PATIENT REGISTRATION

Date: ___________________

Personal Information:

First Name: ___________________________Last Name: __________________________Middle Initial: ____

Preferred Name: ________________________

Patient is: □ Responsible Party □ Policy Holder

Responsible Party: (if someone other than the patient)

First Name: ________________________Last Name: ________________________Middle Initial: ________

Address: ____

City, State, Zip: ____

Home Phone: __________________Work Phone: ______________Cell Phone: ________________________

Birth date: ____________Social Security #:________________________Drivers Lic#:__________________

○ Responsible Party is Policy Holder for Patient ○ Primary Policy Holder ○ Secondary Policy Holder

Patient Information:

Address: ____

City, State, Zip: ____

Home Phone: _________________Work Phone:________________Cell Phone: _______________________

Sex: ○ Female ○ Male Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Birth date: ________________Social Security #:_________________Drivers Lic#:____________________

E-mail: ___________________________________ □ I would like to receive email correspondences

Preferred Dentist: _________________________Preferred Hygienist: ________________________________

Referred By: __________________________________

Primary Insurance Information:

Name of Insured: ________________________Relationship to Insured: ○Self ○Spouse ○Child ○ Other

Employer ID: ________________________ Group ID: ____

Insured Social Security #:________________________Insured Birth date: _____________________________

Employer: ________________________________Insurance Company: _______________________________

Address: ____

City, State, Zip: ____

New Patient Dental Questionnaire

Carolina Bright Smiles would like to help each patient reach their dental goals. Please take a few moments and provide us the following valuable information*:*

Name:____

I entered this practice to obtain:

(Please check all that apply)

____ **Comprehensive Exam** of my entire mouth and a consultation concerning my treatment options.
____ **Smile Design Consultation** to learn more about my cosmetic treatment options.
____ **Emergency Exam** for a specific area of concern. **Are you in pain?** ____Yes ____ No
Please describe:
____ **2nd opinion** concerning treatment options presented elsewhere.
____ **Other:** Please explain:

What are your present dental concerns?

I would rate the value I place on my oral health as: _____Very Important to me
_____ Moderately important to me
_____ Very low importance to me

I would rate the condition of my teeth and gums: _____ Very good
_____ Good
_____ Acceptable
_____ In need of treatment
_____ In need of extensive treatment

I would rate my previous dental experiences and quality of care: _____Exceptional
_____Above average
_____Average
_____Below average
_____Poor

Date of last dental visit: __________
On that visit I had: _____ Routine Cleaning
_____ X-Rays
_____ Restorative Care
_____ Emergency Care

I have avoided dental care in the past: _____ Yes _____ No If yes, Why?

I have concerns in pursing future dental treatment: _____ Yes _____ No
My concerns are:
_____ I am fearful of dental treatment. Please explain:
_____ Financial
_____ Scheduling concerns. Please explain:
_____ Other:

I consider my smile: _____Very appealing
_____ Nice

_____ Acceptable to me
_____ In need of improvement

I experience the following with my teeth/mouth:

(Please check all that apply)

_____ Tenderness when chewing
_____ Food caught between teeth
_____ Loose teeth
_____ Recurring sore in or around mouth
_____ Bleeding sore gums
_____ Jaw aches/feels tired/soreness
_____ Clenching/grinding problem
_____ Jaw clicking/popping
_____ Floss breaking-Explain where:
_____ Bad breath, unpleasant taste

What are your dental expectations?

MEDICAL HISTORY

PATIENT NAME ____ Birth Date _____________________________________

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: ____
Do you take, or have you taken, Phen-Fen or Redux?	Yes	No	
Are you on a special diet?	Yes	No	
Do you use tobacco?	Yes	No	
Do you use controlled substances?	Yes	No	
Do you need to pre-medicate?	Yes	No	If yes, please explain: ____

Women: Are you

Pregnant/Trying to get pregnant?	Yes	No
Taking oral contraceptives?	Yes	No
Nursing?	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?

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

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

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 ____ DATE ______________________

Compound Authorization for Release of Information (HIPAA)

Name of Patient: ____

Date of Birth: _____/_____/_______

The purpose of this authorization is to inform the patient or others with pertinent patient information. The patient has requested that _______Carolina Bright Smiles_____________ is to release the following information about the above named patient to the entities named below:

Entity to Receive Information. Check each person/entity that you approve to receive information.	**Description of information to be released.** Check each that can be given to person/entity on the left in the same section.
❑ Voice Mail	❑ Results of lab tests/x-rays ❑ Other________________________________
❑ Give information to employer ❑ Give information to school	❑ Appointment absentee information
❑ Spouse (provide name) ___________________	❑ Family billing information ❑ Financial ❑ Dental/Medical as follows:_______________
❑ Parent (provide name)____________________	❑ Family Billing Information ❑ Financial ❑ Dental/Medical as follows:________________
❑ Other (provide name) ____________________ _______________________________________	❑ Financial ❑ Dental/Medical as follows ________________
❑ Support Group (provide name)_____________	❑ Demographic Information

Right of the Patient: I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to _______________________________________. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward. I understand that information used or disclosed as result of this authorization may be subject to re- disclosure by the recipient and may no longer be protected by federal or state law. I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

____

Signature of Patient or Legal Representative

____ Date___________________________

Description of Legal Representative Authority (provide supporting documentation)

Notice of Privacy Practices
Acknowledgement of Receipt

Patient Information:________________________________ DOB: ________________

____

____

I have received a copy of the Notice of Privacy Practices for the above named practice.

