Third Creek Dentistry

Third Creek DENTISTRY

Patient (Mr. Mrs. Ms. Dr.) _____
Last First Middle Nickname

☐ Male ☐ Female

Mailing _____ Street _____
City _____ State _____ Zip _____
Home # _____ Work # _____ Ext. _____
Date of Birth _____ Cell # _____
Social Security Number _____ Employer _____
Email _____ ☐ Have you ever been a patient of our practice? ☐ Yes ☐ No

Which phone # is better to reach you during the day? ☐ Home ☐ Work ☐ Cellular

Marital Status? ☐ Married ☐ Divorced ☐ Legally Separated ☐ Widowed ☐ Single

Who will be responsible for your account? ☐ Self (Same as above) ☐ Spouse ☐ Father ☐ Mother

Name _____
Last First Middle Nickname
Mailing _____ Street _____
City _____ State _____ Zip _____
Home # _____ Work # _____ Ext. _____
Cell # _____ Employer _____
Social Security Number _____ Date of Birth _____

Whom may we thank for referring you to our office?
_____
Dentist _____
Medical Doctor _____

Emergency contact:
Name _____
Address _____
Phone # _____ Relation _____

Mission Statement

Our team is dedicated to providing you with the highest quality dental care. We strive to give you a gentle and caring experience in a professional manner.

MEDICAL HISTORY

NAME: _____ DATE OF BIRTH: _____ AGE: _____

Have you ever had or do you have (Please circle Yes or No)

Diabetes	Yes	No
Seizures, last episode_____	Yes	No
Hepatitis	Yes	No
HIV/AIDS	Yes	No
Hemophilia	Yes	No
Cancer, type_____	Yes	No
Stomach Ulcer	Yes	No
High blood pressure	Yes	No
Radiation therapy, year_____	Yes	No
Chemotherapy, year_____	Yes	No
Tuberculosis	Yes	No
Sinus problems	Yes	No
Asthma active	Yes	No

Reflux/GERD	Yes	No
Prosthetic heart valve	Yes	No
History of endocarditis	Yes	No
Joint replacement, date_____	Yes	No
Heart attack, date_____	Yes	No
Pacemaker	Yes	No
Stroke	Yes	No

Has a medical doctor advised taking antibiotics prior to dental treatment due to concerns for your heart or replacement joint? Yes No

If so, explain_____

Are you allergic to or have had a reaction to (Please circle Yes or No)

Penicillin(ie. Amoxicillin)	Yes	No
Aspirin	Yes	No
Codeine	Yes	No
Erythromycin	Yes	No
Dental numbing/local anesthetic	Yes	No

Latex	Yes	No
Milk	Yes	No
Sulfa drugs	Yes	No
Other Drugs:	Yes	No

what? _____

Medical doctor's name _____ City _____ Phone #_____

Name of preferred pharmacy_____ City_____ Phone #_____

Are you taking aspirin every day?..... Yes No

Are you taking any drugs or medications? ..... Yes No

What? _____ for what? _____

What? _____ for what? _____

What? _____ for what? _____

What? _____ for what? _____

Do you have any disease, condition, or problem not listed above that you think I should know about? Yes No

If so, explain _____

Women:

Are you pregnant or nursing? ..... Yes No

Are you taking birth control pills? ..... Yes No

DENTAL HISTORY

Why are you seeking dental care at this time? _____

Are you having dental pain? _____

Have you had a dental examination in the last 2 years? _____

Were x-rays taken during your last dental examination? _____

Have you had any serious trouble with any previous dental treatment? _____

If so, explain _____

Do you use tobacco products? Yes No What? _____

_____ Date _____

Signature of person completing medical history

Primary Dental Insurance Company

Subscriber Name_____

Subscriber Employer _____

Insurance Company Name _____

Subscriber ID # _____ Group # _____

Subscriber Date of Birth _____ Relation_____

I attest that this is the only insurance policy I am aware of. This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize and direct payment of any benefit otherwise payable to me directly to the treating physician or practice.

Signature _____Date_____

New Patients!!! How did you find us?

