CAPITAL PERIODONTAL

William T. Baldock, Jr. DMD, MS • William T. Baldock DDS, MS

GENERAL PATIENT INFORMATION

Patient Registration

Full Name: _____

Date of Birth: _____

Social Security Number: _____

Gender: ☐ Male ☐ Female ☐ Other ☐ Decline to answer

Home Phone Number: _____ Mobile Phone: _____

Email: _____

Home Address: _____

City, State and ZIP: _____

Billing Address: _____

City, State and ZIP: _____

Work Information:

Employer: _____

Employer Phone Number: _____

Preferred Method of Contact: ☐ Phone ☐ Email ☐ Text Message ☐ All options listed

Emergency Contact:

Full Name: _____

Phone Number: _____

Relationship to Patient: _____

Whom may we thank for referring you? _____

Financial Information

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

Guarantor Name: _____

SSN/ID: _____

Relationship to Patient: _____

Primary Dental Insurance Company – Subscriber and Insurance Company Details

Subscriber Name: _____

Relationship to Patient: _____

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: _____

Relationship to Patient: _____

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: _____

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

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 Prolapse
- □ 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 Blood Pressure
- ☐ 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
- ☐ Restless Leg Syndrome
- ☐ 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 Papillomavirus)
- ☐ Cortisone Treatment
- ☐ Chemical Dependency

Patient Dental History

What is your primary reason for seeking dental care?

_____

Primary 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: _____

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: _____

CAPITAL PERIODONTAL

William T. Baldock, Jr. DMD, MS • William T. Baldock DDS, MS

HIPAA AUTHORIZATION FORM

Form Revised 01/2024

The privacy of your health information is important to us. Dr. William T. Baldock, Jr., and his staff are committed to following the guidelines set forth by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This Notice applies to all of the records of your care generated by this office whether made by yourgeneral 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, LLC's Notice of Privacy Practices.)

_____***Initial*** **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, Jr. and the staff of Capital Periodontal Associates, LLC, 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, LLC, to include insurance information, financial information, making and canceling appointments on my behalf.

☐ Spouse: _____ ☐ Primary Physician: _____

☐ Child(ren): _____ ☐ Other: _____

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 Name **Date**

_____

Patient's/Guardian's Signature

☐ I refuse to sign this authorization

HIPAA

NOTICE OF PRIVACY PRACTICES FOR THE OFFICES OF:

William T. Baldock, Jr., DMD, MS · William T. Baldock, DDS, MS

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.

If you have any questions about this notice, please contact

William T. Baldock, Jr., DMD, MS · William T. Baldock, DDS, MS

Of our office at

2621 Mitcham Drive, Suite 101
Tallahassee, FL 32308

info@capitalperio.com
(850) 942-8111
(850) 942-8114

Who Will Follow This Notice

This notice describes the information privacy practices followed by our employees, staff and other office personnel. The practices described in this notice will also be followed by health care providers you consult with by telephone (when your regular health care provider from our office is not available) who provide "call coverage" for your health care provider.

Your Health Information

This notice applies to the information and records we have about your health, health status, and the health care and services you receive at this office. We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.

How We May Use and Disclose Health Information About You

For Treatment

We may use health information about you to provide you with medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, office staff or other personnel who are involved in taking care of you and your health.

For example, your doctor may be treating you for a heart condition and may need to know if you have other health problems that could complicate your treatment. The doctor may use your medical history to decide what treatment is best for you. The doctor may also tell another doctor about your condition so that doctor can help determine the most appropriate care for you.
Different personnel in our office may share information about you and disclose information to people who do not work in our office in order to coordinate your care, such as phoning in prescriptions to your pharmacy, scheduling lab work and ordering x-rays.

Family and Friends

We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you have instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

We may disclose health information about you to your family members or friends if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgment that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse when you bring your spouse with you into the exam room during treatment or while treatment is discussed.

For Payment

We may use and disclose health 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. For example, we may need to give your health plan information about a service you received here so your health plan will pay us or reimburse you for the service. We may also tell your health plan about a treatment you are going to receive to obtain prior approval, or to determine whether your plan will cover the treatment.

For Health Care Operations

We may use and disclose health information about you in order to run the office and make sure that you and our other patients receive quality care. For example, we may use your health information to evaluate the performance of our staff in caring for you. We may also use health information about all or many of our patients to help us decide what additional services we should offer, how we can become more efficient, or whether certain new treatments are effective.

Appointment Reminders

We may use and disclose medical information to contact and remind you about appointments for treatment or medical care at the office. If you are not home, we may leave this information on your answering machine or in a message left with person answering the phone.

Sign-in Sheet

We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

Treatment Alternatives

We may tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Health-Related Products and Services

We may tell you about health-related products or services that may be of interest to you.

