NORTH CAROLINA
premier dental

PATIENT REGISTRATION AND MEDICAL HISTORY

Please complete the following confidential information. If you have any questions, please ask a staff member for assistance.

PATIENT INFORMATION

TODAY'S DATE _____/_____/_____

FIRST NAME _____ M.I. _____ LAST NAME _____ GENDER: M ☐ F☐

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

EMAIL ADDRESS _____ EMPLOYMENT: Full-time ☐ Part-time ☐ Retired ☐ Student ☐

OCCUPATION _____ EMPLOYER_____

EMPLOYER ADDRESS _____ CITY _____ STATE _____ ZIP _____

SOC. SEC. _____DATE OF BIRTH ____/____/_____ AGE_____ MARITAL STATUS: Single ☐ Married ☐ Widowed ☐ Divorced ☐

NAME YOU PREFER TO BE CALLED_____ WHO REFERRED YOU TO US? _____

PERSON RESPONSIBLE FOR THE ACCOUNT

CHECK HERE IF SAME AS ABOVE ☐

FIRST NAME _____ M.I. _____ LAST NAME _____ GENDER: M ☐ F☐

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

EMAIL ADDRESS _____ EMPLOYMENT: Full-time ☐ Part-time ☐ Retired ☐ Student ☐

OCCUPATION _____ EMPLOYER_____

EMPLOYER ADDRESS _____ CITY _____ STATE _____ ZIP _____

SOC. SEC. _____DATE OF BIRTH ____/____/_____ AGE_____ MARITAL STATUS: Single ☐ Married ☐ Widowed ☐ Divorced ☐

DENTAL INSURANCE

PRIMARY CARRIER:

INSURANCE COMPANY _____

EMPLOYER _____

EMPLOYEE _____

SOC. SEC. _____

GROUP NO. _____

DATE EMPLOYED _____

SECONDARY CARRIER:

INSURANCE COMPANY _____

EMPLOYER _____

EMPLOYEE _____

SOC. SEC. _____

GROUP NO. _____

DATE EMPLOYED _____

PRESENT HEALTH

1. How would you describe your present health? EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR ☐ OTHER _____
2. Are you now under the care of a physician? ..... YES ☐ NO ☐
   If so, what condition is being treated? _____
3. Name of physician: _____ Phone: _____
   Address of physician: _____
4. Do you take any medications? Please answer yes for pills, patches, inhalers, non-prescription drugs, and vitamins. ..... YES ☐ NO ☐
   If so, what medications? _____
5. Have you ever taken or are you currently taking any bone-related medications (e.g., bisphosphonates, denosumab, Aredia, Zometa, Prolia, XGEVA)? ..... YES ☐ NO ☐

PAST MEDICAL HISTORY

6. Have you ever had any serious illness or operation or been hospitalized within the last five years? ..... YES ☐ NO ☐
   If so, what and when? _____
7. Do you have any allergies? ..... YES ☐ NO ☐
   If so: Aspirin? ☐ Penicillin? ☐ Codeine? ☐ Local Anesthetics? ☐ Sedatives? ☐ Metal? ☐ Latex? ☐ Sulfa drugs?☐
   Other? ☐ If other, please explain: _____

CARDIOVASCULAR

8. Have you ever had any heart trouble? YES ☐ NO ☐
   If so: heart attack? ☐ heart failure? ☐ heart disease? ☐ heart infection? ☐ chest pain/angina? ☐
   damaged heart valves? ☐ prosthetic heart valves? ☐ stints? ☐ cardiac pacemaker? ☐
   inborn heart defects? ☐ mitral valve prolapse? ☐ murmurs? ☐
   If so, when? _____
9. Have you ever had a stroke? YES ☐ NO ☐
   If so, when? _____
10. Have you ever had rheumatic fever? YES ☐ NO ☐
11. Do you have a cardiac pacemaker? YES ☐ NO ☐
12. Do you have high blood pressure? YES ☐ NO ☐
13. Do you have high cholesterol? YES ☐ NO ☐
14. Do you ever have chest pain? YES ☐ NO ☐
15. Do you become short of breath after climbing one flight of stairs? YES ☐ NO ☐
16. Are you subject to fainting spells and/or dizziness? YES ☐ NO ☐
17. Do your ankles swell? YES ☐ NO ☐