________________________________ ________________________________
Signature Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- ❑ An emergency existed & a signature was not possible at the time.
- ❑ The individual refused to sign.
- ❑ A copy was mailed with a request for a signature by return mail.
- ❑ Unable to communicate with the patient for the following reason: ____
- ❑ Other:____
____

Prepared By ________________________________

Signature ____

Date ____

Notice of Privacy Practices

This Notice of Privacy Practices (Notice) describes how your protected health information (PHI) may be used and disclosed and your rights with this information. Please review it carefully.

If you have any questions about this Notice please contact:

Privacy Officer
603 Hampton Pointe, Suite #1
Hillsborough, NC 27278
www.carolinabrightsmiles.com
919-644.7400

Effective Date: January 1, 2015 **Revised: December 1, 2016**

We are committed to protect the privacy of your personal health information. This Notice describes how we may use (within our practice) and disclose (share outside of our practice) your PHI to carry out treatment, payment or health care operations. We may also share your information for other purposes that are permitted or required by law. This Notice also describes your rights to access and control your PHI. We are required by law to maintain the privacy of your PHI. We will follow the terms outlined in this Notice. We may change our Notice, at any time. Any changes will apply to all PHI held by this practice.

At any time, you may obtain a copy of this Notice by:

- Obtaining a Notice from within our office.
- If requested, having a copy of the Notice sent to you by mail.
- Reviewing the Notice on our website.

Uses and Disclosures of your PHI

We may use or disclose your PHI to provide health care treatment for you.
Your PHI may be used and disclosed by your dentist, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. We may also share your PHI with people outside of our practice that may provide medical care for you such as home health agencies.

We may use and disclose your PHI to obtain payment for services. We may share your PHI to others in order to bill or collect payment for services. There may be services for which we share information with your health plan to determine if services/procedures will qualify for coverage.
PHI may be shared with the following:

- Those involved with the paying of your bill
- Billing companies
- Insurance companies, health plans
- Government agencies in order to assist with qualification of benefits
- Collection agencies

We may use or disclose your PHI, as-needed, in order to support our health care operations (business activities).
Examples of uses and disclosures for healthcare operations include the following:

- Reviewing and improving the quality, efficiency and cost of care that we provide to you and other patients.
- Providing training programs for students, trainees, healthcare providers or non-healthcare professionals (for example, billing clerks) to help them practice or improve their skills.
- Cooperating with outside organizations that assess the quality of care we provide. These organizations might include government agencies or accrediting bodies like the Joint Commission and the Accreditation Association of Ambulatory Healthcare, Inc.
- Cooperating with outside organizations that evaluate, certify or license healthcare providers, staff or facilities in a particular field or specialty. For example, we may use or disclose health information so that one of our nurses may become certified in a specific field of nursing.

- Assisting various people who review our activities. Health information may be seen by doctors reviewing services provided to you, and by accountants, lawyers and others who assist us in complying with applicable laws.
- Conducting business management and general administrative activities related to our organizations and services we provide.
- Resolving grievances within our organizations.
- Complying with this Notice and with applicable laws. If required by law: The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. An example, we may be required to report suspected abuse or neglect.

We may use and disclosure your PHI in other situations without your permission:

- If required by law: The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. An example, we may be required to report suspected abuse or neglect.
- Public health activities: The disclosure will be made for the purpose of controlling disease, injury or disability and only to public health authorities permitted by law to collect or receive information. We may also notify individuals who may have been exposed to a disease or may be at risk of contracting or spreading a disease or condition.
- Health oversight agencies: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.
- Legal proceedings: To assist in any legal proceeding or in response to a court order, in certain conditions in response to a subpoena, or other lawful process.
- Police or other law enforcement purposes: The release of PHI will meet all applicable legal requirements for release.
- Coroners, funeral directors: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law
- Medical research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.
- Special government purposes: Information may be shared for national security purposes, or if you are a member of the military, to the military under limited circumstances.
- Correctional institutions: Information may be shared if you are an inmate or under custody of law which is necessary for your health or the health and safety of other individuals.
- Workers' Compensation: Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.

Other uses and disclosures of your health information.

- Business Associates: Some services are provided through the use of contracted entities called "business associates". We will always release only the minimum amount of PHI necessary so that the business associate can perform the identified services. We require the business associate(s) to appropriately safeguard your information. Examples of business associates include billing companies and collection agencies.
- Health Information Exchange: We may make your health information available electronically to other healthcare providers outside of our facility who are involved in your care.
- Fundraising activities: We may contact you in an effort to raise money but you may opt out of receiving such communications.
- Treatment alternatives: We may provide you treatment options or other health related services that may improve your overall health.
- Appointment reminders: We may contact you as a reminder about upcoming appointments or treatment. We may contact you by phone, mail or electronic mail (email). We may leave a message with your answering service or a person who answers your phone.

