SixForks FAMILY DENTISTRY

Patient Registration and Dental History

1 Patient Information

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Name

Address _____

Email _____

City _____

State _____ Zip _____

Sex ☐ M ☐ F _____

Birth date _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced Partnered for ____ years

Patient Employer/School _____

Occupation _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birth date _____

SS# _____

Spouse's Employer _____

Whom may we thank referring you? _____

2 Dental Insurance

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? _____

Subscriber's Name _____

Birth date _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to

Dr. _____ 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.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Compan(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

3 Phone Numbers

Phone (_____) _____ Phone (_____) _____ Ext _____ Cell (_____) _____

Spouse's Work (_____) _____ Best time and place to reach you _____

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

Name _____ Relationship _____

Home Phone (_____) _____ Work Phone (_____) _____

4 Dental History

Reason for today's visit _____

_____

Former Dentist _____

City/State _____

Date of last dental visit _____

Date of last dental X-rays _____

Place a mark on "yes" or "no" to indicate if you have had any of the following

Bad breath	☐ Yes	☐ No
Bleeding gums	☐ Yes	☐ No
Blisters on lips or mouth	☐ Yes	☐ No
Burning sensation on tongue	☐ Yes	☐ No
Chew on one side of mouth	☐ Yes	☐ No
Cigarette, pipe, or cigar smoking	☐ Yes	☐ No
Clicking or popping jaw	☐ Yes	☐ No
Dry Mouth	☐ Yes	☐ No
Fingernail Biting	☐ Yes	☐ No
Food collection between the teeth	☐ Yes	☐ No
Foreign objects	☐ Yes	☐ No
Grinding teeth	☐ Yes	☐ No
Gums swollen or tender	☐ Yes	☐ No
Jaw pain or tiredness	☐ Yes	☐ No
Lip or cheek biting	☐ Yes	☐ No
Loose teeth or broken fillings	☐ Yes	☐ No
Mouth breathing	☐ Yes	☐ No
Mouth pain, brushing	☐ Yes	☐ No
Orthodontic treatment	☐ Yes	☐ No
Pain around ear	☐ Yes	☐ No
Periodontal treatment	☐ Yes	☐ No
Sensitivity to cold	☐ Yes	☐ No
Sensitivity to heat	☐ Yes	☐ No
Sensitivity to sweets	☐ Yes	☐ No
Sensitivity when biting	☐ Yes	☐ No
Sores or growth in your mouth	☐ Yes	☐ No

How often do you floss? _____

How often do you brush? _____

SixForks FAMILY DENTISTRY

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 a important interrelationship with the dentistry you will receive. Thank you for answering the following question.

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	_____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	○ Yes	○ No	_____
Are you on a special diet?	○ Yes	○ No	
Do you use tobacco? Do you use controlled substances?	○ Yes	○ No	

Woman: Are you
☐ Pregnant/Trying to get pregnant? ☐ Nursing
☐ Taking oral contraceptive?

Are you allergic to any of the following

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics ☐ Sulfa Drugs
☐ Other If yes, please explain: _____

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

☐ AID/HIV Positive	☐ Cold Sores/Fever Blisters	☐ Glaucoma	☐ Leukemia	☐ Sickle Cell Disease
☐ Alzheimer's Disease	☐ Congenital Heart Disorder	☐ Hay Fever	☐ Liver Disease	☐ Sinus Trouble
☐ Anaphylaxis	☐ Convulsions	☐ Heart Attack/Failure	☐ Low Blood Pressure	☐ Spina Bifida
☐ Anemia	☐ Cortisone Medicine	☐ Heart Murmur	☐ Lung Disease	☐ Stomach/Intestinal Disease
☐ Angina	☐ Diabetes	☐ Heart Pacemaker	☐ Mitral Valve Prolapse	☐ Stroke
☐ Arthritis/Gout	☐ Drug Addiction	☐ Heart Trouble/Disease	☐ Osteoporosis	☐ Swelling of Limbs
☐ Artificial Heart Valve	☐ Easily Winded	☐ Hemophilia	☐ Pain in Jaw Joints	☐ Thyroid Disease Tonsilitis
☐ Artificial Joint	☐ Emphysema	☐ Hepatitis A	☐ Parathyroid Disease	☐ Tuberculosis
☐ Asthma	☐ Epilepsy or Seizures	☐ Hepatitis B or C	☐ Psychiatric Care	☐ Tumors of Growths
☐ Blood Disease	☐ Excessive Bleeding	☐ Herpes	☐ Radiation Treatments	☐ Ulcers
☐ Blood Transfusion	☐ Excessive Thirst	☐ High Blood Pressure	☐ Recent Weight Loss	☐ Venereal Disease
☐ Breathing Problem	☐ Fainting Spells/Dizziness	☐ High Cholesterol	☐ Renal Dialysis	☐ Yellow Jaundice
☐ Bruise Easily	☐ Frequent Cough	☐ Hives or Rash	☐ Rheumatic Fever	
☐ Cancer	☐ Frequent Diarrhea	☐ Hypoglycemia	☐ Rheumatism	
☐ Chemotherapy	☐ Frequent Headaches	☐ Irregular Heartbeat	☐ Scarlet Fever	
☐ Chest Pains	☐ Genital Herpes	☐ Kidney Problems	☐ Shingles	

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

Preferred Pharmacy: _____ Pharmacy Location: _____ Phone: _____

Comments: _____

To the best of my knowledge, the questions in 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 _____

Patient Consent Form

HIPAA Agreement

Notification:

As you may be aware, a new federal law went into effect on April 14, 2003. The Health Insurance Portability and Accountability Act (HIPAA) requires Six Forks Family Dentistry: **Norman and Woodall DDS, PLLC, dba Six Forks Family Dentistry** to provide you with its Notice of Privacy Practices. It outlines your privacy rights as a patient.

