Donald L. Hardee, DDS, PA

Family, Esthetic, and Implant Dentistry
215 Commerce Street | Greenville, NC 27858
Phone 252-756-6626 ~ Fax 252-756-2147

1. ABOUT YOU

Today's Date: _____ Patient Name: _____
LAST FIRST MI
What you prefer to be called: _____ Male ☐ Female ☐ Birthdate: _____ Age: _____

SS#: _____ Mailing Address: _____
CITY STATE ZIP
Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____ Referred By: _____

Employer: _____ How long? _____ Employer's Address: _____
CITY STATE ZIP
Occupation: _____ Status: Minor ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐

Spouse's Name: _____ Do you have any children? Yes ☐ No ☐ How Many? _____

Are you a full time student? ☐ Yes ☐ No If yes, School Name: _____

2. INSURANCE INFORMATION

Primary Dental Insurance

Co. Name: _____
Address: _____
CITY STATE ZIP
Phone Number: _____
Insured's SS#: _____
Insured's ID#: _____
Group # (Plan, Local, Policy#): _____
Insured's Name: _____
Relation: _____ Date of Birth: _____
Insured's Employer: _____

Secondary Dental Insurance

Co. Name: _____
Address: _____
CITY STATE ZIP
Phone Number: _____
Insured's ID#: _____
Group# (Plan, Local, Policy#): _____
Insured's Name: _____
Relation: _____ Date of Birth: _____
Insured's Employer: _____

3. ACCOUNT INFORMATION

Person ultimately responsible for account

Name: _____ Relation: _____
Billing Address: _____
CITY STATE ZIP
SS#: _____ Work Phone: _____

_____ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company.
INITIALS

4. IN EVENT OF EMERGENCY

Whom should we contact? _____ Relation: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Who is your Medical Doctor? _____ Medical Doctor's Phone: _____

(Continued on back)

(Continued from front)

5. DENTAL INFORMATION

Reason for today's visit: Exam ☐ Emergency ☐ Consultation ☐ Are you in pain? No ☐ Yes ☐ How long?_____

Please circle any of the following problems:

Discomfort, clicking or popping in jaw	Lost/Broken Filling(s)	Bad Breath
Blisters/Sores in or around mouth	Sensitive Teeth/Gums	Ringing in Ears
Teeth grinding/Locking jaw	Broken/Chipped Tooth	Red, swollen or bleeding gums

Other:_____

Do you require pre-medication?: Yes ☐ No ☐ Don't Know ☐

Previous Dentist:_____ Phone Number:_____ Last Dental Exam:_____ Last Dental X-rays:_____

Times a day you brush:_____ Times a week you floss:_____ What type of tooth brush bristles do you use? Soft ☐ Medium ☐ Hard ☐

Do your gums bleed when you floss and/or brush? Yes ☐ No ☐ Have you had your teeth bleached? Yes ☐ No ☐

Have you ever been told you had periodontal disease? Yes ☐ No ☐ Have you ever had braces? Yes ☐ No ☐ When?_____

How would you rate your smile? (worst) 1 2 3 4 5 6 7 8 9 10 (best)

6. MEDICAL HISTORY

Please list ALL medications you are taking and why:_____

Are you allergic to any of the following? Latex ☐ Penicillin/Amoxicillin ☐ Aspirin ☐ Tetracycline ☐ Erythromycin ☐ Clindamycin ☐ Dental Anesthetics ☐

Foods:_____ Others:_____

Do you have or have you had any of the following diseases, medical conditions, procedures?

Y ☐ N ☐ Heart Attack/Stroke	Y ☐ N ☐ Thyroid Problems	Y ☐ N ☐ Cancer/Tumors	Y ☐ N ☐ Cosmetic Surgery
Y ☐ N ☐ Heart Surgery/Pacemaker	Y ☐ N ☐ Kidney Problems	Y ☐ N ☐ Shingles	Y ☐ N ☐ X-ray or Cobalt Treatment
Y ☐ N ☐ Heart Murmur	Y ☐ N ☐ Liver Problems	Y ☐ N ☐ Hepatitis	Y ☐ N ☐ Chemotherapy
Y ☐ N ☐ Rheumatic Fever	Y ☐ N ☐ Respiratory Problems	Y ☐ N ☐ HIV+/AIDS/ARC	Y ☐ N ☐ Arthritis/Rheumatism
Y ☐ N ☐ Nitral Valve Prolapse	Y ☐ N ☐ Sinus Problems	Y ☐ N ☐ Asthma	Y ☐ N ☐ Difficulty Breathing
Y ☐ N ☐ Artificial Bones/Joints	Y ☐ N ☐ Stomach Problems/Ulcers	Y ☐ N ☐ Artificial Valves	Y ☐ N ☐ Diabetes/Hypoglycemia
Y ☐ N ☐ Heart Disease	Y ☐ N ☐ Psychiatric Problems	Y ☐ N ☐ Emphysema	Y ☐ N ☐ Severe/Frequent Headaches
Y ☐ N ☐ Congenital Heart Defect	Y ☐ N ☐ Venereal Disease or STD	Y ☐ N ☐ Anemia	Y ☐ N ☐ Fainting/Seizures/Epilepsy
Y ☐ N ☐ Chest Pains	Y ☐ N ☐ Alcohol/Drug Abuse	Y ☐ N ☐ Leukemia	Y ☐ N ☐ High/Low Blood Pressure
Y ☐ N ☐ Scarlet Fever	Y ☐ N ☐ Tuberculosis TB	Y ☐ N ☐ Frequent Neck Pain	Y ☐ N ☐ Bleeding Problems
Y ☐ N ☐ Nervousness	Y ☐ N ☐ Jaw Problems TMJ/TMD	Y ☐ N ☐ Back Problems	Y ☐ N ☐ Glaucoma
Y ☐ N ☐ Pregnancy	Y ☐ N ☐ Osteoporosis	Y ☐ N ☐ Transplants	Y ☐ N ☐ Jaundice
Y ☐ N ☐ Lupus/MS/MD	Y ☐ N ☐ Fever Blisters	Y ☐ N ☐ Bulimia/Anorexia	

Please list any other surgeries or medical conditions you have or ever had:_____

_____

Do you use tobacco? Yes ☐ No ☐ Smoke ☐ Chew Tobacco/Snuff ☐ How much?_____ How long?_____

Please rate your general health from 1-10:_____ Do you wear contact lenses? Yes ☐ No ☐

FOR WOMEN: Are you taking Birth Control pills? Yes ☐ No ☐ How many children have you had?_____

Are you pregnant? Yes ☐ No ☐ How long?_____ Are you nursing? Yes ☐ No ☐

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.

Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account.

I authorize 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.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature_____ Date_____

Adult Patient ☐ Parent/Guardian ☐ Spouse ☐

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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 April 1, 2003 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 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 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 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 disclose 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 heath 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, or 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 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 $ for each page, $ per hour for staff 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.

Restrictions: 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 website 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 alternate 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 rights 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:_____
Telephone:_____Fax:_____
E-mail:_____

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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 as required by law.

/ /

Test Patient 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)