REGISTRATION

Patient Information

Date ______

SS/HIC/Patient ID # ______

Patient Name ______
Last Name

______
First Name / Middle Initial

Address ______

City ______

State ______ Zip ______

E-mail ______

Sex ☐ M ☐ F Age ______

Birthdate ______

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for ______ years

Occupation ______

Patient Employer/School ______

Employer/School Address ______

______

Employer/School Phone (_____) ______

Spouse's Name ______

Birthdate ______

SS# ______

Spouse's Employer ______

Whom may we thank for referring you? ______

Dental Insurance

Who is responsible for this account? ______

Relationship to Patient ______

Insurance Co. ______

Group # ______

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name ______

Birthdate ______ SS# ______

Relationship to Patient ______

Insurance Co. ______

Group # ______

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with ______ and assign directly to
Name of Insurance Company(ies)

Dr.______ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

______
Signature of Patient, Parent, Guardian or Personal Representative

______
Please print name of Patient, Parent, Guardian or Personal Representative

______ ______
Date / Relationship to Patient

Phone Numbers

Home (______) ______ Work (______) ______ Ext ______ Cell Phone (______) ______

Spouse's Work (______) ______ Best time and place to reach you ______

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name ______ Relationship ______

Home Phone (______) ______ Work Phone (______) ______

Dental History

Reason for today's visit ______

______

Former Dentist ______

City/State ______

Date of last dental visit ______

Date of last dental X-rays ______

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Bad breath ☐ Yes ☐ No

Bleeding gums ☐ Yes ☐ No

Blisters on lips or mouth ☐ Yes ☐ No

Burning sensation on tongue ☐ Yes ☐ No

Chew on one side of mouth ☐ Yes ☐ No

Cigarette, pipe, or cigar smoking ☐ Yes ☐ No

Clicking or popping jaw ☐ Yes ☐ No

Dry mouth ☐ Yes ☐ No

Fingernail biting ☐ Yes ☐ No

Food collection between the teeth ☐ Yes ☐ No

Foreign objects ☐ Yes ☐ No

Grinding teeth ☐ Yes ☐ No

Gums swollen or tender ☐ Yes ☐ No

Jaw pain or tiredness ☐ Yes ☐ No

Lip or cheek biting ☐ Yes ☐ No

Loose teeth or broken fillings ☐ Yes ☐ No

Mouth breathing ☐ Yes ☐ No

Mouth pain, brushing ☐ Yes ☐ No

Orthodontic treatment ☐ Yes ☐ No

Pain around ear ☐ Yes ☐ No

Periodontal treatment ☐ Yes ☐ No

Sensitivity to cold ☐ Yes ☐ No

Sensitivity to heat ☐ Yes ☐ No

Sensitivity to sweets ☐ Yes ☐ No

Sensitivity when biting ☐ Yes ☐ No

Sores or growths in your mouth ☐ Yes ☐ No

How often do you floss? ______

How often do you brush? ______

Health History

Physician's Name______________________ Date of last visit ______________________

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Condition			Condition			Condition		
AIDS/HIV	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Respiratory Disease	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Fainting or dizziness	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Arthritis, Rheumatism	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Artificial Heart Valves	☐ Yes	☐ No	Headaches	☐ Yes	☐ No	Shortness of Breath	☐ Yes	☐ No
Artificial Joints	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Heart Problems	☐ Yes	☐ No	Skin Rash	☐ Yes	☐ No
Back Problems	☐ Yes	☐ No	Hepatitis Type _______	☐ Yes	☐ No	Special Diet	☐ Yes	☐ No
Bleeding abnormally, with extractions or surgery	☐ Yes	☐ No	Herpes	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Swollen Feet or Ankles	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Jaundice	☐ Yes	☐ No	Swollen Neck Glands	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No	Jaw Pain	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Circulatory Problems	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Congenital Heart Lesions	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No	Tumor or growth on head or neck	☐ Yes	☐ No
Cortisone Treatments	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No	Ulcer	☐ Yes	☐ No
Cough, persistent or bloody	☐ Yes	☐ No	Nervous Problems	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No	Weight Loss, unexplained	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No			
			Radiation Treatment	☐ Yes	☐ No			

Do you wear contact lenses? ☐ Yes ☐ No

Women:

Are you pregnant? ☐ Yes ☐ No Due date______________________ Are you nursing? ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ No

Medications

List any medications you are currently taking and the correlating diagnosis:

____

____

____

Pharmacy Name ______________________

Phone (______) ______________________

Allergies

☐ Aspirin ☐ Local Anesthetic

☐ Barbiturates (Sleeping pills) ☐ Penicillin

☐ Codeine ☐ Sulfa

☐ Iodine ☐ Other______________

☐ Latex ______________

Updates (To be filled in at future appointments)

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? ______________________

Are you taking any new medications?______________ If so, what? ______________________

Patient's Signature ______________________ Date ______________

Doctor's Signature ______________________ Date ______________

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? ______________________

Are you taking any new medications?______________ If so, what? ______________________

Patient's Signature ______________________ Date ______________

Doctor's Signature ______________________ Date ______________

This notice describes how information about you may be used and disclosed and how you can gain access to this information. Please review it carefully.

