_

Responsible Party ( if someone other than the patient )

First Name: \_\_\_\_\_

Last Name: \_\_\_\_\_

Middle Initial: \_\_\_\_\_

Address: \_\_\_\_\_

Address 2: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Pager: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Ext: \_\_\_\_\_

Cellular: \_\_\_\_\_

Birth Date: \_\_\_\_\_

Soc Sec: \_\_\_\_\_

Drivers Lic: \_\_\_\_\_

Responsible Party is also a Policy Holder for Patient

Primary Insurance Policy Holder

Secondary Insurance Policy Holder

Patient Information

Address: \_\_\_\_\_

Address 2: \_\_\_\_\_

City: \_\_\_\_\_

State / Zip: \_\_\_\_\_

Pager: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Ext: \_\_\_\_\_

Cellular: \_\_\_\_\_

Sex:  Male  Female

Marital Status:  Married  Single

Divorced

Separated

Widowed

Birth Date: \_\_\_\_\_

Age: \_\_\_\_\_

Soc Sec: \_\_\_\_\_

Drivers Lic: \_\_\_\_\_

E-mail: \_\_\_\_\_

I would like to receive correspondences via e-mail.

Section 2

Section 3

Employment Status:  Full Time

Part Time

Retired

Referred by: \_\_\_\_\_

Student Status:  Full Time

Part Time

Medicaid ID: \_\_\_\_\_

Pref. Dentist: \_\_\_\_\_

Employer ID: \_\_\_\_\_

Pref. Pharmacy: \_\_\_\_\_

Carrier ID: \_\_\_\_\_

Pref. Hyg: \_\_\_\_\_

Primary Insurance Information

Name of Insured: \_\_\_\_\_

Relationship to Insured:  Self

Spouse

Child

Other

Insured Soc. Sec: \_\_\_\_\_

Insured Birth Date: \_\_\_\_\_

Employer: \_\_\_\_\_

Ins. Company: \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

Address 2: \_\_\_\_\_

Address 2: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Rem. Benefits: \_\_\_\_\_

Rem. Deduct: \_\_\_\_\_

Secondary Insurance Information

Name of Insured: \_\_\_\_\_

Relationship to Insured:  Self

Spouse

Child

Other

Insured Soc. Sec: \_\_\_\_\_

Insured Birth Date: \_\_\_\_\_

Employer: \_\_\_\_\_

Ins. Company: \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

Address 2: \_\_\_\_\_

Address 2: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Rem. Benefits: \_\_\_\_\_

Rem. Deduct: \_\_\_\_\_

Eaglesoft Medical History

Patient Name:

Birth Date:

Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication

Are you under a physician's care now?  Yes  No If yes

Have you ever been hospitalized or had a major operation?  Yes  No If yes

Have you ever had a serious head or neck injury?  Yes  No If yes

Are you taking any medications, pills, or drugs?  Yes  No If yes

Do you take, or have you taken, Phen-Fen or Redux?  Yes  No If yes

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?  Yes  No If yes

Are you on a special diet?  Yes  No

Do you use tobacco?  Yes  No

Women: Are you...

Pregnant/Trying to get pregnant?  Nursing?  Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin  Penicillin  Codeine  Acrylic  
 Metal  Latex  Sulfa Drugs  Local Anesthetics

