GENERAL PATIENT INFORMATION

Patient Registration

Patient Information

Full Name: _____

Date of Birth: _____

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

Sex: ☐ Male ☐ Female

SSN/ID: _____

Email Address: _____

Home Phone Number: _____

Cell Phone Number: _____

Drivers License

State: _____

Number: _____

Home Address:

Address: _____

City, State and ZIP: _____

Billing Address:

Address: _____

City, State and ZIP: _____

Work Information

Employer: _____

Occupation: _____

Work Phone Number: _____

Method of Contact: ☐ Phone ☐ Email ☐ Text Message ☐ Any of the previous ones

Emergency Contact:

Full Name: _____

Phone Number: _____

Relation: _____

How did you hear about our office?

Who may we thank for referring you? _____

GENERAL PATIENT INFORMATION

Financial Information

Patient's Payment Details – Guarantor (Person responsible for paying the bill)

Guarantor Name: _____

SSN/ID: _____

Relation to Patient: _____

Patient's Student Status

Student Status: _____

College: _____

College Address: _____

Primary Dental Insurance Company – Subscriber and Insurance Company Details

Subscriber Name: _____

Date of Birth: _____

SSN/ID: _____

Employer: _____

Policy Number: _____

Group Number: _____

Coverage Type: ☐ Individual ☐ Family ☐ Prepaid / Capitation

Insurance Company: _____

Company Phone Number: _____

Company City, State, ZIP: _____

Secondary Dental Insurance Company – Subscriber and Insurance Company Details

Subscriber Name: _____

Date of Birth: _____

SSN/ID: _____

Employer: _____

Policy Number: _____

Group Number: _____

Coverage Type: ☐ Individual ☐ Family ☐ Prepaid / Capitation

Insurance Company: _____

Company Phone Number: _____

Company City, State, ZIP: _____

Pharmacy Information

Name: _____

Address: _____

Pharmacy Phone Number: _____

Medicaid Number: _____

I authorize the dentist to release any information, including diagnosis, treatment plans/records and radiographs to third party payers and/or health practitioners. I authorize and request that my insurance company (if applicable) pay directly to the dental group or dentist benefits that are, otherwise, payable to me. I understand that my dental insurance may pay less than the actual bill for service or may not cover certain treatment.

I hereby certify that the foregoing information is accurate and complete and that in consideration of treatment and services rendered to me or my dependents by this dental office, I accept responsibility and agree to be obligated to pay the office in accordance with its payment and credit terms and policies.

Signature: _____

PATIENT MEDICAL HISTORY

Patient's Medical History

Physician Information

Physician's Full Name: _____

Address: _____

City, State and ZIP: _____

Are you currently under a physician's Care? ☐ Yes ☐ No

If Yes, for what?

Are you taking any medication, drugs or pills? ☐ Yes ☐ No

If so, please list the names and dosages of each:

Have you been hospitalized in the last two years? ☐ Yes ☐ No

If Yes, for what?

Do you Smoke? ☐ Yes ☐ No How Much? _____

Women Only

Are you pregnant? ☐ Yes ☐ No What is your due date? _____

Are you nursing? ☐ Yes ☐ No Are you taking birth control pills? ☐ Yes ☐ No

Are you on Hormone Therapy? ☐ Yes ☐ No

Patient's Current or Previous Conditions

Select any of the following if you presently have or have had the condition in the past:

Medical Alerts

- ☐ Allergic to Penicillin
- ☐ Allergic to Tetracycline
- ☐ Allergic to Aspirin
- ☐ Allergic to Codeine
- ☐ Allergic to 'Novocaine'
- ☐ Allergic to Latex Rubber
- ☐ Pre-Medication required
- ☐ Mitral Valve Prolaspe
- ☐ Heart Problems
- ☐ Pacemaker
- ☐ HIV Positive
- ☐ Prior Hepatitis
- ☐ Other