C. Elaine Brown, D.D.S., M.S., P.A.

NOTICE OF PRIVACY PRACTICES

1. C. Elaine Brown, D.D.S., M.S., P.A. may use and disclose protected health information for treatment, payment, and healthcare operations. Examples of these include, but are not limited to, requested preschool or sports physicals, foster care homes, home health agencies, and/or referral to other providers for treatment. Payment examples include, but are not limited to, insurance companies for claims including coordination of benefits with other insurers, and/or collection agencies. Healthcare operations include, but are not limited to, internal quality control and assurance, including auditing of records.
2. C. Elaine Brown, D.D.S., M.S., P.A. is permitted or required to use or disclose protected health information without the individual's written consent or authorization in certain circumstances. Two examples of such are for public health requirements or court orders.
3. C. Elaine Brown, D.D.S., M.S., P.A. will not use or disclose PHI for marketing purposes and/or disclosures constituting a sale of PHI without the individual's Authorization.
4. C. Elaine Brown, D.D.S., M.S., P.A. will not sell or make any other use or disclosure of a patient's protected health information without the patient's written authorization. Such authorization may be revoked at any time. Revocation must be requested in writing.
5. C. Elaine Brown, D.D.S., M.S., P.A. will abide by the terms of this notice currently in effect at the time of the disclosure.
6. C. Elaine Brown, D.D.S., M.S., P.A. reserves the right to change the terms of its notice and to make new notice provisions effective for all protected health information that it maintains. C. Elaine Brown, D.D.S., M.S., P.A. will provide each patient with a copy of any revisions of its Notice of Information Practices at the time of the patient's next visit, or at the patient's last known address if there is a need to use or disclose any protected health information of the patient. Copies may also be obtained at any time at the office of C. Elaine Brown, D.D.S., M.S., P.A. Any patient, guardian or personal representative has the right to object to the use of their health information for directory purposes.
7. Any patient, guardian or personal representative has the right to inspect and obtain copies of the patient's dentall record. The records will be provided within 30 days of the request, and a reasonable charge may be assessed for any copies after the first request in a 12-month period. If C. Elaine Brown, D.D.S., M.S., P.A. is unable to act within the required period, C. Elaine Brown, D.D.S., M.S., P.A. may provide the patient with written notice of the reason for delay and expected date of completion of the request. This extension of time will not exceed 30 days.
8. Any patient, guardian or personal representative has the right to request amendments be made to the patient's medical record.
9. Any patient, guardian or personal representative has the right to request a 6-year accounting of all disclosures of the patient's dental record. The history will be

provided within 30 days of the request, and a reasonable charge may be assessed for any copies after the first request in a 12-month period. If C. Elaine Brown, D.D.S., M.S., P.A. is unable to act within the required period, C. Elaine Brown, D.D.S., M.S., P.A. may provide the patient with written notice of the reason for delay and the expected date of completion of the request. This extension of time will not exceed 30 days.

10. Any patient, guardian or personal representative has the right to request restrictions as to how the patient's health information may be used or disclosed to carry out treatment, payment, or healthcare operations. C. Elaine Brown, D.D.S., M.S., P.A. is not required to agree to the restrictions requested, but if C. Elaine Brown, D.D.S., M.S., P.A. does agree, C. Elaine Brown, D.D.S., M.S., P.A. must abide by those restrictions.
11. Any patient, guardian or personal representative has the right to restrict disclosure of certain Personal Health Information to a health plan for payment or health care operation purposes, but not for treatment purposes, for items or services that have been paid in full and out-of-pocket.
12. Any affected patient will be notified by the C. Elaine Brown, D.D.S., M.S., P.A. Security Officer following a breach of unsecured Personal Health Information of the affected patient. The Practice has permission to contact me via e-mail.
13. Any person/patient may file a complaint to C. Elaine Brown, D.D.S., M.S., P.A. and to the U.S. Secretary of Health and Human Services if the patient believes his or her privacy rights have been violated. To file a complaint with the Practice, please contact the Privacy Officer at C. Elaine Brown, D.D.S., M.S., P.A., Attention: Privacy Officer, 2601 C- Oakcrest Avenue, Greensboro, NC 27408, telephone (336)286-8111. All complaints will be addressed, and the results will be reported to the Privacy Officer.
14. It is the policy of C. Elaine Brown, D.D.S., M.S., P.A. that no retaliatory action will be made against any individual who submits or conveys a complaint of suspected or actual non-compliance of the privacy standards.

