PATIENT RECORD

Name: _____
Last First Initial

Date of Birth: ____/____/____ Married: YES NO

Mailing Address:_____

City: _____ State: _____ Zip:_____

Home Phone: _____ Cell: _____

Email address: _____

Preferred contact method (Circle): Phone / Text / EMail

Do you have dental insurance? YES NO If so, please list:

Employer/Group name: _____
Please present us with your insurance card and photo ID

SSN#: _____ Member ID#:_____

Emergency Contact: _____

Who referred you? _____

DENTAL INFORMATION

When was your last dental visit? _____

What was done? _____

Any problem/complaint at this time? _____

How long has it been a problem? _____

Do your gums bleed while brushing or flossing?	YES	NO
Are your teeth hot/cold sensitive to liquids or foods?	YES	NO
Do you have any sore/lumps in/near your mouth?	YES	NO
Have you had any head, neck or jaw injuries?	YES	NO
Have you ever experienced any of the following:		
Clicking of the jaw	YES	NO
Pain (jaw, ear, side of face)	YES	NO
Difficulty opening/closing jaw	YES	NO
Do you have frequent headaches?	YES	NO
Do you clench or grind your teeth?	YES	NO
Do you bite your lips/cheeks frequently?	YES	NO
Have you had prolonged bleeding after extractions?	YES	NO
Have you ever had any orthodontic treatment?	YES	NO
Do you wear dentures/partials? Date placed	YES	NO
Do you like your smile?		
Do you want a whiter smile? YES NO		
Have you had any cavities with the past 2 years?	YES	NO
Do you have an unpleasant taste/odor in your mouth?	YES	NO
Do you have dry mouth often?	YES	NO
Have you ever worn a bite appliance (Nightguard)?	YES	NO
Do you wear a CPAP?	YES	NO

MEDICAL INFORMATION

Physician: _____ Phone: _____

Are you under medical treatment now? _____

Please list any medications you are currently taking:

_____

_____

Are you **allergic** to any medications/metals/latex? YES NO
List:_____

Have you been hospitalized in the last 5 years? YES NO

Why? _____

Have you ever taken Fosamax, Boniva, Actenol or any other medications for bone density disorders?	YES	NO
Do you use tobacco?	YES	NO
Do you use controlled substances?	YES	NO
Women only: Are you pregnant?	YES	NO
Are you nursing?	YES	NO

Are you required to premedicate with antibiotics before any dental treatment?	YES	NO
Do you have any history or are you currently being treated for any of the following:		
Digestive conditions	YES	NO
Heart or circulatory conditions	YES	NO
Neurological conditions	YES	NO
Lung or breathing conditions	YES	NO
Autoimmune disorders	YES	NO

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING:

Diabetes	YES	NO
Anemia	YES	NO
Joint Replacement	YES	NO
Angina	YES	NO
Kidney Disease	YES	NO
Cancer	YES	NO
Tuberculosis/Measles/Chicken Pox	YES	NO
Respiratory Problems/Shortness of Breath	YES	NO
AIDS/HIV	YES	NO
Radiation Therapy	YES	NO
Liver Disease	YES	NO
Head/Neck Injuries	YES	NO
Thyroid Disorders	YES	NO
Osteoporosis	YES	NO
Heart Disease	YES	NO
Tumor/Abnormal Growth	YES	NO

Is there anything else we should know about your health that we have not covered?_____

RELEASE:
I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. If I am here on an emergency basis, I understand that this examination will address only my immediate problem or emergency and should not be confirmed as a complete examination with resulting treatment.

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dentist.
I understand that my dental insurance carrier of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts.

PATIENT OR GUARDIAN SIGNATURE

_____**DATE:**_____

Authorization to Release Health Information

Expires upon one time release

Patient Information:

Patient Name: _____ Date of Birth: _____

Address: _____

City, State, Zip: _____

I authorize the dental practice below to release my health information:

_____

_____

_____

Please forward copies of my x-rays and health information to:

Mills River Family Dental

Michael Stohl, DMD / Brian Pearce, DMD / Matthew Mayer, DDS / Nicole Dolezar, DMD/ Kyle Nunez. DDS

3340 Boylston Highway Ste 30

Mills River, NC 28759

Email: office.mrfd@gmail.com Fax: 828-891-6002

Please provide the information listed below at the request of the patient:

This authorization shall be in effect until the information has been forwarded as requested.

Patient Information

I understand that my treatment will not be conditioned on signing this authorization and that I have the right to refuse to sign this authorization. I understand that information 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 revoke this authorization by sending a written notification to the address below and that a revocation is not effective if the information has already been disclosed but will be effective going forward.

I understand that I have the right to inspect or copy the protected health information as described in this document. I can do this by written notification to Mills River Family Dental, 3340 Boylston Highway, Mills River, NC 28759

.

_____ _____

Signature of Patient or Personal Representative Date

Appointment Agreement

We make every effort to value your time and we schedule your appointment time just for you.

We truly appreciate your courtesy of giving us a 48-hour notice if you have a conflict with your appointment and need to schedule a different day or time. We are committed to your oral health and keeping your scheduled appointments allows us to be partners in your dental care. If you need to cancel your appointment less than 48-hours before your scheduled appointment time, you will be charged $25.

We ask that your new patient paperwork be completed no later than ONE WEEK prior to your appointment. This allows us time to request any previous records, verify insurance and communicate important information prior to your appointment.

