HEALTH HISTORY & REGISTRATION

PATIENT INFORMATION

NAME: Last _____ First _____ Middle Initial _____

Sex: M F Birthdate _____ Age _____ Social Security # _____

RESIDENCE: Street _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ E-mail _____

Employer _____ Occupation _____ Number of years employed _____

If patient is a minor give Parent's or Guardian's name _____

Marital Status _____ Whom may we thank for referring you to our office _____

PERSON RESPONSIBLE FOR ACCOUNT IF OTHER THAN YOURSELF

NAME: Last _____ First _____ Middle Initial _____

RESIDENCE: Street _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Marital Status _____

Social Security # _____ Birthdate _____ Relation to the patient _____

Employer _____ Occupation _____ Number of years employed _____

RESPONSIBLE PARTY'S SPOUSE

Name _____ Home Phone _____

Social Security # _____ Birthdate _____ Cell Phone _____

Employer _____ Occupation _____

EMERGENCY INFORMATION: RELATIVE NOT LIVING WITH YOU.

Name _____ Relationship _____

Address _____ City, State _____

Home Phone _____ Cell Phone _____ Work Phone _____

DENTAL INSURANCE INFORMATION – PRIMARY COVERAGE

Insured's Name _____

Insurance Company _____ E-Mail _____

Insurance Company's Address _____

Insured's Employer _____

Insured's S.S. # _____ Group # _____ Local # _____

SECONDARY INSURANCE COVERAGE – If you have double dental coverage, complete this for the second carrier

Insured's Name _____

Insurance Company _____ E-Mail _____

Insurance Company's Address _____

Insured's Employer _____

Insured's S.S. # _____ Group # _____ Local # _____

DENTAL HISTORY

How long since you have seen a dentist?_____ Last COMPLETE dental exam. Date?_____

Last FULL MOUTH X-RAYS or PANOREX. Date?_____

Name of Previous Dentist:_____ City:_____ State:_____

Are you having dental problems now? If so, what are they? _____

Please circle the appropriate response to the following questions:

What is your present dental condition?	poor	fair	good	excellent
Do you wear dentures?			Yes	No
If so, are you unhappy with your dentures?			Yes	No
Would you like to know more about permanent replacements?			Yes	No
Have you had any periodontal (gum) treatments?			Yes	No
Do your gums bleed, or feel tender?			Yes	No
Have you worn braces on your teeth?			Yes	No
Would you like for your teeth to be whiter?			Yes	No
Would you like for your smile to look better?			Yes	No
Are you anxious about dental treatment?			Yes	No

If yes, rank your anxiety on a scale from #1 (no anxiety) to #10 (Uncontrollable fear)

1 2 3 4 5 6 7 8 9 10

Do you have loose teeth?	Yes	No
Are any of your fillings broken?	Yes	No
Do you have any areas where food collects between your teeth?	Yes	No
Do you have headaches, earaches, or neck pain?	Yes	No
Does your jaw ever pop?	Yes	No
Do you ever wake up with a sore jaw?	Yes	No
Are you grinding or clenching your teeth?	Yes	No
Have you noticed any sores or growths in your mouth?	Yes	No
Are your teeth sensitive?	Yes	No

If yes, to what? Hot Cold Sweets Biting

Please rank the following items in order in which they would keep you from having dental treatment (#1=most #4=least):

Fear of pain #_____ Lack of concern #_____ Cost of treatment #_____ Missing work time #_____

MEDICAL HISTORY

Are you under a PHYSICIANS CARE *NOW?* Yes No

If so, for what condition? _____

General Physician's Name:_____ City, State_____ Phone #:_____

List any major illnesses or operations:_____

Are you PREGNANT? Yes No Are you NURSING? Yes No

Has your medical doctor told you to premedicate before dental appointments? Yes No

Have you ever taken a bisphosphonate such as Fosamax, Boniva, or Actonel? Yes No

Please check all the following you have had or presently have:

Abnormal Bleeding ❑	Circulatory Problems ❑	Hepatitis ❑	Shingles ❑
Aids/HIV Positive ❑	Cortisone Treatments ❑	Herpes ❑	Shortness of Breath ❑
Anaphylaxis ❑	Cough (persistent) ❑	High Blood Pressure ❑	Skin Rash ❑
Anemia ❑	Cough up Blood ❑	Kidney Disease ❑	Spina Bifida ❑
Arthritis ❑	Diabetes ❑	Liver Disease ❑	Stroke ❑
Artificial Heart Valve ❑	Epilepsy ❑	Mitral Valve Prolapse ❑	Surgical Implant ❑
Artificial Joint ❑	Fainting ❑	Nervous Problems ❑	Swelling of Feet/Ankles ❑
Asthma ❑	Glaucoma ❑	Osteoporosis ❑	Thyroid Disease ❑
Allergy (i.e. latex, food) ❑	Headaches ❑	Pacemaker ❑	Tobacco Habit ❑
(list)_____	Heart Murmur ❑	Psychiatric Care ❑	Tonsillitis ❑
Blood Disease ❑	Heart Problems (list) ❑	Rapid weight gain/loss ❑	Tuberculosis ❑
Cancer ❑	_____	Respiratory Disease ❑	Ulcer/Colitis ❑
Chemical Dependency ❑	Heart Surgery ❑	Rheumatic Fever ❑	Venereal Disease ❑
Chemotherapy ❑	Hemophilia ❑	Scarlet Fever ❑	

List Any MEDICATIONS You Are CURRENTLY TAKING:

_____

_____

_____

List Any MEDICATIONS You Are ALLERGIC TO:_____

_____

_____

_____

Is there any other Medical or Dental information that you feel we should know about?_____

_____

Signature: _____ **Date:** _____

Sean M. Hamilton, D.D.S., P.L.L.C.
1506-A Wayne Memorial Drive
Goldsboro, NC 27534

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.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper , or orally, are kept properly confidential. This act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health Information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include teeth cleaning services.

- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

- Health care operations include the business aspect of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost- management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individual identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that request, except to the extent that we have already taken action relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to re move it.

- The right to reasonably request to receive confidential communications of protected health information from us by alternative means or at alternative locations.

- The right to inspect and copy your protected health information.

- The right to amend your protected health information.

- The right to receive an accounting of disclosures of protected health information.

- The right to obtain and we have the obligation to provide to you a paper copy of this notice from us at your first service delivery date.

- The right to provide and we are obligated to receive a written acknowledgement that you have received a copy of our Notice of Privacy Practices.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14, 2003 and we are required abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

Sean M. Hamilton
1506-A Wayne Memorial Drive
Goldsboro, NC 27534
919-731-4447

For more information about HIPAA
or to file a complaint:

The U.S. Department of Health & Human services
Office of Civil Rights
200 Independence avenue, S.W.
Washington, D.C. 20201
202-619-0257
toll free: 1-877-696-6775

Sean M. Hamilton, D.D.S., P.L.L.C.
1506-A Wayne Memorial Drive
Goldsboro, NC 27534

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

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 or indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. 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 above 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 health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____ Date: _____

Relationship to patient: _____

Signature: _____

Office use only

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date	initials	Reason

Authorization for Release of Information

Name of Patient _____ Date of Birth _____

Hamilton Dental Staff 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.
❑ Voice Mail	❑ Results of lab tests/x-rays Other_____
❑ Spouse (provide name & phone number) _____	❑ Financial ❑ Medical as follows:_____ _____
❑ Parent (provide name & phone number) _____	❑ Financial ❑ Medical as follows:_____ _____
❑ Other (provide name & phone number _____	❑ Financial ❑ Medical as follows _____ _____

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)

_____

Revised January 2010