Effective Date:___________________________

Name of Patient:_________________________

Signature of Patient or Legal Guardian:________________________________

Date:_______________

CONSENT FORM
(For Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations)

I understand that as part of my dental care, C. Elaine Brown, D.D.S, M.S., P.A. originates and maintains dental records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care and treatment. I also understand this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and treatment information to my bill
- A means by which a third party payer can verify that services billed were actually provided
- And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a **Notice of Information Practices** that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand the Practice reserves the right to change their notice and practices, and prior to implementation, will mail a copy of any revised notice to the address that I have provided if there is a need to use or disclose any protected health information. I also understand that I have the right to restrict as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that the Practice is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the Practice has already taken action in reliance thereon.

With this consent, C. Elaine Brown, D.D.S, M.S., P.A. may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With this consent, C. Elaine Brown, D.D.S, M.S., P.A. may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and other printed material as long as they are marked Personal and Confidential.

With this consent, C. Elaine Brown, D.D.S, M.S., P.A. may e-mail to me appointment reminder cards and patient statements. I have the right to request that C. Elaine Brown, D.D.S, M.S., P.A. restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to C. Elaine Brown, D.D.S, M.S., P.A. to use and disclose my PHI to carry out my TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. **If I do not sign this consent, C. Elaine Brown, D.D.S, M.S., P.A. may decline to provide treatment to me.**

Print Patient Name:___________________________________

Account Number:____________________

Signature of Patient or Legal Guardian:________________________________

Date:_________________

Hipaa Consent Form 802 (form2)

PERMISSION TO DISCUSS PHI

Patient Name: ______________________ **Date of Birth:** __________________

Account Number: __________________

I hereby give my permission to the person(s) listed below to receive information about the care of the above named patient:

NAME	RELATIONSHIP
____________________________	____________________________
____________________________	____________________________
____________________________	____________________________
____________________________	____________________________
____________________________	____________________________
____________________________	____________________________
____________________________	____________________________
____________________________	____________________________
____________________________	____________________________

____

Signature of Patient, Parent or Guardian

____

Date

In order to obtain information by telephone, the party calling the practice must share the patient identifier with the staff.

Patient Identifier: _________________________

OFFICE POLICIES OF C. ELAINE BROWN, DDS, MS, PA

Appointments

Our office hours are Tuesday, Wednesday and Thursday from 8:00 am until 5:00 pm and Friday from 7:30 am until 3:30 pm. Appointments are reserved for you with one of our periodontal team members and we make every effort to see you at your reserved time. Therefore, it is very important that you arrive on time and keep all of your appointments. In the event it is required to reschedule an appointment with our office a 48 hours notice is required. This is to allow our staff to accommodate other patients. The notice must be given during normal business hours in order to be honored. A broken appointment is defined as any appointment missed, canceled or rescheduled without 48 hours notice. Due to the cost our office incurs with broken appointments a fee of $50 per hour will be charged to your account and must be paid prior to scheduling your next appointment. We realize emergencies can arise without notice and we will give special consideration if warranted.

Finances

Payment in full is expected at the time of treatment for patients who do not have dental insurance coverage. If you do have dental insurance we will file your insurance as a courtesy but we do require that you pay your co-pay at the time of treatment. We will do our best to give you as accurate estimate on treatment as we can but please realize our estimate is based off the information an insurance representative gives us over the telephone. We will be glad to submit a pre-authorization with your insurance carrier just put in that request with our administrative staff. We do ask that you keep in mind a pre-authorization can take 30 days to receive back from the insurance company and it too is not a guarantee of payment. Any amount unpaid by your insurance is your responsibility.

Forms of Payment

For your convenience we accept cash, checks, Visa, MasterCard & Discover. We also offer a 6-month no interest payment plan with CareCredit if you qualify.

Returned Checks

A service fee of $35 will be assessed for all returned checks. The returned check amount and the service fee must be paid within 10days in the form of cash, money order of certified check. Future appointments will be delayed until this is corrected. A second returned check will result in suspension of checks as a form of payment in our office.

I understand the office policies of C. Elaine Brown, DDS, MS, PA as stated above.

________________________________ _______________________

Patient/Guardian Date