BLOOD

18. Have you ever had abnormal bleeding problems after a cut or tooth extraction? YES ☐ NO ☐
19. Do you bruise easily? YES ☐ NO ☐
20. Do you bleed easily? YES ☐ NO ☐
21. Have you ever had severe or spontaneous nose bleeds? YES ☐ NO ☐
22. Do you have AIDS (HIV infection)? YES ☐ NO ☐
23. Do you have any systemic blood infections? YES ☐ NO ☐

ENDOCRINE

24. Do you have diabetes? YES ☐ NO ☐
25. Have you ever received treatment for any endocrine or glandular disorder? YES ☐ NO ☐
26. Do you have arthritis? YES ☐ NO ☐
    If so: rheumatoid? ☐ osteoarthritis? ☐

NERVOUS

27. Do you suffer from frequent or severe headaches? YES ☐ NO ☐
28. Have you ever had severe pains of head or face? YES ☐ NO ☐
29. Have you ever had epilepsy or convulsions? YES ☐ NO ☐
30. Do you consider yourself excessively anxious or nervous? YES ☐ NO ☐
31. Do you suffer from depression? YES ☐ NO ☐
    If so, are you seeking treatment? _____

RESPIRATORY

32. Do you have frequent colds? YES ☐ NO ☐
33. Do you suffer from chronic sinusitis or frequent sinus infections? YES ☐ NO ☐
34. Do you have asthma? YES ☐ NO ☐
35. Have you had tuberculosis or a persistent cough? YES ☐ NO ☐
36. Do you smoke? YES ☐ NO ☐
    If yes, what and how much? _____

GASTROINTESTINAL AND GENITOURINARY

37. Have you ever had yellow jaundice or hepatitis? YES ☐ NO ☐
38. Have you ever had any liver or gall bladder problems? YES ☐ NO ☐
39. Have you ever had any stomach problems (e.g., acid reflux, GERD, IBD, or other gastrointestinal disorder)? YES ☐ NO ☐
40. Have you had any kidney or bladder difficulty? YES ☐ NO ☐
41. Have you ever had syphilis, herpes, gonorrhea or any other sexually transmitted disease? YES ☐ NO ☐
    If so, what? _____

OTHER

42. Have you ever been treated for any skin disease? YES ☐ NO ☐
43. Have you ever received x-ray or radioactive isotope treatment? YES ☐ NO ☐
44. Do you ever doze off unintentionally during the day? YES ☐ NO ☐
45. Do you have any impairment or disorder of your eyes, ears, nose or throat? YES ☐ NO ☐
46. Have you ever had a tumor or cancer? YES ☐ NO ☐
    a. If so, what type? _____
47. Do you have any prosthetic replacement joints? YES ☐ NO ☐

WOMEN'S HEALTH

48. Are you pregnant or are you anticipating pregnancy within the next year? ..... YES ☐ NO ☐
49. Have you undergone, or are you presently undergoing menopause? ..... YES ☐ NO ☐
50. Are you taking birth control medication? ..... YES ☐ NO ☐

