Affordable Dentistry & Orthodontics

Duane K. Taylor, D.D.S.

1 PATIENT CONFIDENTIAL INFORMATION

Date: _____

SSN #: _____ Driver's License #: _____

Patient Name (Last Name) _____ (First Name) _____

Address _____

City _____ State _____ Zip Code _____

Email: _____

PHONE NUMBERS

Home (_____)_____ Work (_____)_____

Cell (_____)_____ Spouse's Work (_____)_____

Best Time and place to reach you? _____

IN CASE OF AN EMERGENCY CONTACT (Specify someone who does not live in your household)

Name _____ Relationship_____

Home Ph. _____ Work Ph. _____

Sex M ☐ F Age: _____ Birthdate: _____

Marital Status: Married Widowed Single Separated Divorced

Patient Employer / School _____

Occupation

_____

Employer / School Address

_____

Employer / School Phone (_____) _____

Responsible Party Name

_____

Birthdate _____ SSN# _____

2 DENTAL INSURANCE

Primary Insurance Company : _____

Group #: _____ Insurance Co. Phone # : _____

Subscribers Name _____

Secondary Insurance Co. _____

Group # _____ Insurance Co. Phone # _____

Subscribers Name _____

Relationship to Patient: _____

Birthdate _____ SSN # _____

Do you have: (Circle All That Applies)

Flex Spending Acct Health Savings Acct. Care Credit

ASSIGNMENT AND RELEASE

I certify that I and/or my dependent(s) have insurance coverage with _____and assign directly to Dr. Duane K. Taylor DDS, PC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Dr. Duane Taylor may use my healthcare information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determined insurance benefits or the benefits payable for related services.

_____ _____

Signature of Patient, Parent, Guardian or Personal Rep. DATE

_____

Printed Name of Patient, Parent, Guardian or Personal Rep.

_____

Relationship to Patient

Affordable Dentistry and Orthodontics

1441 North Cockrell Hill Road

Dallas, Texas 75211

"We take pride in serving our patients; by offering full service, quality care with cutting edge technology in a cheerful, fun and relaxed environment."

INSURANCE

1. If you have insurance, we will be happy to determine the coverage you have available as a courtesy to you.
2. We will advise you as accurately as possible based upon the information gathered from your insurance carrier. Your insurance company alone is responsible for the amount of money paid on your claim.
3. Pre-estimates from insurance companies are NOT guaranties.
4. You the patient are responsible to us for the cost of your treatment. Your insurance company is responsible to you.
5. We will help you as best we can by filing claims and seeking answer from your insurance carrier.

"I understand that I am responsible for the entire amount of the bill minus what my insurance actually pays. I understand that the estimate given by the insurance company may not be honored by the insurance company. I understand that I will be responsible for the difference if my insurance company does not pay the full amount."

Patient or Guardian Signature:

_____

Date: _____

NO SHOW POLICY

As a patient here at Affordable Dentistry we value your time; therefore we must institute a firm no-show policy for all of our patients. In order to keep an organized office we must make sure you are aware of this in advance. When appointments are made we reserve time on our schedule and put resources into those appointments. When appointments are missed without notice, those resources go to waste. We will make all efforts to give you notice if we must reschedule your appointment, we hope you will do the same for us. There will be a $50 charge for missed appointments if you do not give us a 48 hour notice in advance. If you are late by more than 10 minutes, your appointment may need to be rescheduled. If you have a history of no-shows, meaning you have no-showed more than two times we will have to collect a non-refundable $50 deposit on all future appointments that will go toward the cost of treatment.

PAYMENTS FOR SERVICES RENDERED

We understand that dental treatment does not come cheaply and the impact it can have on a family's budget. We hope to be able to work with you on these financial obligations. We accept cash, check, most major credit cards, and offer in-office financing (with approved credit).

CELL PHONES

Cell phones are not tolerated in the treatment areas. If you are on the phone when the doctor is ready your appointment will have to be rescheduled. We understand that today's lifestyle is hectic and busy, so if you must make a phone call, please, do so before you come to the treatment area.