Do you use controlled substances?  Yes  No If yes

Other?  If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive <input type="radio"/> Yes <input type="radio"/> No	Cortisone Medicine <input type="radio"/> Yes <input type="radio"/> No	Hemophilia <input type="radio"/> Yes <input type="radio"/> No	Radiation Treatments <input type="radio"/> Yes <input type="radio"/> No
Alzheimer's Disease <input type="radio"/> Yes <input type="radio"/> No	Diabetes <input type="radio"/> Yes <input type="radio"/> No	Hepatitis A <input type="radio"/> Yes <input type="radio"/> No	Recent Weight Loss <input type="radio"/> Yes <input type="radio"/> No
Anaphylaxis <input type="radio"/> Yes <input type="radio"/> No	Drug Addiction <input type="radio"/> Yes <input type="radio"/> No	Hepatitis B or C <input type="radio"/> Yes <input type="radio"/> No	Renal Dialysis <input type="radio"/> Yes <input type="radio"/> No
Anemia <input type="radio"/> Yes <input type="radio"/> No	Easily Winded <input type="radio"/> Yes <input type="radio"/> No	Herpes <input type="radio"/> Yes <input type="radio"/> No	Rheumatic Fever <input type="radio"/> Yes <input type="radio"/> No
Angina <input type="radio"/> Yes <input type="radio"/> No	Emphysema <input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Rheumatism <input type="radio"/> Yes <input type="radio"/> No
Arthritis/Gout <input type="radio"/> Yes <input type="radio"/> No	Epilepsy or Seizures <input type="radio"/> Yes <input type="radio"/> No	High Cholesterol <input type="radio"/> Yes <input type="radio"/> No	Scarlet Fever <input type="radio"/> Yes <input type="radio"/> No
Artificial Heart Valve <input type="radio"/> Yes <input type="radio"/> No	Excessive Bleeding <input type="radio"/> Yes <input type="radio"/> No	Hives or Rash <input type="radio"/> Yes <input type="radio"/> No	Shingles <input type="radio"/> Yes <input type="radio"/> No
Artificial Joint <input type="radio"/> Yes <input type="radio"/> No	Excessive Thirst <input type="radio"/> Yes <input type="radio"/> No	Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No	Sickle Cell Disease <input type="radio"/> Yes <input type="radio"/> No
Asthma <input type="radio"/> Yes <input type="radio"/> No	Fainting Spells/Dizziness <input type="radio"/> Yes <input type="radio"/> No	Irregular Heartbeat <input type="radio"/> Yes <input type="radio"/> No	Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No
Blood Disease <input type="radio"/> Yes <input type="radio"/> No	Frequent Cough <input type="radio"/> Yes <input type="radio"/> No	Kidney Problems <input type="radio"/> Yes <input type="radio"/> No	Spina Bifida <input type="radio"/> Yes <input type="radio"/> No
Blood Transfusion <input type="radio"/> Yes <input type="radio"/> No	Frequent Diarrhea <input type="radio"/> Yes <input type="radio"/> No	Leukemia <input type="radio"/> Yes <input type="radio"/> No	Stomach/Intestinal Disease <input type="radio"/> Yes <input type="radio"/> No
Breathing Problems <input type="radio"/> Yes <input type="radio"/> No	Frequent Headaches <input type="radio"/> Yes <input type="radio"/> No	Liver Disease <input type="radio"/> Yes <input type="radio"/> No	Stroke <input type="radio"/> Yes <input type="radio"/> No
Bruise Easily <input type="radio"/> Yes <input type="radio"/> No	Genital Herpes <input type="radio"/> Yes <input type="radio"/> No	Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Swelling of Limbs <input type="radio"/> Yes <input type="radio"/> No
Cancer <input type="radio"/> Yes <input type="radio"/> No	Glaucoma <input type="radio"/> Yes <input type="radio"/> No	Lung Disease <input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No
Chemotherapy <input type="radio"/> Yes <input type="radio"/> No	Hay Fever <input type="radio"/> Yes <input type="radio"/> No	Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No	Tonsillitis <input type="radio"/> Yes <input type="radio"/> No
Chest Pains <input type="radio"/> Yes <input type="radio"/> No	Heart Attack/Failure <input type="radio"/> Yes <input type="radio"/> No	Osteoporosis <input type="radio"/> Yes <input type="radio"/> No	Tuberculosis <input type="radio"/> Yes <input type="radio"/> No
Cold Sores/Fever Blisters <input type="radio"/> Yes <input type="radio"/> No	Heart Murmur <input type="radio"/> Yes <input type="radio"/> No	Pain in Jaw Joints <input type="radio"/> Yes <input type="radio"/> No	Tumors or Growths <input type="radio"/> Yes <input type="radio"/> No
Congenital Heart Disorder <input type="radio"/> Yes <input type="radio"/> No	Heart Pacemaker <input type="radio"/> Yes <input type="radio"/> No	Parathyroid Disease <input type="radio"/> Yes <input type="radio"/> No	Ulcers <input type="radio"/> Yes <input type="radio"/> No
Convulsions <input type="radio"/> Yes <input type="radio"/> No	Heart Trouble/Disease <input type="radio"/> Yes <input type="radio"/> No	Psychiatric Care <input type="radio"/> Yes <input type="radio"/> No	Venereal Disease <input type="radio"/> Yes <input type="radio"/> No
Yellow Jaundice <input type="radio"/> Yes <input type="radio"/> No			