We may use or disclose your PHI in the following situations UNLESS you object.

- We may share your PHI with friends, family members, or other persons directly identified by you at the level they are involved in your care or payment of services. If you are not present or able to agree/object, the healthcare provider, using professional judgment, will determine if it is in your best interest to share the information. For example, we may discuss post procedure instructions with the person who drove you to the facility unless you tell us specifically not to share the information.
- We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death.
- We may use or disclose your PHI to an authorized public or private entity to assist in disaster relief efforts.

The following uses and disclosures of PHI require your written authorization:

- Marketing
- Disclosures of for any purposes which require the sale of your information
- Release of psychotherapy notes: Psychotherapy notes are notes by a mental health professional for the purpose of documenting a conversation during a private session. This session could be with an individual or with a group. These notes are kept separate from the rest of the medical record and do not include: medications and how they affect you, start and stop time of counseling sessions, types of treatments provided, results of tests, diagnosis, treatment plan, symptoms, prognosis.

- All other uses and disclosures not recorded in this Notice will require a written authorization from you or your personal representative. A written authorization explains how you want your information to used and disclosed and no further use or disclosure of your PHI will occur. Your written authorization may be revoked at any time, but must be made in writing.

Your PHI and your Privacy Rights

You have certain rights related to your PHI. All requests to exercise your rights must be made in writing. Please obtain the proper form associated with the right you would like to exercise from the office manager and direct your request to our privacy officer.

You have the right to see and obtain a copy of your PHI.

This means you may inspect and obtain a copy of PHI about you that is contained in a designated record set for as long as we maintain the PHI. If requested we will provide you a copy of your records in an electronic format. There are some exceptions to records which may be copied and the request may be denied. We may charge you a reasonable cost based fee for a copy of the records.

You have the right to request a restriction of your PHI.

You may request for this practice not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. We are not required to agree with these requests. If we agree to a restriction request we will honor the restriction request unless the information is needed to provide emergency treatment.

> **There is one exception**: We must accept a restriction request to restrict disclosure of information to a health plan if you pay in full out of pocket for a service or product, unless it is otherwise required by law.

You have the right to request for us to communicate in a different way or at a different location.

We will agree to reasonable requests. We may also request alternative address or other method of contact such as mailing information to a post office box. We will not ask for an explanation from you about the request.

You may have the right to request an amendment of your PHI.

You may request an amendment of your health information if you feel that the information is not correct along with an explanation of the reason for the request. In certain cases, we may deny your request for an amendment at which time you will have an opportunity to disagree.

You have the right to a list of people or organizations who we have shared your PHI.

This right applies to disclosures for purposes other than treatment, payment or healthcare operations. You have the right to obtain a listing of these disclosures that occurred after April 14, 2003. You may request a list for the previous six years or a shorter timeframe. If you request more than one list within a 12 month period you may be charged a reasonable fee.

You have the right to obtain a paper copy of this notice from us, upon request.

We will provide you a copy of this Notice the first day we treat you at our facility. In an emergency situation we will give you this Notice as soon as possible.

You have the right to receive notification of any breach of your PHI.

We will notify you in the event that your information has been involved in a breach. Our practice will send this information to you by letter or email, unless you object.

Complaints

If you think we have violated your rights or you have a complaint about our privacy practices please can contact our:

Complaint Officer
603 Hampton Pointe, Suite #1
Hillsborough, NC 27278
www.carolinabrightsmiles.com

You may also complain to the United States Secretary of Health and Human Services if you believe your privacy rights have been violated.
If you file a complaint we will not retaliate against you for filing a complaint.

Dental Record Release

Patient Information:

Name ____

Date of Birth________________

Address____

Phone _____________________

email____

Covered Entity to release or receive information:

Name ____

Phone ______________________

Address ____

F ax ________________________

email____

The patient has requested that the following Protected Health Information is to be released for treatment purposes:

- ☐ **Recent X-rays/Panoramic films**
- ☐ **Periodontal charting**
- ☐ **Other**
- ☐ **Clinical Notes**
- ☐ **Complete Record**

Patient Rights:

I understand that this authorization may be revoked at any time by giving written notice to the releasing covered entity. I understand that once my dental records have been released, the covered entity cannot revoke the information that has already been disclosed but no further releases will occur.

I understand that the information disclosed from this dental record release may be subject to redisclosure by the recipient for treatment, payment or operational purposes and the releasing covered entity has no control over the use and disclosure of the information.

I understand that this dental record release shall remain in effect until the information has been received by the requesting covered entity.

Date_________________________

____
Signature of Patient or Legal Representative

____
Print Name of Patient or Legal Representative

____
Description of Legal Representative Authority (provide supporting documentation)

We at Carolina Bright Smiles use reasonable means to protect the security and confidentiality of emails sent and received, but we cannot guarantee the security and confidentiality of all email communications.