VISITORS

To prevent overcrowding of the operatory, only one family member may come back with you when you are called for your appointment. For children, one parent may accompany them. For adults, one child or one adult may accompany them. The dentist and staff will not have the necessary room if you bring more than one family member.

Please sign to show that you have read and understand the above information

Patient or Guardian Signature:

_____

Date: _____

Affordable Dentistry

1441 N. Cockrell Hill Rd, Dallas, TX 75211
Phone: 214-330-7771 Fax: 214-330-9242

NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGMENT RECEIPT

Name of Patient: _____

Patient's Date of Birth: _____

Last Four Numbers of Soc. Security:_____
I acknowledge that I have been provided a copy of Affordable Dentistry's Notice of Privacy Practices.

_____ _____
Signature of Patient (or Personal Representative) Date

*****

I acknowledge that I declined a copy of Affordable Dentistry's Notice of Privacy Practices provided:

_____ _____
Signature of Patient (or Personal Representative) Date

For office use only

We attempted to obtain acknowledgement of receipt of our notice of privacy practice, but acknowledgment could not be obtained because:

_____ Individual refused to sign

_____ Communication bariers prohibited obtaining the acknowledgment

_____ An emergency situation prevented us from obtaining acknowledgement

_____ Other (Please Specity)

_____

_____

AFFORDABLE DENTISTRY & ORTHODONTICS

DENTAL HISTORY

Most recent dental exam _____

Most recent dental treatment _____

How often do you have your teeth cleaned? _____

Do your gums bleed when you brush? _____

WHAT IS YOUR IMMEDIATE DENTAL CONCERN? _____

Are you experiencing discomfort? _____

How long have you had the discomfort? (Day/Weeks) _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

1.	Are you happy with your smile?	YES	NO
2.	Periodontal (gum) treatment When? _____	YES	NO
3.	An unpleasant taste or odor in your mouth	YES	NO
4.	Dry mouth, throat, and/or eyes	YES	NO
5.	Difficulty opening your mouth widely	YES	NO
6.	Tension headaches	YES	NO
7.	Clench or grind your teeth	YES	NO
8.	Cigarette, pipe or cigar smoking	YES	NO
9.	Clicking or popping jaw	YES	NO

Supplemental Denture History:

If you are wearing a partial or complete artificial denture, please complete the following:

YES NO Has your present denture been relined? When _____

YES NO Is your present denture a problem? Describe _____

YES NO Satisfied with the appearance? _____

YES NO Satisfied with the comfort? _____

YES NO Satisfied with the chewing ability? _____

When did you receive your first partial or complete denture? _____

How long have you worn your present denture? _____

Patient Signature _____ Date _____

FOR OFFICE USE: Reviewed by

Front Desk: _____ Date: _____

Doctor: _____ Date: _____

Assistant: _____ Date: _____

Oral Cancer Screening

Dear Patient, (Please put the word "yes" or "no" next to each line.)

Do any of the following apply to you?

_____ Persistent sore throat, or a feeling that something is caught in the throat.

_____ Pain or bleeding in the mouth that does not resolve

_____ Difficulty chewing, swallowing or moving the jaws or tongue

_____ Fever of unknown origin, especially when prolonged

_____ Ear and/or jaw pain _____ Chronic bad breath

_____ Changes in speech _____ Hoarseness

_____ Loosening of teeth or toothache _____ Dentures that no longer fit

_____ Unexplained weight loss _____ Fatigue

_____ Feels like something is caught _____ Loss of appetite

If any of these conditions exist, does the patient's primary physician know? _____ (Yes or No)

Name of Physician: _____ Telephone #: (_____)_____-_____

DOCTOR SECTION: *(WNL=within normal limits; if abnormal, circle findings)*

_____ Floor of the mouth _____ Soft Palate

_____ Lining of the mouth _____ Gingival Tissue

_____ Lips _____ Head & Neck _____ Lymph Nodes _____ Ear Pain

_____ Tongue: numbness _____ difficult movement

_____ Throat: soreness _____ difficultly in swallowing

_____ Jaw: Difficult movement _____ clicking, popping

_____ Red or white patch on any oral tissues, tongue, tonsil or lining of the mouth

_____ Irritation, lump, or thick patch in the mouth, neck, or throat

Notes: _____

_____

_____

Recommendations: _____

_____

_____

Doctor/Staff Signature: _____

SLEEP EVALUATION / CLINICALS

Patient Name: _____ Date of Birth: ____/____/____

Gender: M ____ F ____ Height: _____ Weight: _____ Blood Pressure: _____

Please check any of the following you may have:

☐ Diabetes	☐ Heart Disease	☐ Stroke	☐ Insomnia
☐ Frequent Urination at Night	☐ Heart Failure	☐ Depression	☐ Overweight
☐ Erectile Dysfunction	☐ Morning Headaches	☐ ADHD	☐ Hypertension
☐ Atrial Fibrillation	☐ Renal Failure	☐ Chronic Pain	☐ GERD

Please check Yes or No to the following questions:

1. Do you snore or have been told that you snore?	☐YES	☐NO
2. Do you often feel tired, fatigued, or sleepy during the daytime?	☐YES	☐NO
3. Has anyone observed you stop breathing or gasp for air during your sleep?	☐YES	☐NO
4. Do you have or are you being treated for high blood pressure?	☐YES	☐NO

If you answered Yes to 2 or more of the above, please continue:

Epworth Sleepiness Scale	Never doze off	Slight chance of dozing	Moderate chance of dozing	High Chance of dozing
1. Do you get sleepy, or doze off, while sitting and reading?	0☐	1☐	2☐	3☐
2. Do you get sleepy, or doze off, while watching TV?	0☐	1☐	2☐	3☐
3. While sitting or inactive in a public place?	0☐	1☐	2☐	3☐
4. As a passenger in a car for an hour without a break?	0☐	1☐	2☐	3☐
5. Lying down to rest in the afternoon?	0☐	1☐	2☐	3☐
6. Sitting and talking to someone?	0☐	1☐	2☐	3☐
7. Sitting quietly after lunch without alcohol?	0☐	1☐	2☐	3☐
8. In a car, while stopped for a few minutes at a traffic light?	0☐	1☐	2☐	3☐
			Total Score	

Have you ever been diagnosed with Sleep Apnea?	☐YES	☐NO
Are you currently using CPAP? (or any other apnea/snoring device)	☐YES	☐NO
Are you currently taking any sleeping aids (prescribed or OTC)?	☐YES	☐NO
Are you currently taking any prescribed narcotic medication?	☐YES	☐NO
Are you aware of clenching or grinding your teeth?	☐YES	☐NO

Untreated Sleep Disorders are related to many health and financial complications:

*Diabetes *Premature death *5X the risk of heart attack *2X the risk of stroke *Weight gain *6X the risk of a serious automobile accident *Increased risk of cancer *Hypertension *Depression *Erectile dysfunction *Daytime fatigue *ADHD *GERD *Decreased job performance *RLS/PLM *Increased cost of healthcare *Chronic/migraine headaches * Post-surgical complications/death *Chronic pain *Weakened immune system *Renal failure *Heart disease

Provider Signature/Initials* _____ Today's Date: _____

*To be filed for reference and review in patient's chart notes

Affordable Dentistry
Dr. Duane K Taylor

GENERAL TREATMENT CONSENT FORM

Please read and initial the items checked below
and read and sign the section at the bottom of the form

Patient Name: _____

1. **TREATMENT NEEDED**
I understand that I am having the following work done: filling___ cleaning ___sealants ___root canal___crowns___general anesthesia ___ bridge ___ extraction ____ nitrous _____Other _____
Initials____

2. **DRUGS AND MEDICATION**
I understand that antibiotics, analgesics and other medications can cause allergic reactions which may cause redness or swelling of tissues, pain, itching, vomiting and/or anaphylactic shock.
Initials____

3. **CHANGES IN TREATMENT PLAN**
I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/all changes necessary. Any additional cost will be explained at time of treatment.
Initials____

