Rockingham Family Dentistry **(336) 623 - 2221**

////////////////////////////// PATIENT INFORMATION //////////////////////////////

Patient Name: ____ Date: ___ / ___/ ___
Last First MI (Preferred Name)

Gender > ☐ Male ☐ Female Family Status > ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Social Security # *(if you have ins.)*: __________________________ Birth Date: ______________________

Phone (Home): _______________ (Work): _______________ Ext: _____ (Cell): ______________________

Address: ____
Street Apartment #

____
City State Zip Code

E-Mail Address ____ Last dental visit date ___ / ___/ ___

How were you referred to our practice: ____

Reason for this visit? ____

If you could change anything about your smile, what would you change? ______________________________

____

Have you ever had any complications following dental treatment? ☐ Yes ☐ No

If yes, please explain ____

* **If patient is not financially responsible (i.e Child) we need parent or responsible party information** *

The following is for: ☐ the patient's spouse ☐ the patient's parent or guardian ☐ the person responsible for payment

Name: ____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Other

Social Security #: *(if you have ins.)* _________________________ Birth Date: ______________________

Phone (Home): _______________ (Work): _______________ Ext: _____ (Cell): ______________________

Address: ____
Street Apartment #

____
City State Zip Code

////////////////////////// EMPLOYMENT INFORMATION //////////////////////////

The following is for: ☐ Parent or guardian ☐ Other (relationship) _____________ * for person responsible for payment

Employer Name: ____________________________________ Occupation: ______________________

Address: ____
Street City, State Zip Code Phone

Fill out the below information only if you have Dental Insurance

////////////////////////////// INSURANCE INFORMATION //////////////////////////////

(Only if you have DENTAL insurance)

Primary Insurance Plan Name / Address: ____

____

Name of Insured (person): ________________________________ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _______________ ID #: ____________________ Group #: ____________________

Insured's Address: ____
Street City State Zip Code

Insured's Employer Name: ____

Address: ____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Child ☐ Spouse Other ____________________

(If you have secondary DENTAL insurance let us know)

HEALTH AND DENTAL HISTORY FORM

Rockingham Family Dentistry

Patient Name: ____

Have you ever had any of the following? Please check those that apply:

Allergies to:
- ☐ Dental Anesthetic
- ☐ Codeine Allergy
- ☐ Penicillin Allergy
- ☐ Allergy other med.

____

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- ☐ Seasonal Allergy
- ☐ Environmental Allergy
- ☐ Latex / rubber Allergy
- ☐ Other Allergy

____

____

- ☐ AIDS
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer / Tumors
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy / Seizure
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Headache / Migraine
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease

- ☐ Mental Health Care
- ☐ Anxiety Disorders
- ☐ Pacemaker
- ☐ Pregnancy
  Due date:__________
- ☐ Radiation Treatment
- ☐ Respiratory Problems
  Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
  Stroke
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ STD

Describe any :
Tobacco use -----
_________/ day or wk

Alcohol -----
_________/ day or wk

Soft Drinks -----
_________/ day or wk

Coffee / Tea ----
_________/ day or wk

Ounces of water -----
_________/ day or wk

Is your water fluoridated? (circle one)
Yes / No / Don't know

Is your diet medically supervised? (circle one)
Yes / No

Any unexplained change in weight? (circle one)
Yes / No

Dental Questions
How often do you brush your teeth? _______times / day _______times / week
How often do you floss your teeth ? _______times / day _______times / week _______times / month
Do your gums bleed when you brush or floss your teeth ? Yes / No
Are your teeth sensitive to: Hot / Cold / Sweet / Sour / Pressure / None (circle any)

Dental Questions
Are you especially anxious or fearful about dentistry? Yes / No
Do you have any jaw: pain / clicking / locking (circle any)
Have you had an injury to your head, neck or jaw ? Yes / No
Do you wear retainers, night guard or other appliance? Yes / No
Have you ever lost any teeth? Yes / No
Age of current partial or denture ___________
Any mouth odor or unpleasant taste? Yes / No
Have you ever had any: ☐ Periodontal Treatment ☐ Orthodontic Treatment ☐ Clenching / Grinding

Name of Physician: ______________________________________ Phone: ________________

Do you have any other health problems that you would like to talk to the Doctor about? ☐ Yes ☐ No

Have you been admitted to a hospital or needed Emergency care during the past two years? □ Yes □ No

If yes, please explain: ____

List all Medications you are presently taking including herbal medications, vitamins, etc.

____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature: ____ **Date:** __________________

CONSENT FOR SERVICES

I AUTHORIZE THE DENTIST TO RELEASE ALL MEDICAL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS AND I ASSIGN DIRECTLY TO DENTIST ALL INSURANCE BENEFITS FOR SERVICES RENDERED; I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE.

