

# Family Dental Center of Caledonia, L.L.C.

120 W. Main St. • Caledonia, MN 55921-1109

(507)725-5254

## Welcome to our Practice

Chart#: \_\_\_\_\_  
FOR OFFICE USE ONLY

Patient Name: \_\_\_\_\_  
Last First MI Preferred Name

Title: \_\_\_\_\_ Gender:  Male  Female Family Status:  Married  Single  Child  Other  
Mr/Ms/Mrs/etc

Birth Date: \_\_\_\_\_ SS#: \_\_\_\_-\_\_-\_\_\_\_ Prev. Visit: \_\_\_\_\_

Email Address: \_\_\_\_\_ Best time to call: \_\_\_\_\_

Phone: \_\_\_\_\_  
Home Mobile Work Ext Fax Other

Address: \_\_\_\_\_  
Address 1 Address 2  
City State Zip Code

## HIPAA Acknowledgement

Purpose of Consent: By signing this form, you will consent to our use of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Stacey Johanson Yahnke D.D.S

Telephone: 507-725-5254

Fax: 507-725-5406

Address: 120 W. Main St., Caledonia, MN 55921

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

Signature \_\_\_\_\_ Date \_\_\_\_\_

If this Consent is signed by a personal representative on behalf of the patient, please list your name and relationship to patient below:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Response Date:

