

# PATIENT REGISTRATION

Patient Number ABC Today's Date \_\_\_\_\_

**Patient's Name** \_\_\_\_\_ Sex: M F Birthdate \_\_\_\_\_ Age \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Please Circle One Single Married Separated Widow Your Soc. Sec. # \_\_\_\_\_

Home Ph.# \_\_\_\_\_ Cell Ph.# \_\_\_\_\_ E-mail Address \_\_\_\_\_

Your Employer \_\_\_\_\_ Work Ph.# \_\_\_\_\_ How Long Employed \_\_\_\_\_

Are you a full time student?  Yes  No *If patient is minor we need:* Mother's  Father's    
DOB

**Person responsible for account** Driver's License # \_\_\_\_\_ Relationship \_\_\_\_\_

Name of spouse (parent if minor) \_\_\_\_\_ Spouse's (parent's) Soc. Sec. # \_\_\_\_\_

Spouse's (parent's) Employer \_\_\_\_\_ Work Ph.# \_\_\_\_\_ Cell Ph.# \_\_\_\_\_

**EMERGENCY INFORMATION**  
*Name, address, & telephone of a relative not living with you* \_\_\_\_\_

Reason for this visit \_\_\_\_\_

**How did you hear about our office?** \_\_\_\_\_

DENTAL INSURANCE INFORMATION (Primary Carrier)	If you have double digit insurance coverage, complete this for the 2nd coverage
Insured's name _____	Insured's name _____
Insured's employer _____	Insured's employer _____
Insurance Co _____	Insurance Co _____
Insurance Co Address _____	Insurance Co Address _____
Phone # _____ DOB _____	Phone # _____ DOB _____
SS# _____	SS# _____
Group # _____ Local # _____	Group # _____ Local # _____

## FINANCIAL POLICY

Thank you for choosing our office as your dental healthcare provider. We are committed to providing you with the highest quality lifetime dental care, so that you may attain optimum oral health. The following is a statement of our financial policy, which we require that you read, agree to, and sign prior to any treatment. Please note that payment of your bill is considered part of your treatment. Payment is due at the time service is provided. Our office accepts cash, personal checks, MasterCard, Visa and Discover. Outside financing is available upon request and approval.

**Please check if you would like more information about financing options.**

**Please Note:** Returned checks will be subject to additional fees. In the case it becomes necessary for our office to enlist a collection service and/or legal assistance, you will be responsible for any collection and/or legal charges up to 35%.

**Do You Have Insurance?**

- As a courtesy to you we will help you process all your insurance claims. Please understand that we will provide an insurance estimate to you, however it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits ultimately determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible.
- All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company. Our office is not a party to that contract.
- Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
- We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office.
- We ask that you pay the deductible and co-payment, which is the estimated amount not covered by your insurance company, by cash, check, MasterCard, Visa, or Discover at the time we provide the service to you.
- Insurance payments are ordinarily received within 30-60 days from the time of filing. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.
- We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.

We thank you for the opportunity to serve your dental health care needs and welcome any questions you may have concerning your care or our financial policy.

**Consent:**

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO MY DENTAL OFFICE. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance, rebilling, collection charge and/or attorney fee will be added to any overdue balance.

By signing below, you are authorizing us to call you at any number you provide including calls to mobile/cellular or similar devices for any lawful purpose. You agree to any fees or charges that you may incur for an incoming call from us, and/or outgoing calls to us, to or from any such number, without reimbursement from us.

\_\_\_\_\_  
 Patient Signature (Parent if child)

\_\_\_\_\_  
 Date

# DENTAL HISTORY

Please check any of the following problems that apply to you.

	Yes	No
-Sensitivity (hot; cold, sweet, pressure) Where? UR LR UL LL	<input type="checkbox"/>	<input type="checkbox"/>
-Headaches, earaches, neck pain	<input type="checkbox"/>	<input type="checkbox"/>
-Jaw joint pain	<input type="checkbox"/>	<input type="checkbox"/>
-Teeth or fillings breaking	<input type="checkbox"/>	<input type="checkbox"/>
-Grinding or clenching teeth	<input type="checkbox"/>	<input type="checkbox"/>
-Bleeding, swollen or irritated gums	<input type="checkbox"/>	<input type="checkbox"/>
-Loose, tipped or shifting teeth	<input type="checkbox"/>	<input type="checkbox"/>
-Bad breath	<input type="checkbox"/>	<input type="checkbox"/>
Do you have or have you had any of the following?		
-Dentures	<input type="checkbox"/>	<input type="checkbox"/>
-Partial dentures	<input type="checkbox"/>	<input type="checkbox"/>
-Braces	<input type="checkbox"/>	<input type="checkbox"/>
-Periodontal (gum) treatments	<input type="checkbox"/>	<input type="checkbox"/>

Please share the following dates:

- Your last cleaning \_\_\_\_\_ / \_\_\_\_\_  
 - Your last oral cancer screening \_\_\_\_\_ / \_\_\_\_\_  
 - Your last complete X-Rays \_\_\_\_\_ / \_\_\_\_\_

Name of Previous Dentist \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_  
 Phone Number \_\_\_\_\_

	Yes	No
If you could whiten your teeth for a cost anyone could afford, would you do it?	<input type="checkbox"/>	<input type="checkbox"/>
Do you smoke or use chewing tobacco?	<input type="checkbox"/>	<input type="checkbox"/>
How much? _____ For how long? _____		
If I could change my smile, I would:		
-Make it whiter	<input type="checkbox"/>	<input type="checkbox"/>
-Make it straighter	<input type="checkbox"/>	<input type="checkbox"/>
-Close spaces	<input type="checkbox"/>	<input type="checkbox"/>
-Replace black metal fillings with tooth colored restorations	<input type="checkbox"/>	<input type="checkbox"/>
-Repair chipped teeth	<input type="checkbox"/>	<input type="checkbox"/>
-Replace missing teeth	<input type="checkbox"/>	<input type="checkbox"/>
-Replace old crowns that don't match	<input type="checkbox"/>	<input type="checkbox"/>
-Have a smile makeover	<input type="checkbox"/>	<input type="checkbox"/>

ON A SCALE OF 1-10, WITH 10 BEING THE HIGHEST RATING:

How important is your dental health to you?  
 1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health?  
 1 2 3 4 5 6 7 8 9 10

Where do you want your dental health to be?  
 1 2 3 4 5 6 7 8 9 10

Why did you leave your previous dentist? \_\_\_\_\_

What is the most important thing to you about your future smile and dental health? \_\_\_\_\_  
 What is the most important thing to you about your dental visit today? \_\_\_\_\_

# MEDICAL HISTORY

Please check any of the following problems/conditions that apply to you:

	YES	NO		YES	NO		YES	NO		YES	NO
AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	HIV Positive	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>
Allergies (Seasonal)	<input type="checkbox"/>	<input type="checkbox"/>	Drug Addiction	<input type="checkbox"/>	<input type="checkbox"/>	HPV (Human Papilloma Virus)	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>
Angina (Chest pain)	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Jaw Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>	Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Problems	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Heart Valve	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Joints	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Heart Conditions	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>	Heart Lesions (Congenital)	<input type="checkbox"/>	<input type="checkbox"/>	Nervousness/Depression	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Bruise Easily	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Diseases	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Heart Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Pregnant Currently	<input type="checkbox"/>	<input type="checkbox"/>	Other _____		
Cervical Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A	<input type="checkbox"/>	<input type="checkbox"/>	Radiation (head/neck)	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Cortisone Medication	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis C	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>	_____		

Are you allergic or have you reacted adversely to any of the following medications?

	YES	NO		YES	NO		YES	NO		YES	NO
Aspirin	<input type="checkbox"/>	<input type="checkbox"/>	Percodan	<input type="checkbox"/>	<input type="checkbox"/>	Tetracycline	<input type="checkbox"/>	<input type="checkbox"/>	Valium	<input type="checkbox"/>	<input type="checkbox"/>
Darvon	<input type="checkbox"/>	<input type="checkbox"/>	Latex	<input type="checkbox"/>	<input type="checkbox"/>	Codeine	<input type="checkbox"/>	<input type="checkbox"/>	Penicillin	<input type="checkbox"/>	<input type="checkbox"/>
Nitrous Oxide	<input type="checkbox"/>	<input type="checkbox"/>	Local Anesthetic	<input type="checkbox"/>	<input type="checkbox"/>	Erythromycin	<input type="checkbox"/>	<input type="checkbox"/>	Sulfa	<input type="checkbox"/>	<input type="checkbox"/>
									Other _____		

Have you ever taken any the following medications?

	YES	NO		YES	NO
Actonel	<input type="checkbox"/>	<input type="checkbox"/>	Zometa	<input type="checkbox"/>	<input type="checkbox"/>
Aredia	<input type="checkbox"/>	<input type="checkbox"/>	Boniva	<input type="checkbox"/>	<input type="checkbox"/>
Fosamax	<input type="checkbox"/>	<input type="checkbox"/>	Herbal	<input type="checkbox"/>	<input type="checkbox"/>
Reclast	<input type="checkbox"/>	<input type="checkbox"/>	Supplements		

Are you under a physician's care? What for?

What medications are you currently taking?  
 \_\_\_\_\_  
 Family Physician \_\_\_\_\_ Phone Number \_\_\_\_\_

**Consent:**

The undersigned hereby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I have read, understand and agree to the above terms and conditions.

Patient Signature (Parent if child) \_\_\_\_\_ Date \_\_\_\_\_ Dentist Signature \_\_\_\_\_

# NOTICE OF PRIVACY PRACTICES

## Asheboro Dental Care

**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 **June 1st, 2010**, and will remain in effect until we replace it.

We may change our privacy practices from time to time. If we do, we will revise this Notice so you will have an accurate summary of our practices. The revised Notice will apply to all of your health information. We may also revise this notice from time to time. If we make any material revisions to this Notice, we will provide you with a copy of the revised Notice which will specify the date on which such revised Notice becomes effective. We are required to abide by the terms of the Notice that is currently in effect. 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

#### **A. Use and Disclosure for Treatment, Payment, and Health Care Operations**

We must disclose your health information to you, as described in the Patient Rights section of this Notice. We also use and disclose health information about you for treatment, payment, and health care operations. For example:

- **Treatment:** We may disclose your health information to a physician or other health care provider providing treatment to you.
- **Payment:** We may use and disclose your health information to obtain payment for services we provide to you.
- **Health care Operations:** We may use and disclose your health information in connection with our health care operations, including quality assessment and improvement activities, review of the competence or qualifications of health care professionals, evaluation of practitioner and provider performance, training programs, accreditation, certification, and licensing and credentialing activities.

**Your Authorization:** In addition to our use of your health information for treatment, payment, or health care 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.

**Disclosures To Your Family and Friends:** We may disclose your health information to a family member, friend, or other person identified by you to the extent necessary to help with your health care or with payment for your health care, but only if you agree that we may do so.

**Disclosures To Persons Involved in Your Care:** We may also 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, 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 use or disclosure. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment, and we will disclose only health information that is directly relevant to the person's involvement in your health care. 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.

**Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders (such as voicemails, postcards, letters).

**Patient-Related Communications:** We may use or disclose your health information to provide patient-related communications such as intraoral photography, "no cavity club" for children, and telephoned-in prescriptions.

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

#### **B. Use and Disclosure for the Public Need**

In particular situations involving the public need, we may disclose your health information without obtaining your authorization. Those situations include the following circumstances:

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

**Public Health Activities:** We may disclose your health information to authorized public health officials so they may carry out their public health activities. For example, we may share your health information with government officials that are responsible for controlling disease, injury, or disability.

**Health Oversight Activities:** We may release your health information to government agencies authorized to conduct audits, investigations, and inspections, as well as civil, administrative or criminal investigations, proceedings, or actions.

**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.

**Product Monitoring, Repair and Recall:** We may disclose your health information to a person or company that is regulated by the Food and Drug Administration for the purpose of: (1) reporting or tracking product defects or problems; (2) repairing, replacing, or recalling defective or dangerous products; or (3) monitoring the performance of a product after it has been approved for use by the general public.

**Lawsuits And Disputes:** We may disclose your health information if we are ordered to do so by a court or administrative tribunal that is handling a lawsuit or other dispute. We may also disclose your health information in response to a subpoena, discovery request, or other lawful request by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain a court order protecting the information from further disclosure.

**Law Enforcement:** We may disclose your health information to law enforcement officials for certain reasons including to comply with court orders or laws that we are required to follow, and to assist law enforcement officers with identifying or locating a suspect, fugitive, witness, or missing person.

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# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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**Purpose:** This form is used to obtain acknowledgment of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgment.

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**\*\*You May Refuse to Sign This Acknowledgment\*\***

I, \_\_\_\_\_, have received a copy of this office's Notice of Privacy Practices.

\_\_\_\_\_  
{Please Print Name}

\_\_\_\_\_  
{Signature}

\_\_\_\_\_  
{Date}

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**For Office Use Only**

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

- Individual refused to sign
  - Communications barriers prohibited obtaining the acknowledgment
  - An emergency situation prevented us from obtaining acknowledgment
  - Other (Please Specify)
- 
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Asheboro Dental Care 336-625-4216

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# Authorization to Release Information

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**Purpose:** This form is used to obtain authorization to release information regarding yourself covered under the Privacy Act to people other than yourself.

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I, \_\_\_\_\_, authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself.

_____ {Please Print Name}	_____ Relationship
_____ {Please Print Name}	_____ Relationship
_____ {Please Print Name}	_____ Relationship

**Asheboro Dental Care**  
**350 N Cox St #18**  
**Asheboro, NC 27203**  
**Ph:(336)625-4216 Fax:(336)629-9317**  
**Gary Cameron, DDS Peter Son, DMD**

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Date \_\_\_\_\_

Our office is now able to send email and text messages to patients to confirm appointments! This is a great tool for our patients to utilize when a phone call isn't possible. However, we understand some patients prefer to simply be called.

Please indicate below if you would like to receive email and text message appointment confirmation and reminders from our office. If so, please provide your cell phone numbers and/or email address. As always, we will never share your cell phone and email information with any 3<sup>rd</sup> party companies.

\_\_\_\_\_ **Yes**, I would like to receive a text message confirmation.

\_\_\_\_\_ **No**, please do not text me regarding my appointments.

Cell phone number \_\_\_\_\_

\_\_\_\_\_ **Yes**, I would like to receive email appointment confirmations.

\_\_\_\_\_ **No**, please do not email me regarding my appointments.

Email address \_\_\_\_\_

Printed Name \_\_\_\_\_

Signature \_\_\_\_\_

Parent/Guardian \_\_\_\_\_

Please check any additional information you would like to receive via email/text.

\_\_\_\_\_ Newsletters

\_\_\_\_\_ Promotions