Medical Conditions

- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Chest Pain
- ☐ Congenital Heart Problem
- ☐ Artificial Heart Valve
- ☐ Heart Surgery
- ☐ High/Low Blood Pressure
- ☐ Rheumatic Fever
- ☐ Anemia
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Stroke
- ☐ Deep Vein Clot
- ☐ Hemophilia
- ☐ Excessive Bleeding when Cut
- ☐ Sickle Cell Disease
- ☐ Glaucoma
- ☐ Diabetes
- ☐ Excessive Thirst
- ☐ Scarlet Fever
- ☐ Thyroid Disease
- ☐ Parathyroid Disease
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Hepatitis A or B
- ☐ Yellow Jaundice
- ☐ Cancer
- ☐ X-Ray or Cobalt Treatment
- ☐ Chemotherapy
- ☐ Ulcers
- ☐ Gastrointestinal Upset
- ☐ Acid Reflux
- ☐ Lung Disease
- ☐ Tuberculosis
- ☐ Shortness of Breath
- ☐ Emphysema
- ☐ Asthma
- ☐ Sinus Trouble
- ☐ Hay Fever
- ☐ Frequent Cough
- ☐ Rheumatism
- ☐ Arthritis/Gout
- ☐ Osteoporosis
- ☐ Swelling of Feet/Ankles
- ☐ Artificial Joint Replacement
- ☐ Psychiatric Care
- ☐ Epilepsy or Seizures
- ☐ Extreme Nervousness
- ☐ Fainting or Dizziness
- ☐ Hypoglycemia
- ☐ Hives
- ☐ Cold Sores/Fever Blisters
- ☐ Venereal Disease
- ☐ Herpes
- ☐ HPV (Human Papillary Virus)
- ☐ Cortisone Treatment
- ☐ Chemical Dependency

PATIENT DENTAL HISTORY

Patient's Dental History

What is your primary reason for seeking dental care?

_____

Previous Dentist Information

Dentist's Full Name: _____

City, State and ZIP: _____

Month and Year of Last Visit: _____

What was done at your last visit? _____

Date of Last full mouth x-rays: _____

Reason for leaving previous dentist: _____

How often do you visit the dentist? ☐ Annual Check Up ☐ Twice a Year Check Up

☐ Only when I have a problem ☐ Other

Please choose the appropriate answer

Are you nervous about receiving dental treatment? ☐ Yes ☐ No

Do you gag easily? ☐ Yes ☐ No

Have you had previous problems with dental care? ☐ Yes ☐ No

If so, please explain?

Are your teeth sensitive to hot, cold, pressure or sweets? ☐ Yes ☐ No

Do you have problems with teeth/fillings breaking? ☐ Yes ☐ No

Are you aware of an uncomfortable bite? ☐ Yes ☐ No

Do your gums feel tender and/or bleed? ☐ Yes ☐ No

Does food catch between your teeth? ☐ Yes ☐ No

Have you had periodontal (gum) treatments? ☐ Yes ☐ No

Do you get sores in or around your mouth? ☐ Yes ☐ No

Do you have regular headaches, earaches or neck pains? ☐ Yes ☐ No

Do you grind or clench your teeth? ☐ Yes ☐ No

Do you hear a "clicking" sound when you open/close your mouth? ☐ Yes ☐ No

Does your jaw ever get "stuck?" ☐ Yes ☐ No

Do you have a Temporomandibular (TMJ) jaw disorder? ☐ Yes ☐ No

Are you missing teeth that have not been replaced? ☐ Yes ☐ No

Have you had excessive bleeding after an extraction? ☐ Yes ☐ No

Do you take any Bisphosphonate medication such as Fosamax, Boniva, Actonel, Aredia or Zometa? ☐ Yes ☐ No

Have you had mouth sores that take long to heal? ☐ Yes ☐ No

Do you have any dental implants? ☐ Yes ☐ No

Do you wear dentures (partials or full)? ☐ Yes ☐ No

Do you have any crowns (caps) or bridges? ☐ Yes ☐ No

Do you chew tobacco? ☐ Yes ☐ No

Do you have a dry mouth? ☐ Yes ☐ No

Are you unhappy with the appearance of your teeth? ☐ Yes ☐ No

Would you like your smile to look better? ☐ Yes ☐ No

Would you like whiter teeth? ☐ Yes ☐ No

Do you regularly use dental floss? ☐ Yes ☐ No

Do you brush at least once daily? ☐ Yes ☐ No

Is there anything else that you would like us to know?