4. **REMOVAL OF TEETH**
Alternatives to removal have been explained to me (root canal therapy, crowns and periodontal surgery, etc.) and I authorize the Dentist to remove the following teeth _____ and any other necessary for reasons in paragraph #3. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue (Parasthesia) that can last for an indefinite period of time (days or months) or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility.
Initials____

5. **CROWNS AND BRIDGES**
I understand that sometimes it is not possible to match the color or match the color or natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns are delivered. I realize the final opportunity to make changes in my new crown or bridge (including shape, fit, size, and color) will be done before final cementation
Initials____

6. **DENTURES (COMPLETE OR PARTIAL)**
I realize that full or partial dentures are artificial, constructed of plastic, metal and /or porcelain. The problems of wearing these appliances have been explained to me, including looseness, soreness and possible breakage. I realize that the final opportunity to make changes in my new dentures (including shape, fit, size, placement and color) will be the "teeth in wax" try –in visit. I understand that most dentures require relining approximately 3-12 months after placement. The cost for the procedure is not included in the initial denture fee.
Initials____

7. **ENDODONTIC TREATMENT (ROOT CANAL)**
I realize there is no guarantee that root canal treatment will save my tooth and that complications can occur from the treatment, and that occur from the treatment, and that occasionally metal objects are cemented in the tooth or extend through the root, which does not necessarily affect the success of the treatment. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apioectomy).
Initials____

8. **PERIODONTAL LOSS (TISSUE & BONE)**
I understand that I have a serious condition, causing gum and bone infection or loss and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including gum surgery, replacements and/or extractions. I understand that undertaking any dental procedures may have a future adverse effect on my periodontal condition.
Initials____

I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

Signature: _____ **Date:** _____
Patient/Parent or Guardian of minor children

Office Representative: _____ **Date:** _____

HEALTH HISTORY

PATIENT NAME _____ Primary Care Physician's Name _____

Primary Care Physician's Phone No. _____ Date of Last Visit _____

List all the doctors that are currently treating you: _____

Have you ever taken any of the group of drugs collective referred to as "fen-phen"? These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). Yes _____ No _____

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 that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ☐Yes ☐No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? ☐Yes ☐No If yes, please explain: _____

Have you ever had a serious head or neck injury? ☐Yes ☐No If yes, please explain: _____

Are you taking any medications, pills or drugs? ☐Yes ☐No If yes, please explain: _____

Are you on a special diet? ☐Yes ☐No If yes, please explain: _____

Do you snore? ☐Yes ☐No

Have you been diagnosed with sleep apnea? ☐Yes ☐No

Do you wake up tired all the time? ☐Yes ☐ No

Please list all medications & supplement that you are currently taking:

_____

Women: Are you Pregnant/Trying to get pregnant? ☐Yes ☐No Taking oral contraceptives? ☐Yes ☐No Nursing? ☐Yes ☐No