DENTAL HEALTH

1. What is your chief dental complaint or concern?_____
2. Are you currently having dental pain? ..... YES ☐ NO ☐
   If yes, please explain:_____
3. How often do you get your teeth cleaned? 1-2 times/year ☐ less than 1 time/year ☐ more than 2 times/year ☐
4. Date of last cleaning: _____
5. What do you do daily to care for your teeth?_____
6. Do you use a toothpaste with fluoride? ..... YES ☐ NO ☐
7. Do you use fluoride products other than toothpaste? ..... YES ☐ NO ☐
8. Do your gums bleed when you brush your teeth? ..... YES ☐ NO ☐
9. Do you feel you have bad breath or a bad taste in your mouth? ..... YES ☐ NO ☐
10. Does food catch between your teeth? ..... YES ☐ NO ☐
11. Have you noticed any shift in your teeth or bite? ..... YES ☐ NO ☐
12. Are any of your teeth loose? ..... YES ☐ NO ☐
13. Are there spaces between your teeth now where there were none before? ..... YES ☐ NO ☐
14. Do you have any sensitivity in your teeth to hot, cold or pressure? ..... YES ☐ NO ☐
    If so, where: _____
15. Do any of your teeth ache or throb? ..... YES ☐ NO ☐
16. Do you ever have trouble chewing? ..... YES ☐ NO ☐
17. Do you have any pain or clicking in your jaw on opening or closing? ..... YES ☐ NO ☐
18. Do you ever wake up with a sore jaw? ..... YES ☐ NO ☐
19. Do you ever notice yourself clenching or grinding your teeth? ..... YES ☐ NO ☐
    If so, when? _____
20. Are there sores or growths in your mouth? ..... YES ☐ NO ☐
21. Do you feel you have enough teeth to chew with? ..... YES ☐ NO ☐
22. If not, would you like to have more teeth? ..... YES ☐ NO ☐
23. Are the cosmetics of your smile important to you? ..... YES ☐ NO ☐
24. Do you feel your teeth are white enough? ..... YES ☐ NO ☐
25. Is there anything about your smile you want to change? ..... YES ☐ NO ☐
    If so, what?_____
26. Are you worried about receiving dental treatment? ..... YES ☐ NO ☐
27. Do you need to be pre-medicated before dental care? ..... YES ☐ NO ☐
28. Have you had any bad dental experiences? ..... YES ☐ NO ☐
    If yes, please explain: _____

PAST DENTAL HISTORY

29. Have you ever had an acute sore mouth or gum boils? ..... YES ☐ NO ☐
30. Did you ever wear braces for straightening your teeth? ..... YES ☐ NO ☐
31. Have you ever had previous periodontal or gum treatments? ..... YES ☐ NO ☐
    If so, when? _____ Where? _____
32. Have you ever had dental implants? ..... YES ☐ NO ☐
33. Have you ever had any serious problems associated with previous dental treatment? ..... YES ☐ NO ☐
    If so, explain_____
34. Have you had an unusual reaction to a dental procedure or anesthetic? ..... YES ☐ NO ☐
    If so, explain_____
35. Have you ever experienced prolonged bleeding following a dental treatment? ..... YES ☐ NO ☐
36. Have you had an injury to your teeth, jaws or face? ..... YES ☐ NO ☐
37. Have you ever been told that you need to take an antibiotic before dental treatment? ..... YES ☐ NO ☐
38. Do you have any disease, condition, or problem not listed above that you think we should know about? ..... YES ☐ NO ☐
    If so, please explain _____

I testify that the above is an accurate representation of my medical condition. I understand it is very important to promptly report any changes in my medical or dental status, and I agree to do so. I give my permission to obtain from my physician additional information regarding my medical history.

Signature _____ Date _____

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.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 7/1/18 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, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice 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.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.

Teaching & Educational Purposes. We may use your health information for teaching or educational purposes. We will not disclose your name, address or other personal information, only the clinical aspects of your case.

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

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

* Prevent or control disease, injury or disability;
* Report child abuse or neglect;
* Report reactions to medications or problems with products or devices;
* Notify a person of a recall, repair, or replacement of products or devices;
* Notify a person who may have been exposed to a disease or condition; or
* Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or violence.

National Security. We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities.

We may disclose to correctional institution or law enforcement official having lawful custody the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or

administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

Other Uses and Disclosures of PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

Your Health Information Rights

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible.

We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure. If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to the additional requests.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests.

However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

Amendment. You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or if you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

North Carolina Premier Dental
1622 East Highway 54, Durham, NC 27713
Telephone: 919-544-3721
Fax: 919-544-3722

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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

Print Full Name_____

Signature_____

Date_____

Relationship to Patient (if not signed by Patient)_____

----------**For Office Use Only**----------

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

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify) _____

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