Please notify us if you do not wish to be contacted for appointment reminders, or if you do not wish to receive communications about treatment alternatives or health-related products and services. If you advise us in writing (at the address listed at the top of this Notice) that you do not wish to receive such communications, we will not use or disclose your information for these purposes.

Special Situations
We may use or disclose health information about you without your permission for the following purposes, subject to all applicable legal requirements and limitations:

To Avert a Serious Threat to Health or Safety

We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Required by Law

We will disclose health information about you when required to do so by federal, state or local law.

Research

We may use and disclose health information about you for research projects that are subject to a special approval process. We will ask you for your permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the office.

Organ and Tissue Donation

If you are an organ donor, we may release health information to organizations that handle organ procurement, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate such donation and transplantation.

Military, Veterans, National Security & Intelligence

If you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about you. We may also release information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation
We may disclose your health information as necessary to comply with worker's compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

Public Health Risks

We may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.

Health Oversight Activities

We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes

If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order.

Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.

Law Enforcement

We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.

Coroners, Medical Examiners and Funeral Directors
We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.

Proof of Immunization
We will disclose proof of immunization to a school where the law requires the school to have such information prior to admitting a student if you have agreed to the disclosure on behalf of yourself or your dependent.

Specialized Government Functions
We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

Information Not Personally Identifiable

We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.

Change of Ownership
In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

Breach Notification
In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current email address, we may use email to communicate information related to the breach. In some circumstances, our business associate may provide the notification. We may also provide notification by other methods as appropriate.

Other Uses and Disclosures of Health Information

We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written Authorization. If you give us Authorization to use or disclose health information about you, you may revoke that Authorization, in writing, at any time. If you revoke your Authorization, we will no longer use or disclose information about you for the reasons covered by your written Authorization, but we cannot take back any uses or disclosures already made with your permission.

If we have HIV or substance abuse information about you, we cannot release that information without a special signed, written authorization from you that complies with the law governing HIV or substance abuse records.

Your Rights Regarding Health Information About You

You have the following rights regarding health information we maintain about you:

Right to Inspect and Copy

You have the right to inspect and copy your health information, such as medical and billing records, that we use to make decisions about your care. You must submit a written request to:

William T. Baldock, Jr. DMD, MS - William T. Baldock, DDS, MS

Of our office at

2621 Mitcham Drive Suite 101
Tallahassee, FL 32308

info@capitalperio.com

(850) 942-8111
(850) 942-8114

in order to inspect and/or copy your health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other associated supplies. We may deny your request to inspect and/or copy in certain limited circumstances. If you are denied access to your health information, you may ask that the denial be reviewed. If such a review is required by law, we will select a licensed health care professional to review your request and our denial. The person conducting the review will not be the person who denied

your request, and we will comply with the outcome of the review.

Right to Amend or Supplement

If you believe health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by this office.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

a) We did not create, unless the person or entity that created the information is no longer available to make the amendment.

b) Is not part of the health information that we keep.

c) You would not be permitted to inspect and copy.

d) Is accurate and complete.

It must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically). We may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions

You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

We are Not Required to Agree to Your Request

We may not (and are not required to) agree to your restrictions with one exception: If you pay in full (out of pocket) for a service you receive from us, and you request that we do not submit the claim for this service to your health insurer or health plan for reimbursement, we must honor that request.

If we do agree we will comply with your request unless the information is needed to provide you emergency treatment.

We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice

You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive it electronically, you are still entitled to a paper copy. To obtain such a copy, contact:

William T. Baldock, Jr., DMD, MS · William T. Baldock, DDS, MS

Right to an Accounting of Disclosures

You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you for purposes other than treatment, payment and health care operations. To obtain this list, you must submit your request in writing to:

William T. Baldock, Jr., DMD, MS · William T. Baldock, DDS, MS

Of our office at

2621 Mitcham Drive Suite 101
Tallahassee, FL 32308

info@capitalperio.com

(850) 942-8111
(850) 942-8114

CHANGES TO THIS NOTICE

We reserve the right to change this notice, and to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a summary of the current notice in the office with its effective date in the top right-hand corner. You are entitled to a copy of the notice currently in effect.

To request restrictions, you may complete and submit a Request For Restricting Uses and Disclosures and Confidential Communications Form Information to:

William T. Baldock, Jr., DMD, MS · William T. Baldock, DDS, MS

Right to Request Confidential Communications

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.
To request confidential communications, you may complete and submit the Requests For Restricting Uses and Disclosures and Confidential Communications to:

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact:

William T. Baldock, Jr., DMD, MS · William T. Baldock, DDS, MS

You will not be penalized for filing a complaint.

Signature _____