Have you ever had any serious illness not listed  Yes  No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X

Date: \_\_\_\_\_

# Patient Advisory and Acknowledgment

## Receiving Dental Treatment During the COVID-19 Pandemic

Dear Patient:

You have come to our office today for a routine dental evaluation and/or treatment that will be done during the COVID-19 pandemic. Please be advised of the following:

While our office complies with State Health Department and the Centers for Disease Control and Prevention infection control guidelines to prevent the spread of the COVID-19 virus, we cannot make any guarantees.

Our staff are symptom-free and, to the best of their knowledge, have not been exposed to the virus. However, since we are a place of public accommodation, other persons (including other patients) could be infected, with or without their knowledge.

In order to reduce the risk of spreading COVID-19, we have asked you a number of "screening" questions below. For the safety of our staff, other patients, and yourself, please be truthful and candid in your answers.

PATIENT/RESPONSIBLE PARTY

DATE

**PLEASE ANSWER "YES" OR "NO" WITH YOUR INITIALS, TO THE FOLLOWING QUESTIONS:**

ARE YOU CURRENTLY AWAITING THE RESULTS OF A COVID-19 TEST?

YES

NO

DO YOU HAVE A FEVER?

YES

NO

DO YOU HAVE ANY SHORTNESS OF BREATH?

YES

NO

DO YOU HAVE A DRY COUGH?

YES

NO

DO YOU HAVE A RUNNY NOSE?

YES

NO

DO YOU HAVE A SORE THROAT?

YES

NO

DO YOU HAVE SNEEZING, WATERY EYES, AND/OR SINUS PAIN/PRESSURE THAT IS UNUSUAL AND NOT RELATED TO SEASONAL ALLERGIES?

YES

NO

HAVE YOU EXPERIENCED HEADACHES, FATIGUE, OR WEAKNESS?

YES

NO

HAVE YOU LOST YOUR SENSE OF TASTE AND/OR SMELL?

YES

NO

WITHIN THE LAST 14 DAYS, HAVE YOU TRAVELLED TO ANY FOREIGN COUNTRY?

YES

NO

WITHIN THE LAST 14 DAYS, HAVE YOU TRAVELLED WITHIN THE UNITED STATES?

YES

NO

IF SO, WHERE?



## **SANDIA PARK FAMILY DENTISTRY**

12540 NM HIGHWAY 14

SANDIA PARK, NM 87047

TELEPHONE: (505) 888-3392 FAX: (505) 830-9086

### **PATIENT INFORMED CONSENT**

1. **\*SELF-PAY PATIENTS** – Full payment is required at the time services are rendered.  
  
**\*CURRENT INSURANCE CARDS MUST BE PRESENTED AT THE TIME OF SERVICE\***
2. You, as the patient, are responsible for finding out from your insurance company whether certain procedures must be pre-authorized, or what costs are not covered by your insurance company. If these procedures require pre-authorization and they are not, ***you, personal representative will be responsible for the entire payment.***
3. We release copies of patient records only if the patient, or parent/guardian of minor, or personal representative has signed a release of records form. It is also important to note that a fee will be assessed if the patient requests their records.
4. In order to provide the best possible service and availability to all of our patients, please be on time for each of your appointments. Showing up late will cause our staff to run behind for the next scheduled patient. Should you need to cancel your appointment, we require **24 HOURS ADVANCE NOTIFICATION TO AVOID A \$50.00 MISSED APPOINTMENT FEE.**
5. **In rare cases when there is excessive abuse of missed appointments, we may discharge patients from our practice.**

SIGNATURE (Patient or Parent/Guardian of Minor): \_\_\_\_\_ Date: \_\_\_\_\_



# SANDIA PARK FAMILY DENTISTRY

12540 NM HIGHWAY 14

SANDIA PARK, NM 87047

TELEPHONE: (505) 888-3392 FAX: (505) 830-9086

## FINANCIAL RESPONSIBILITY CONTRACT

In agreeing to be responsible for your dental care, Sandia Park Family Dentistry requires that you be responsible for your *financial obligation* to us.

