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Patient's Last Name_____First Name_____MI_____Birthdate___/___/_____

Prefers the Name_____Soc Sec #_____-____-_____Male [ ] Female [ ] Marital Status_____

Address/City/State/Zip_____

Phone Numbers: Home_____Work_____Mobile_____Other_____

Parent's Name, if minor_____Soc Sec #_____-_____-_____Birthdate___/___/_____

Spouse's Name, if applicable_____Soc Sec #_____-_____-_____Birthdate___/___/_____

Email Address:_____ Who referred you to us: _____

Employer/Insurance Information

Primary Dental Insurance_____Employer_____

Policyholder's Name_____Soc Sec #_____-____-_____Birthdate____/___/_____

Secondary Dental Insurance_____Employer_____

Policyholder's Name_____Soc Sec #_____-_____-_____Birthdate____/____/_____

Dental History

Reason for today's visit_____Previous Dentist's Name/Phone #_____

Last dental visit was on_____Last xrays were taken on_____How often do you brush?_____Floss?_____

Do you have any other dental problems now? If yes, please describe: [ ] No [ ] Yes,_____

Is there anything else about having dental treatment that you would like us to know?_____

Medical History

Primary Physician's Name_____Phone #_____

Have you been under the care of a doctor during the past 2 years? If yes, explain:_____

Are you taking any medication, drugs or pills now, including regular dosages of aspirin? If yes, explain:_____

Are you allergic to any medication or substances? If yes, explain:_____

Please indicate which of the following you have had, or have at present:

[ ] Heart (Surgery/Disease/Attack)	[ ] Stroke	[ ] Hepatitis A or B
[ ] Congenital Heart Disease	[ ] Diabetes	[ ] H.I.V. Positive
[ ] Heart Murmur	[ ] Thyroid Problems	[ ] Hemophilia
[ ] High Blood Pressure	[ ] Tuberculosis	[ ] Sickle Cell Disease
[ ] Mitral Valve Prolapse	[ ] Liver Disease	[ ] Cold Sores/Fever Blisters
[ ] Artificial Heart Valve	[ ] Sinus Trouble	[ ] Epilepsy or Seizures
[ ] Heart Pacemaker	[ ] Allergies/Hives	[ ] Fainting or Dizzy Spells
[ ] Rheumatic Fever	[ ] Asthma	[ ] Chemotherapy
[ ] Artificial Joints (hip, knee, etc.)	[ ] Latex Sensitivity	[ ] Radiation Therapy
[ ] Contact Lenses	[ ] Blood Thinner: _____	[ ] Psychiatric/Psychological Care

Do you have any disease, condition or problem not listed? If so, please list:_____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge and will notify the doctor of any change in my health or medication. I understand I am financially responsible for any and all fees, including those not covered and/or paid by insurance, if applicable. I authorize payment of the dental benefits otherwise payable to me directly to Arthur & Nicholson, DDS, PA and to the extent permitted under applicable law, I authorize release of information relating to services provided in order to obtain payment.

Patient's Signature (Parent, if minor)_____Date_____

03/03

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

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PAYMENT OPTIONS

Payment is expected at the time of service; therefore, we have these options available for your convenience:

PRE-PAYMENT COURTESY

- A pre-payment courtesy of 5% will be subtracted from the total obligation if the entire treatment plan is paid in full, with cash or check, 48 hours before the start of treatment.

CREDIT CARD

- In order to facilitate access to the very best health care possible, you may choose from any of the following (including a combination thereof): VISA, MasterCard, Discover Card or CareCredit.

1/2 AND 1/2

- With this option, after an initial down-payment of 50%, you will make equal payments at each visit over the treatment time.
- Payments can be made through pre-authorized credit card charges.

THIRD-PARTY FINANCING

- With fast approval from a CareCredit, a third party finance company, your payments can be much lower than those available through our office. They specialize in helping patients obtain the treatment that they need. We will help you process the necessary information or visit **www.CareCredit.com** to apply or get further details .

I have reviewed the above payment options available. I am also aware that any insurance estimates are not guaranteed amounts payable by insurance and any amounts unpaid by insurance are my financial responsibility.

_____ _____

Patient/Guarantor Signature **Date**

551 Becker Drive
Roanoke Rapids, NC 27870
(252) 537-1054 office (252) 537-1211 fax

Name _____
(Last) (First)

Date_____

How did you learn about our practice? Please select **ALL** that apply.

_____ Friend/Family Name:_____

_____ Staff Member Name:_____

_____ Other Dentist/Doctor Name:_____

_____ Our Website

_____ Internet Search Search Engine Used:_____

_____ Insurance Company Which Insurance?_____

_____ Direct Mail Postcard

_____ Phonebook

_____ LHI

_____ Drive by/Outdoor sign

_____ Radio Which station?_____

_____ Veteran's Administration

_____ Fundraiser

_____ Other Specify:_____

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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 4/14/03, 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 not charge you for 5 or less pages. Otherwise, $0.10 per page, postage if you want the copies mailed to you, and no charge for staff time to locate and copy your health information. 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 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: Office Administrator/Privacy Official Telephone: (252)537-1054 Fax: (252)537-1211

Address: 551 Becker Drive, P O Box 1091, Roanoke Rapids, NC 27870