Please help us know where our advertising has worked the best. Indicate by checking the line next to the place where you found out about us. If you saw an ad or were referred by another physician or current patient, please fill in the blank next to that option telling us the name of the specific patient or doctor. Thanks for your assistance!

_____ Website
_____ Flyer/Brochure
_____ Phonebook
_____ Coffee News

_____ Newspaper, if so which one? _____
_____ Current patient, if so who? _____
_____ Doctor, if so who? _____
_____ Billboard

Financial Policy

This is an agreement between Third Creek Dentistry and the Patient named on this form.

By executing this agreement, you are agreeing to pay for all services that are received.

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, and new charges to the account, the finance charge, if any, and any payments or credits applied to your account during the month.

Payment Options: We accept cash, checks, money orders, care credit and most major credit cards.

Payments: Unless we approve other arrangements in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid by the end of the month.

Charges to Account: We shall have the right to cancel your privilege to make charges against your account at any time. Future visits would then need to be paid at the time of service.

Patient's name: _____

Responsible party (if not the patient) _____

Signature: _____Date: _____

Co-Signature: _____Date: _____

Contracted and Non-Contracted Insurance: Insurance is a contract between you and your insurance company. We are NOT a party to this contract, in most cases. We will bill your primary insurance company as a **courtesy** to you. Although we may **estimate** what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by your insurance. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower payment from the insurance company.

Finance Charge: A finance charge will be imposed on each item to your account, which has not been paid within (90) days of the time the item was added to the account. The finance charge will be computed at the rate of 1.5% per month or an annual percentage rate of 18%.

Credit History: If your account becomes delinquent, we have the option to report your account status to any credit reporting agency such as the credit bureau. Efforts will be made to collect the unpaid balance, before reporting to the credit bureau.

Third Creek Dental

Acknowledgement of Receipt Of Notice of Privacy Practices

Patient Name & Address: _____

_____

_____

I have received a copy of the Notice of Privacy Practices for the above named practice.

_____ _____

Signature Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- ☐ An emergency existed & a signature was not possible at the time.
- ☐ The individual refused to sign.
- ☐ A copy was mailed with a request for a signature by return mail.
- ☐ Unable to communicate with the patient for the following reason:

  _____
- ☐ Other: _____

  _____

Prepared By _____

Signature _____

Date _____

Third Creek Dentistry
Authorization for Release of Information – Compound Release

Name of Patient _____ Date of Birth _____

Third Creek Dentistry is authorized to release protected health information about the above-named patient in the following manner and/or to selected persons.

Check each person/entity approved to receive information.	Check type of information that can be given to person/entity on the left in the same section.
☐ Voice Mail	☐ Appointment Reminders
☐ Other person (s) (provide name and phone number)(i.e. Spouse, Stepparent, Grandparent, Relative, Friend, Parent etc.) 1)_____ 2)_____ 3)_____	☐ Financial ☐ Treatment
☐ Email communication-Provide email address* _____ *For email communication to occur, please accept the disclosure below:	☐ Financial ☐ Treatment ☐ Appointment reminders ☐ Breach notification
☐ Text communication – Provide number * _____ *For text communication to occur, accept the disclosure below:	☐ Appointment reminder ☐ 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.	
☐ Photo of patient received by patient or legal guardian ☐ Photo taken by staff (Example: pre/post procedure)	☐ May be posted in office ☐ May be posted on website ☐ May be posted on social media

Patient Rights:

- I have the right to revoke this authorization at any time by contacting our office.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- 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 have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization will remain in effect until revoked by the patient.

_____ Date _____

Signature of Patient or Personal Representative

*Description of Personal Representative's Authority (attach necessary documentation)

Revised Jan 2018

THIRD CREEK DENTISTRY

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED BY Third Creek Dentistry AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

YOUR RIGHTS: When it comes to your health information you have certain rights. This section explains your rights.