*Please read each paragraph and sign where indicated to acknowledge your understanding and acceptance. If you are a minor (under 18 years of age), your parent or legal guardian must accept financial responsibility on your behalf.*

1. I agree to pay for all services provided to me by Sandia Park Family Dentistry **at the time services are rendered**, unless those services are covered by my insurance company.
2. I understand that my insurance company may require that I pay co-payments, co-insurance and/or deductibles. I agree to pay these in full at the time services are rendered.
3. I understand and agree that if, after 45 days of billing and/or insurance is filed, my contracted insurance has not paid Sandia Park Family Dentistry, I may request that the office contact my insurance to find out why they have not paid on my outstanding claim(s). I may also be required to contact my insurance company myself to ask for resolution of the unpaid claim(s).
4. I understand and agree that if, after 45 days of billing, whether my non-contracted insurance company has made a payment or not on my account, I am responsible for the total balance due on that account.
5. I understand and agree that if a balance on my account remains unpaid after 45 days, that account may be sent to a collection agency. I will then be responsible for any amount due plus cost of collection, including, but not limited to:
  - All collection expenses charged by the collection agency;
  - Court costs;
  - Attorneys' fees; and
  - Any discounts I may have received on my account will be reversed.
6. If my account is sent to a collection agency, Sandia Park Family Dentistry may require me to permanently seek further dental care elsewhere.
7. I am aware that there is a \$50 cancellation/no show fee that will be applied to my account if I do not show up to a scheduled appointment or do not give at least 24 hours notice.
8. In rare cases when there is excessive abuse of missed/canceled appointments, we may discharge patient from our practice.

SIGNATURE (Patient or Parent/Guardian of Minor): \_\_\_\_\_ DATE: \_\_\_\_\_



# SANDIA PARK FAMILY DENTISTRY

12540 NM HIGHWAY 14

SANDIA PARK, NM 87047

TELEPHONE: (505) 888-3392 FAX: (505) 830-9086

## Acknowledgment of Receipt of Notice of Privacy Practices

\*You may refuse to sign this acknowledgment\*

I have received a copy of this office's Notice of Privacy Practices

Print name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement

Other (please specify): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_





# SANDIA PARK FAMILY DENTISTRY

12540 NORTH HIGHWAY 14

SANDIA PARK, NM 87047

TELEPHONE: (505) 888-3392 FAX: (505) 830-9086

## NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW PROTECTED HEALTH INFORMATION (PHI) ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 2/10/2015 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

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

**Treatment:** We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

**Payment:** We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities including billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, and insurance company or another third party. For example, we may send claims to your dental health plan containing certain health information.

**Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

**Individuals Involved in Your Care or Payment for Your Care:** We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

**Disaster Relief:** We may use or disclose your health information to assist in disaster relief efforts.

**Required by Law:** We may use or disclose your health information when we are required to do so by law.

**Public Health Activities:** We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability
- Report child abuse or neglect
- Report reactions to medications or problems with products or devices
- Notify a person of a recall, repair or replacement of products or devices

- Notify a person who may have been exposed to a disease or condition, or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence

**National Security:** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody to the protected health information of an inmate or patient.

**Security of HHS:** We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

**Worker's Compensation:** We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

**Law Enforcement:** We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

**Health Oversight Activities:** We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliances with civil rights laws.

**Judicial and Administrative Proceedings:** If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either

by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

**Research:** We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

**Coroners, Medical Examiners, and Funeral Directors:** We may disclose your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

**Fundraising:** We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

#### OTHER USES AND DISCLOSURES OF PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

#### YOUR HEALTH INFORMATION RIGHTS

**Access:** You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

**Disclosure Accounting:** With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to the additional requests.

**Right to Request a Restriction:** You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. **We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan) has paid our practice in full.**

**Alternative Communications:** You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

**Amendment:** You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

**Right to Notification of a Breach:** You will receive notifications of breaches of your unsecured protected health information as required by law.

**Electronic Notice:** you may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (email).

#### QUESTIONS AND COMPLAINTS

If you want more information about your privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or if you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Our Privacy Official (Office Manager): Danielle Wartman  
Address: 12540 North Highway 14; Albuquerque NM 87047

Telephone: (505) 888-3392 Fax: (505) 830-9086  
Email: office@sandiaparkdentistry.com