Signature: ____ **Date:** ____________________

Dental Office Rules & Policies

1. All patients who are over 18 years of age must show their picture ID.
2. If applicable, co-payments must be paid at time of visit.
3. All patients must show their current Dental Insurance Card.
4. Patients must have their current health information with all prescribed medications.
5. We accept cash, check, VISA, MasterCard, and Discover. Payment of your "estimated" portion is due at the time services are rendered, such as your annual deductible and/or percentage of the treatment not covered by insurance. We will contact your insurance in order to provide an "estimate" of your patient portion. However, despite this, we cannot guarantee the payment of insurance benefit nor can we provide 100% accuracy of this estimated amount since many factors are involved that determine the actual payment of benefits once submitted and processed by your insurance.
6. All dental services rendered, whether or not covered by insurance, are ultimately the financial responsibility of the account holder. We will give your insurance company 60 days to remit the payment. If there is still no payment after this time, you will be financially responsible for 100% of the outstanding insurance claim. A statement will be sent to you, and payment in full will be due on the due date printed on the statement. It is the responsibility of the account holder to follow up with their own insurance company regarding the non-payment of a claim. Should our office receive payment from your insurance after it has been paid by you, a prompt refund will be issued.

For All Appointments

1. It is your responsibility to remember your appointment time. However, we will remind you with a courtesy call.
2. If you must cancel, you must call at least 24 hours before your appointed time. Otherwise, a broken appointment note will be added to your record.
3. If you change your phone number, please call and provide our office with the new number.
4. Any broken appointment on a Saturday will result in not being able to see you for three-months on a Saturday.
5. There is a $30 charge for all returned checks
6. If you are going to be more than 10 minutes late, then please call and let us know.

Children

1. Children under 18 will not be seen unless accompanied by a parent/guardian.

I have read and understood the clinic's rules and policies and do hereby agree to all the above.

Signature:____ Date:_____________

Rockingham Family Dentistry

701 S. Van Buren Rd, Eden, NC 27288
Ph: 336-623-2221; Fax: 336-635-2221

NOTICE OF MATERIAL CHANGES TO OUR PRIVACY PRACTICES POLICY
EFFECTIVE: [SEPTEMBER 22, 2013]

BACKGROUND

The Health Insurance and Portability & Accountability Act of 1996 (HIPAA) gives individuals the right to be informed of their healthcare providers' privacy practices and the right to understand and control how their health information is used. Healthcare providers are required to develop and distribute a notice that provides a clear explanation of these rights and practices.
Our Practice has made material changes to our privacy practices, consistent with legal changes to HIPAA and the Health Information Technology for Economic and Clinical Health Act (HITECH). We will be providing all of our patients with our revised and updated Notice of Privacy Practices, and requesting a signed acknowledgment of receipt from each patient.

SUMMARY OF MATERIAL CHANGES TO OUR PRIVACY PRACTICES:

- We have added a statement to our Privacy Practices acknowledging that we may not use or disclose your protected health information for marketing purposes, including disclosures that constitute sales, without your authorization.
- We will be issuing new Patient Release of Records Authorization forms that allow patients to choose whether to allow or limit the Practice from disclosing their protected health information in certain ways, to include opting out of fundraising communications.
- If the Practice maintains a patient's psychotherapy notes, they will not be released unless you the patient signs an authorization or if otherwise required by law.
- Patients have the right to restrict the Practice from disclosing certain protected health information to health plan providers if the patient personally pays for their service in full.
- We have revised our internal privacy breach reporting practices to comply with 2013 changes in the HIPAA and HITECH privacy rules, and patients have a right to receive a notification of breaches of unsecured protected health information.
- Consistent with the Genetic Information Nondiscrimination Act (GINA), our Practice will not use or disclose any genetic information to insurance providers or others for underwriting purposes.

If you would like additional information regarding our privacy practices, or if you have questions or concerns, please contact us as indicated below.

Contact Officer: Sandy Davis

Address: 701 S. Van Buren Rd, Eden, NC 27288

Telephone: 336-623-2221 **Fax:** 336-635-2221 **Email:** contactus@familydentistry4u.com

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided a copy Rockingham Family Dentistry's Notice of Privacy Practices, which has an effective date of 09/22/2013, and which describes how my health information may be used and disclosed.

I understand that you have the right to change the Notice of Privacy Practices at any time, that I will be provided a copy of any updated version, and that I may contact you at any time to request a current Notice of Privacy Practices.

My signature below acknowledges that I have been provided with a copy of the Notice of Privacy Practices:

Patient Name (please print):____ **Date:** _______________

Signature:____

Relationship to Patient:____