It is our philosophy to continue to put our patients first and make your experience a positive one. Thank you for allowing us to share our appointment policy with you. Please let us know if you have any questions.

Appointment Agreement

- I acknowledge an appointment is a reservation.
- I agree to provide a minimum of 48-hour notice if I need to change my appointment for any reason.
- If I cancel my appointment with less than a 48-hour notice, I acknowledge I will be charged $25
- I understand if my new patient paperwork is not complete at least one week prior to my first visit, my appointment may be canceled and will be rescheduled upon completion.

Patient Signature: _____

Date: _____

mills river family
DENTAL

Notice to All Self-Pay Patients

Payment is expected at the time of service. If you are unable to pay for today's services, please let our office staff know before your appointment. Prompt payments help us to keep dental fees more reasonable.

Notice to All Patients with Insurance

Your insurance is a contract between you and your insurance carrier. As such, you are responsible for any amounts that they refuse to pay, as well as your deductible and percentage of payment that is not covered by your insurance carrier. You are expected to pay your part of the payment at the time that services are rendered. If you do not have the funds today to pay your part of your scheduled dental services, please let the front office staff know and arrangements will be made for another appointment.

Patient 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.

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We must follow the privacy practices as described below. This Notice will take effect on 1/1/2013 and will remain in effect until it is amended or replaced by us.

It is our right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer, Christy Wright. Information on contacting us can be found at the end of this Notice.

TYPICAL USES AND DISCLOSURES OF HEALTH INFORMATION

We will keep your health information confidential, using it only for the following purposes:

Treatment: We may use your health information to provide you with our professional services. We have established "minimum necessary or need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

Disclosure: We may disclose and/or share your healthcare information with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so.

Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.

Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible, we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated, we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers and individuals performing similar activities.

Required by Law: We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.) We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

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. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders, including, but not limited to, voicemail messages, postcards or letters.

YOUR PRIVACY RIGHTS AS OUR PATIENT

Access: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian.) There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the Request Form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. Copies, if requested, will have a charge of $25 to cover the time required to locate and copy your health information. If you want the copies mailed to you, postage will also be charged. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our Privacy Officer for a fee and/or for an explanation of our fee structure.

Amendment: You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Non-routine Disclosures: You have the right to receive a list of non-routine disclosures we have made of your health care information. (When we make a routine disclosure of your information to a professional for treatment and/or payment purposes, we do not keep a record of routine disclosures: therefore, these are not available.) You have the right to a list of instances in which we, or our business associates, disclosed information for reasons *other than* treatment, payment or healthcare operations. You can request non-routine disclosures going back 6 years starting on April 14, 2003. Information prior to that date would not have to be released. *(Example: If you request information on May 15, 2004, the disclosure period would start on April 14, 2003 up to May 15, 2004. Disclosures prior to April 14, 2003 do not have to be made available.)*

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We do not have to agree to these additional restrictions, but if we do, we will abide by our agreement. (Except in emergencies.) Please contact our Privacy Officer if you want to further restrict access to your health care information. This request must be submitted in writing.

QUESTIONS AND COMPLAINTS

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can express to us in writing. Request a Complaint Form from our Privacy Officer. We support your right to the privacy of your information and 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.

HOW TO CONTACT US

Practice Name: Mills River Family Dental

Privacy Officer: Christy Wright

Telephone: (828) 891-7999

Fax: (828) 891-6002

Address: 3340 Boylston Highway Ste 30, Mills River, NC 28759

Acknowledgement of Receipt of Notice of Privacy Practices

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

_____

Please print your name here

_____

Signature Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation, it was not possible to obtain an acknowledgement.
- ☐ We weren't able to communicate with the patient.
- ☐ Other (Please provide specific details)

_____

_____

_____

_____ _____

Employee signature Date

Authorization for Release of Information

Name of Patient _____ Date of Birth _____

Mills River Family Dental 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/xrays Other _____
Spouse	Financial Medical as follows: _____
Parent (provide name) _____	Financial Medical as follows: _____
Other (provide name) _____ _____	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 October 2007

Photograph & Video Release Form

(Voluntary)

I, _____, hereby grant Mills River Family Dental permission to the rights of my image, likeness and sound of my voice as recorded on audio or videotape without payment or any other consideration. I understand that my image may be edited, copied, exhibited, published or distributed and I waive the right to inspect or approve the finished product wherein my likeness appears. Additionally, I waive any right to royalties or other compensation arising or related to the use of my image or recording. I also understand that this material may be used in diverse educational settings within an unrestricted geographic area.

Photographic, audio or video recordings may be used for the following purposes:

- Conference presentations
- Educational presentations or courses
- Informational purposes
- Online educational courses
- Educational videos
- Advertisement or marketing

By signing this release, I understand this permission signifies that photographic or video recording of me may be electronically displayed via the Internet or in the public educational setting.

I will be consulted about the use of the photographs and/or video recordings for any purpose other than those listed above.

There is no time limit on the validity of this release, nor is there any geographic limitation on where these materials may be distributed.

This release applies to photographic, audio or video recordings collected as part of the sessions listed on this document only.

By signing this form, I acknowledge that I have completely read and fully understand the above release and agree to be bound thereby. I hereby release any and all claims against any person or organization utilizing this material for educational purposes.

Full Name _____

Mailing Address _____

City/State/Zip _____

Phone _____ Email _____

Signature _____ Date _____

If this release is obtained from a presenter under the age of 19, then the signature of that presenters' parent or legal guardian is also required.

Parent/Guardian Signature _____ Date _____