We may use information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication with Family:

Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend, or any other person you identify, health information irrelevant to that person's involvement in your care or payment related to your care. Health professionals may discuss Protected Health Information (PHI) with parents of minors (under age of 18 or in school and covered by a parent's insurance policy) unless specifically instructed not to do so.

Worker's Compensation or Disability Insurance:
We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by the law.

Public Health:

As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Law Enforcement:

We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

(OVER)

For the Patient's Review and Signature

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and the physician certifications.

I have been informed by you and your **Notice of Privacy Practices** containing a more complete description of the uses and disclosures for my health information. I have been given the right to review such **Notice of Privacy Practices** prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the **Notice of Privacy Practices.**

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name (please print): _____

Signature: _____

Relationship to Patient: _____

Date: _____

SixForks FAMILY DENTISTRY

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

If you have any questions about this Notice please contact the Privacy Officer.
3814 Browning Place, Suite 100, Raleigh, NC 27609
(919) 755-9887

Effective Date: April 13, 2003 **Revised: November 22, 2024**

We are committed to protect the privacy of your personal health information (PHI).

This Notice of Privacy Practices (Notice) describes how we may use within our practice or network and disclose (share outside of our practice or network) 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. Upon your request, we will provide you with any revised Notice by:

- Posting the new Notice in our office.
- If requested, making copies of the new Notice available in our office or by mail.
- Posting the revised Notice on our website: www.RaleighDentalExcellence.com.

Uses and Disclosure of Protected Health Information

We may use or disclose (share) your PHI to provide health care treatment for you.

Your PHI may be used and disclosed by your physician, 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.

EXAMPLE: Your PHI may be provided to a physician to whom you have been referred for evaluation to ensure that the physician has the necessary information to diagnose or treat you. We may also share your PHI from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

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 provide 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 the service will be paid for.

PHI may be shared with the following:

- Billing companies
- Insurance companies, health plans
- Government agencies in order to assist with qualification of benefits
- Collection agencies

EXAMPLE: You are seen at our practice for a procedure. We will need to provide a listing of services such as x-rays to your insurance company so that we can get paid for the procedure. We may at times contact your health care plan to receive approval PRIOR to performing certain procedures to ensure the services will be paid for. This will require sharing of your PHI.

We may use or disclose, as-needed, your PHI in order to support the business activities of this practice which are called health care operations.

EXAMPLES:

- Training students, other health care providers, or ancillary staff such as billing personnel to help them learn or improve their skills.
- Quality improvement processes which look at delivery of health care and for improvement in processes which will provide safer, more effective care for you.
- Use of information to assist in resolving problems or complaints within the practice.

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

EXAMPLES:

- 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. For example, we may be required to report gunshot wounds or 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 or transcription services.

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.

Treatment alternatives: We may provide you notice of 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 use or disclose your PHI in the following situations UNLESS you object.

- We may share your information with friends or 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 protected health information 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 protected health information 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

All other uses and disclosures not recorded in this Notice will require a written authorization from you or your personal representative.

Written authorization simply explains how you want your information used and disclosed. Your written authorization may be revoked at any time, in writing. Except to the extent that your doctor or this practice has used or released information based on the direction provided in the authorization, no further use or disclosure will occur.

Your Privacy Rights

You have certain rights related to your protected health information. All requests to exercise your rights must be made in writing. Forward all requests to Raleigh Dental Excellence Attention Privacy Officer.

You have the right to see and obtain a copy of your protected health information.

This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. 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 protected health information.

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 out of pocket in full for a service or product unless it is otherwise required by law.

You have the right to request for us to communicate in different ways or in different locations.

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 health information.

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 have received your health information from us.

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 them 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.

Additional Privacy Rights

- 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 a right to receive notification of any breach of your protected health information.

Complaints

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

Six Forks Family Dentistry
3814 Browning Place, Suite 100,
Raleigh, NC 27609
(919) 755-9887

You may also complain to the United States Secretary of Health and Human Services if you believe your privacy rights have been violated by us.

If you file a complaint we will not retaliate against you for filing a complaint.

This notice was published and becomes effective on April 13, 2003.

SixForks FAMILY DENTISTRY

Authorization for Release of Information

Patient Name _____ Date of Birth _____

Six Forks Family Dentistry is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

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
☐ Home Phone ☐ Mobile Phone ☐ Work Voice Mail ☐ Email (Provide Address) _____ ☐ Text Message	☐ Appointment Reminders ☐ Results of Lab Tests / X-rays ☐ Financial ☐ Other _____
☐ Spouse (Provide Name): _____	☐ Appointment Reminders ☐ Results of Lab Tests / X-rays ☐ Financial ☐ Other _____
☐ Other (Provide Name): _____	☐ Appointment Reminders ☐ Results of Lab Tests / X-rays ☐ Financial ☐ Other _____
☐ For email and/or text communication I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected.	

Patient Information

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. 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 a result of this authorization may be subject to redisclosure 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.

_____ Date: _____

Signature of Patient or Personal Representative

Description of Personal Representative's Authority (attach necessary documentation

_____

_____

_____