Upon written request:

- Ask to see or get an electronic or a paper copy of your health record or other information we have about you. We will also provide a summary of your health information if requested. We will charge a reasonable, cost based fee. We will provide this information as soon as possible but no later than 30 working days of the request.
- Ask us to correct your health information you think is incorrect or incomplete. We may say "no" but will tell you why in writing within 60 days.
- You can ask us to communicate with you in a certain way (for example, home or office phone) or to send mail to a different address. We will accommodate all reasonable requests.
- Ask us not to use or share certain health information for treatment, payment or our operations. We are not required to agree with your request and may say "no" if it would affect your care.
- If you pay for a service or health care item out of pocket in full and you ask us not to share that information for payment or our operations with your health insurer we will agree unless we are required by law to share that information.
- Ask us for a list or an accounting of the times we have shared your health information for reasons other than treatment, payment, healthcare operations, and when you have asked us to share information. We will provide a list for the past six years for the request. One request per year will be provided free of charge. For additional requests we will charge a reasonable, cost based fee.
- Revoke an authorization to use or disclose PHI at any time except where action has already been taken.

You may also:

- Choose someone to act on your behalf. If you have given someone medical power of attorney or they are your legal guardian, that person can exercise your rights and make choices about your health information. We will ask for proof of this relationship before we take any action.
- Ask for a paper copy of this document even if you have agreed to receive the notice electronically. We will provide that copy promptly.
- File a complaint. If you feel your rights have been violated you may contact the designated Privacy Officer, Jennifer Pennington 11707 Statesville Blvd. Cleveland, NC 27013 704-278-1118 thirdcreekdental@gmail.com
- File a complaint with the US Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Ave, S.W., Washington, D.C. 20201, calling 1.877.696.6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints.
- We will not retaliate for filing a complaint.

OUR RESPONSIBILITIES: The law requires us to:

- Maintain the privacy and security of your protected health information.
- Notify you promptly if a breach occurs that may compromise the privacy or security of your information.
- Follow the duties and privacy practices described in this notice and give you a copy of it.
- Not to use or share you information other what is described in this notice unless you tell us we can in writing. If you tell us we can and then change your mind, just let us know in writing you have changed your mind.

(OVER)

Third Creek Dental
11707 Statesville Blvd.
Cleveland, NC 27013
704-278-1118(P) 704-278-4480(F)

YOUR CHOICES - For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in situations described below, talk to us.

- In these cases you have both the right and the choice to tell us to: share information with your family, close friends, or others involved in your care and share information in a disaster relief situation.

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

- In these cases we never share your information unless you give us written permission:
  - Marketing purposes
  - Sale of your information
  - Most sharing of psychotherapy notes
  - In the case of fundraising, we may contact you for fundraising efforts, but you can tell us not to contact you again.

OUR USES AND DISCLOSURE – We typically use or share your health information in the following ways:

Treatment: We can use your health information and share it with other professionals who are treating you. Example: we may share your health information to an outside doctor for referral. We will also provide your health care providers with copies of various reports to assist them in your treatment.

Payment: We can use or share your health information to bill and get payment from health plans or other entities. Example: we give information about you to your health insurance plan so it will pay for your healthcare.

Health Care Operations: We can use and share your health information to run our practice, improve your care, and contact you when necessary. Example: we use health information about you to manage your treatment and services.

Other ways we can use or share your health information – We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

- **Help with public health and safety issues:** We can share health information about you for certain situations such as: preventing disease, helping with product recalls, reporting adverse reactions to medication, reporting suspected abuse, neglect, or domestic violence, and preventing or reducing a serious threat to anyone's health and safety.
- **Comply with the law**: We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see if we are complying with federal privacy law.
- **Respond to organ and tissue donation requests:** We will share health information about you with organ procurement organizations.
- **Work with a medical examiner or funeral director:** We can share health information with a coroner, medical examiner, or funeral director when you die.
- **Address workers' compensation, law enforcement, and other government requests:**
  - For workers' compensation claims
  - For law enforcement purposes or with a law enforcement official
  - With health oversight agencies for activities authorized by law
  - For special government functions such as military, national security, and presidential protective services
- **Respond to lawsuits and legal actions:** We can share your health information to respond to a court or administrative order, or in response to a subpoena.
- **Research:** We can use or share your information for health research.

CHANGES TO THIS NOTICE - We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office and on our website.

Jennifer Pennington
thirdcreekdental@gmail.com
704-278-1118

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Cleveland, NC 27013
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