Men : Prostate Disorder? ☐Yes ☐No

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics

Other If yes, please explain: _____

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

Alzheimer's disease	☐Yes ☐No	Cortisone Medicine	☐Yes ☐No	Hemophilia	☐Yes ☐No	Recent Weight Loss	☐Yes ☐No
Anaphylaxis	☐Yes ☐No	Diabetes	☐Yes ☐No	Hepatitis A	☐Yes ☐No	Renal Dialysis	☐Yes ☐No
Anemia	☐Yes ☐No	Easily Winded	☐Yes ☐No	Hepatitis B or C	☐Yes ☐No	Rheumatic Fever	☐Yes ☐No
Angina	☐Yes ☐No	Emphysema	☐Yes ☐No	HIV/AIDS	☐Yes ☐No	Rheumatism	☐Yes ☐No
Arthritis/Gout	☐Yes ☐No	Epilepsy or Seizures	☐Yes ☐No	High Blood Pressure	☐Yes ☐No	Scarlet Fever	☐Yes ☐No
Artificial Heart Valve	☐Yes ☐No	Excessive Bleeding	☐Yes ☐No	Hives or Rash	☐Yes ☐No	Shingles / Herpes Zoster	☐Yes ☐No
Artificial Joint	☐Yes ☐No	Excessive Thirst	☐Yes ☐No	Hypoglycemia	☐Yes ☐No	Sickle Cell Disease	☐Yes ☐No
Asthma	☐Yes ☐No	Fainting Spells/Dizziness	☐Yes ☐No	Irregular Heartbeat	☐Yes ☐No	Sinus Trouble	☐Yes ☐No
Blood Transfusion	☐Yes ☐No	Frequent Cough	☐Yes ☐No	Kidney Problems	☐Yes ☐No	Stomach/Intestinal Disease	☐Yes ☐No
Breathing Problem	☐Yes ☐No	Frequent Diarrhea	☐Yes ☐No	Leukemia	☐Yes ☐No	Stroke	☐Yes ☐No
Bruise easily	☐Yes ☐No	Frequent Headaches	☐Yes ☐No	Liver Disease	☐Yes ☐No	Swelling of Limbs	☐Yes ☐No
Cancer	☐Yes ☐No	Glaucoma	☐Yes ☐No	Low Blood Pressure	☐Yes ☐No	Thyroid Disease / Problems	☐Yes ☐No
Chemotherapy	☐Yes ☐No	Hay Fever	☐Yes ☐No	Lung Disease	☐Yes ☐No	Tonsillitis	☐Yes ☐No
Chest Pains	☐Yes ☐No	Heart Attack/Failure	☐Yes ☐No	Mitral Valve Prolapse	☐Yes ☐No	Tuberculosis (T.B.)	☐Yes ☐No
Cold Sores/Fever Blisters	☐Yes ☐No	Heart Murmur	☐Yes ☐No	Pain in Jaw Joints	☐Yes ☐No	Tumors or Growths	☐Yes ☐No
Congenital Heart Disorder	☐Yes ☐No	Heart Pace Maker	☐Yes ☐No	Parathyroid Disease	☐Yes ☐No	Ulcers	☐Yes ☐No
Convulsions	☐Yes ☐No	Heart Trouble/Disease	☐Yes ☐No	Radiation Treatments	☐Yes ☐No	Yellow Jaundice	☐Yes ☐No
Back Problems	☐Yes ☐No	Blood Disease	☐Yes ☐No	Chemical Dependency	☐Yes ☐No	Circulatory Problems	☐Yes ☐No
Drug Addictions	☐Yes ☐No	Heart Stent	☐Yes ☐No	Herpes	☐Yes ☐No	Jaundice	☐Yes ☐No
Jaw Pain	☐Yes ☐No	Nervous Problems	☐Yes ☐No	Pace Makers	☐Yes ☐No	Psychiatric Care	☐Yes ☐No
Respiratory Disease	☐Yes ☐No	Shortness of Breath	☐Yes ☐No	Special Diet	☐Yes ☐No	Spinal Bifida	☐Yes ☐No
Weight Loss (Unexplained)	☐Yes ☐No	Weight Gain (Unexplained)	☐Yes ☐No	Venereal Disease	☐Yes ☐No		

Have you ever had any serious illness not listed above ☐Yes ☐No If yes, please explain:

_____

_____

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 _____ DATE _____

SIGNATURE OF DENTIST _____ DATE _____

Affordable Dentistry, Orthodontics

NEW PATIENT

NAME_____ DATE_____

ADDRESS_____CITY_____STATE___ ZIP_____

PHONE _____ WORK _____ CELL _____

EMAIL_____

HOW DID YOU HEAR ABOUT THIS OFFICE? (Circle One)

PATIENT REFERRAL	WEBSITE	PHONE BOOK	OFFICE SIGN
NEWSPAPER	FLYER	RADIO	TELEVISION
DOCTOR REFERRAL	VALPAK COUPON	INSURANCE REFERRAL	CONVENTION/ SHOW

If you were referred to us by a patient, who referred you? (We would like to thank them)

NAME_____ RELATION_____

ADDRESS_____

CITY_____STATE_____ZIP_____

Thank you for taking the time to fill this out for us.

Affordable Dentistry

(Name of Practice)

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 4/15/03, 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. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available 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.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

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

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.