I authorize the use of my radiographs [x-rays] and/or photographs for educational and promotional use in seminars, publications and the dental office web site. ☐ Yes ☐ No

I hereby certify that the foregoing information is accurate and complete and that I will notify the office of any changes in a timely manner. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in completion of this form.

Signature: _____

HIPAA AUTHORIZATION FORM

Form Revised 11/ 2010

The privacy of your health information is important to us. Dr. William T. Baldock and his staff are committed to following the guidelines set forth by the Health Insurance Portability and Accountability Act of 1996 (HIPPA). This Notice applies to all of the records of your care generated by this office whether made by your general dentist or one of our employees.

In order to release your personal information, including lab results, test results or financial matters, to anyone other than you, please read and sign in designated area(s) below.

The following describes the different ways that your information may be used or disclosed by this office. (For additional details, refer to Capital Periodontal Associates, PA's Notice of Privacy Practices.)

For Treatment: We use medical information about you to provide you with medical/dental treatment and services. We may disclose medical information about you to your referring dentist, doctors, nurses, technicians, and other office personnel who are involved in providing you treatment. _____***Initial***

For Payment: We may use and disclose medical information about you so that the treatment and services you receive at this office may be billed to and payment may be collected from you, an insurance company or a third party. _____***Initial***

For Appointment Reminders: We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care. I grant permission to Dr. William T. Baldock and the staff of Capital Periodontal Associates, PA, the right to contact me via home phone, work phone, mobile phone, e-mail or any other means I have provided in order to notify me of any future appointments or changed appointment. You may be charged $50 for a no show appointment/visit.

_____***Initial***

As Required by Law: We will disclose medical information about you when required to do so by federal, state or local law.

I give consent for the family members or persons listed below to receive information concerning my medical/dental records at Capital Periodontal Associates, PA, to include insurance information, financial information, making and cancelling appointments on my behalf.

_____ _____

_____ _____

I have read and understand the above and agree to the conditions listed and initialed above. *(You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment or payment or your eligibility for benefits.)*

_____ _____

Patient's/Guardian's Signature **Date**

_____

Patient Name (Print)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Form Revised 11/ 2010

You may refuse to sign this Acknowledgement.

I, _____, have received a copy of the ***Notice of Privacy Practices*** for Capital Periodontal Associates.

_____
Printed 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 due to the following:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement

Other, please specify: _____
_____
_____

_____ _____
Staff Member Initials *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. 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 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 November 1, 2010 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 health care operations. For example:

Treatment: We may use and disclose your health information

Payment: We may use and disclose your health information to obtain payment for services we provide you.

Health Care Operations: We may use and disclose your health information in connection with our health care operations. These operations include: quality assessment and improvement activities, reviewing the competence or qualifications of health care 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 health care 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 health care or with payment for your health care, but only if you agree that we may do so.

Persons Involved in Care: We may use and disclose your 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 health care. 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 or disclose your health information for marketing communications without your written authorization.

Required By Law: We may use and 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, e-mails, 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 listed at the end of this Notice. If you request copies, we will charge you $15.00 - $300 for staff time 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, health care operations, and certain other activities, for the last 6 years. 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 on our website or by electronic means (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 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 Officer: Rhonda Baldock
Address: 2621 Mitcham Drive, Suite 101
Tallahassee, FL 32308
Telephone: (850)942-8111
Fax: (850)942-8114