

PATIENT REGISTRATION AND HEALTH HISTORY

PERSONAL INFORMATION (all information is kept strictly CONFIDENTIAL):

FULL NAME: _____ BIRTHDATE _____

ADDRESS: street _____

city _____ state _____ zip code _____

TEL. HOME _____ WORK _____ CELL _____

EMAIL ADDRESS _____ Prefer vs. phone calls? Yes ___ No ___

EMPLOYER _____ SOCIAL SECURITY # of patient _____

INSURANCE CARRIER _____ GROUP# _____

NAME OF INSURED _____ Relationship to patient _____ Date of Birth of insured _____

I.D. AND OR SS# OF INSURED _____

PARENT/GUARDIAN NAME (if minor) _____

NAME OF SPOUSE _____ BIRTHDATE _____

SECONDARY CARRIER _____ GROUP # _____

EMPLOYER _____ ID # _____

WHOM MAY WE CONTACT IN CASE OF EMERGENCY? (Name and number) _____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

DENTAL HISTORY Date of your last dental visit _____

What concerns you most about your dental health? _____

Are you having pain at this time?	Y	N
Have you noticed any loosening of your teeth?	Y	N
Does food tend to become caught between your teeth?	Y	N
Do you suffer from pain and/or swelling of your gums?	Y	N
Do your gums often bleed when you brush your teeth?	Y	N
Do you floss?	Y	N
Problems of the jaw. Have you experienced:		
Clicking of the jaw?	Y	N
Pain (joint, ear, side of face)?	Y	N
Difficulty in opening or closing?	Y	N
Difficulty in chewing?	Y	N
Habits. Do you:		
Clench or grind your teeth?	Y	N
Bite your lips or cheeks regularly?	Y	N
Mouth breathe?	Y	N
Is it important for you to keep your teeth?	Y	N
Are you satisfied with the appearance of your teeth?	Y	N

If not, what would you change? _____

MEDICAL HISTORY

Name _____

PHYSICIAN NAME : _____ PHYSICIAN PHONE # : _____

- 1. Are you in good health? YES NO
- 2. Have you ever had an operation or serious illness requiring hospitalization? YES NO
- 3. Are you now under the care of a physician for any ongoing treatment/therapy? YES NO

If yes for what? _____

- 4. My last physical exam was on : _____
- 5. Are you now taking any medicine, drugs, or pills? YES NO

Please List _____

- 6. Do you have any ALLERGIES (Including medications)? YES NO

If yes to what? _____

- 7. Do you have or have you had any of the following diseases or problems? (Please circle Y or N)

Heart Disease	Y N	Hives or Skin Rash	Y N	Ulcers	Y N
Artificial Heart Valve	Y N	Kidney Trouble	Y N	Arthritis	Y N
High Blood Pressure	Y N	Hepatitis	Y N	Rheumatic Fever	Y N
Heart Murmur	Y N	Jaundice	Y N	Cancer	Y N
Lung Disease	Y N	Liver Disease	Y N	HIV+/AIDS	Y N
Drug/Alcohol Addiction	Y N	Hemophilia	Y N	Mental/Nervous Disorder	Y N
Epilepsy	Y N	Diabetes	Y N	Tuberculosis	Y N
Are you a Smoker	Y N	Use Smokeless Tobacco	Y N	Emphysema	Y N

- 8. Do you have any blood disorders or do you bleed excessively? YES NO
- 9. Have you ever had an injury, surgery, or x-ray therapy to face or jaws? YES NO

If yes, please explain _____

- 10. Do you have a tendency to faint? YES NO
- 11. Do you have frequent severe headaches? YES NO
- 12. Do you have a prosthetic implant? (i.e. Knee or Hip) YES NO

If yes, please specify _____

- 13. WOMEN ONLY - Are you pregnant? (Which month? _____) YES NO
- Are you taking birth control pills? YES NO

- 14. Do you have any disease, condition or problem not listed above that you think the Dentist should know about? YES NO

If yes, please explain:

PATIENT / PARENT SIGNATURE _____ DATE _____

Andrew R. Oblinger, DDS, PA

OFFICE POLICIES

SCHEDULING

We recognize the value of everyone's time! Our office does not "double book" appointment times. The time scheduled is YOUR time.

Our primary goal is excellent dental care! We value our patients and treat them as individuals. Our top priority is the delivery of individualized state-of-the-art dentistry. Because of this and the nature of health care, unforeseen circumstances can arise resulting in appointments taking longer than scheduled. Although we make every effort to run on schedule, unfortunately there may be times when your appointment is delayed.

A 24 HOUR NOTICE IS REQUIRED FOR ANY CANCELLATION. This is required because we have other patients who could be seen during this treatment time. Failure to give 24 HOUR notice may result in a \$30.00 charge. Please arrive FIVE minutes prior to your appointment time to take care of any administrative needs. Late arrivals (greater than 10 minutes) may result in rescheduling. It is unfair for an on-time patient to have to wait because an earlier patient ran late.

INSURANCE

Payment is expected at the time of service. As a courtesy to our patients, we will make every attempt to file your insurance. We require that you pay the estimated portion your insurance is not expected to pay. Remember that these are only estimates; charges not covered by the insurance are the responsibility of the patient. While we make every effort to keep you abreast of insurance maximums, this record keeping is ultimately the responsibility of the patient.

I HAVE READ AND UNDERSTAND THE ABOVE POLICIES:

Name _____ Date _____

INSURANCE ASSIGNMENT OF BENEFITS

Dr. Oblinger agrees to accept your assignment of benefits if you have insurance, meaning that we will have your insurance company send the insurance payment to us, and we will only have you pay what your estimated portion is at the time of service. After insurance pays, if ANY portion of your bill is left, you will be billed for the balance. Of course, if the insurance pays more than we estimated, then you will be sent a refund. In order for us to accept your assignment of benefits, you must sign below. If you would not like to assign Dr. Oblinger benefits, you will be asked to pay all charges up front and the insurance company will reimburse you. This assignment of benefits does not apply if you have a reimbursement plan or if your insurance company will not accept our assignment of benefits (i.e. Delta Dental).

I WOULD LIKE TO ASSIGN MY INSURANCE BENEFITS TO DR. OBLINGER:

Name _____ Date _____

PRIVACY PRACTICES

I HAVE RECEIVED A COPY OF THIS OFFICE'S NOTICE OF PRIVACY PRACTICES.

Name _____ 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.
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 (02/14/03), 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. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available 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.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

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

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may 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, your 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 uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. 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.

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

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

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. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

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 of protected health information of inmate or patient under certain circumstances.

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

PATIENT RIGHTS Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you \$0.10 for each page, \$10.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. 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 these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

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.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

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 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.

Contact Officer: Robin Bridgeman or Andra Rushing

Telephone: 704-827-0206

Fax: 704-827-6964

E-mail: robin.bridgeman@droadfamilydentist.com or andra.rushing@droadfamilydentist.com

Address: 247 West Catawba Ave. Mt. Holly, NC 28120

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