DAVID J. ADAMS, DMD, MS, PA

Periodontics & Implant Dentistry

PATIENT REGISTRATION

Patient Information

Patient's Name _____ Preferred Name _____
First Middle Last

Address _____
Street City State Zip

Home Phone _____ Work Phone _____ Cell Phone _____

Gender: ☐ Male ☐ Female

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birthdate _____ SS # _____ DL # _____

Email address _____ ☐ I would like to receive correspondences via email

Responsible party (If someone other than the patient) _____

General Dentist _____ Phone _____

Medical Doctor(s) _____ Phone _____

Pharmacy Name _____ Phone _____

Dental Insurance Information

Are you covered by dental insurance? ☐ No ☐ Yes – please provide the insurance card for our records

Name of Insured _____ Insured Birthdate _____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other Insured SS # _____

Insured's Employer _____ Employer Phone _____

Employer Address _____

Dental Insurance Company _____ Group # _____

Do you have secondary insurance? ☐ No ☐ Yes – please provide the insurance card for our records

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Please answer the following questions as thoughtfully and thoroughly as possible.

If yes, please explain:

☐ Yes ☐ No Are you under a physician's care now? _____
☐ Yes ☐ No Have you ever been hospitalized or had a major operation? _____
☐ Yes ☐ No Have you ever had a serious head or neck injury? _____
☐ Yes ☐ No Are you taking any medications, pills, or drugs? _____
☐ Yes ☐ No Do you take daily aspirin? _____
☐ Yes ☐ No Do you take Coumadin or Plavix? _____
☐ Yes ☐ No Do you take vitamins/supplements/herbals? _____
☐ Yes ☐ No Have you ever taken Fosamax / Boniva / Actonel / Didronel? _____
☐ Yes ☐ No Do you take, or have you taken, Phen-Fen or Redux? _____
☐ Yes ☐ No Are you on a special diet? _____
☐ Yes ☐ No Do you use tobacco? _____
☐ Yes ☐ No Do you use controlled substances? _____
☐ Yes ☐ No Do you have osteoporosis or osteopenia? _____

Women:

☐ Yes ☐ No Are you pregnant / trying to get pregnant?
☐ Yes ☐ No Are you nursing?
☐ Yes ☐ No Are you taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics
☐ Sulfa drugs ☐ Other: _____

Please describe reaction to each allergy: _____

If no allergies, then check here: ☐ No Known Allergies

Do you have or have you ever had, any of the following?

☐ AIDS/HIV positive	☐ Chest pains	☐ Frequent headaches	☐ Irregular heartbeat	☐ Scarlet fever
☐ Alzheimer's disease	☐ Cold sores/fever blisters	☐ Genital herpes	☐ Kidney problems	☐ Shingles
☐ Anaphylaxis	☐ Congenital heart disorder	☐ Glaucoma	☐ Leukemia	☐ Sickle cell disease
☐ Anemia	☐ Convulsions	☐ Hay fever	☐ Liver disease	☐ Sinus trouble
☐ Angina	☐ Cortisone medicine	☐ Heart attack/failure	☐ Low blood pressure	☐ Spina bifida
☐ Arthritis/gout	☐ Diabetes	☐ Heart murmur	☐ Lung disease	☐ Stomach/Intest. disease
☐ Artificial heart valve	☐ Drug addiction	☐ Heart pace maker	☐ Mitral valve prolapse	☐ Stroke
☐ Artificial joint	☐ Easily winded	☐ Heart trouble/disease	☐ Pain in jaw joints	☐ Swelling of limbs
☐ Asthma	☐ Emphysema	☐ Hemophilia	☐ Parathyroid disease	☐ Thyroid disease
☐ Blood disease	☐ Epilepsy or seizures	☐ Hepatitis A	☐ Psychiatric care	☐ Tonsillitis
☐ Blood transfusion	☐ Excessive bleeding	☐ Hepatitis B or C	☐ Radiation treatments	☐ Tuberculosis
☐ Breathing problems	☐ Excessive thirst	☐ Herpes	☐ Recent weight loss	☐ Tumors or growths
☐ Bruise easily	☐ Fainting spells/dizziness	☐ High blood pressure	☐ Renal dialysis	☐ Ulcers
☐ Cancer	☐ Frequent cough	☐ Hives or rash	☐ Rheumatic fever	☐ Venereal disease
☐ Chemotherapy	☐ Frequent diarrhea	☐ Hypoglycemia	☐ Rheumatism	☐ Yellow jaundice

Have you ever had any serious illness or symptom not listed above? ☐ Yes ☐ No If yes, please explain:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN _____ DATE _____

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Financial Policy

It is the policy of this office that all fees are payable at the time of service. We accept cash, personal single party checks, Mastercard, Visa, American Express & Discover.

As a courtesy to you, if you have dental insurance, we will provide a printed claim form so that you may file the claim with your insurance company. You will be expected to pay in full at the time of service and your insurance company will send any reimbursement directly to you. It is your responsibility to check on claims; however, we will assist you with any information requested by your insurance carrier. Remember, your insurance policy is an agreement between you and your insurance company. We are only a third party to this agreement. No insurance company attempts to cover all dental costs.

If you have any questions regarding your insurance or our financial policy, please discuss them with the business staff prior to your services.

Any parent who brings a minor child for services will be responsible for payment regardless of which parent provides dental insurance for the child.

Any unpaid balance will be charged a financial fee of 18% APR. Any fees incurred such as attorney or collection fees on overdue accounts will be charged to the patient.

To avoid a missed appointment charge of $50, a 24 hour cancellation notice is required.

I have read the above and understand all fees are my financial responsibility.

_____ _____

Patient signature Date

Effective date of notice: December 1, 2005

NOTICE OF PRIVACY PRACTICES

Dr. David J. Adams, DMD, MS, PA

925 Heather Park Drive / Garner, NC 27529 / Phone 919-772-0314 / Fax 919-772-2606

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.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS -- The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; examining your teeth; prescribing medications and faxing them to be filled; referring you to another doctor or clinic for other health care or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or dental care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records. We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we usually will not ask you for special written permission.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION -- In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- when a state or federal law mandates that certain health information be reported for a specific purpose;
- for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
- disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
- disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
- disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- uses or disclosures for health related research;
- uses and disclosures to prevent a serious threat to health or safety;
- uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
- disclosures of de-identified information;
- disclosures relating to worker's compensation programs;
- disclosures of a "limited data set" for research, public health, or health care operations;
- incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information;

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your dental care.

APPOINTMENT REMINDERS -- We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

OTHER USES AND DISCLOSURES -- We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours. If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this Notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION -- The law gives you many rights regarding your health information. You can:

- ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address, fax or E Mail shown at the beginning of this Notice.
- ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E mail to your personal E Mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30 day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

OUR NOTICE OF PRIVACY PRACTICES -- By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our Web site.

COMPLAINTS -- If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or E mail shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION -- If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this Notice.

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
&
CONSENT TO TREATMENT

- We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.

- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims and to communicate with the referring dentist.

- I acknowledge that I received a copy of Dr. Adams' Notice of Privacy Practices.

Patient name (printed) _____

Signature _____ Date _____