TRIANGLE DENTISTRY

SMITH, TART & ASSOCIATES

Patient Information

Date _____ Birthdate _____

Patient Name _____
Last First Middle

Address _____
Street City State Zip

Home Phone _____ Work Phone _____ Cell Phone _____

Social Security # _____ Email _____

If patient is a minor, give parent's or guardian's name _____

Whom may we thank for referring you to our office? _____

Responsible Party Information

Name _____
Last First Middle Marital Status

Residence _____
Street City State Zip

Mailing Address _____
Street City State Zip

How long at this address? _____ Home Phone _____ Work Phone _____

Previous Address (if less than 3 yrs.) _____
Street City State Zip

Social Security # _____ Birthdate _____ Relationship to patient _____

Employer _____ Occupation _____ No. Years Employed ____

Employer Address _____

Dental Insurance Information

Primary

Insured's Name _____ Insured's SS# or ID# _____

Insured's Birthdate _____ Insured's Employer _____

Insurance Co. _____ Group No. _____

Insurance Co. Address _____

Insurance Co. Phone # _____

Do you have dual coverage? ____Yes ____ No

Secondary

Insured's Name _____ Insured's SS# or ID# _____

Insured's Birthdate _____ Insured's Employer _____

Insurance Co. _____ Group No. _____

Insurance Co. Address _____

Insurance Co. Phone # _____

Emergency Information

Name of nearest relative **NOT** living with you _____

Complete Address _____

Phone Number _____

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Medical History

Patient Name_____ Preferred Name _____ DOB _____

Name of Physician/and their specialty _____

Most recent physical examination _____ Purpose _____

What is your estimate of your general health? ____ Excellent ____Good ____ Fair ____ Poor

DO YOU HAVE or HAVE YOU EVER HAD:	YES	NO
Hospitalization for illness or injury _____	☐	☐
An allergic reaction to		
☐ Aspirin, ibuprofen, acetaminophen, codeine		
☐ Penicillin		
☐ Erythromycin		
☐ Tetracycline		
☐ Sulfa		
☐ Local anesthetic		
☐ Fluoride		
☐ Metals (nickel, gold, silver, _____)		
☐ Latex		
☐ Other _____		
Heart problems or cardiac stent within last six months	☐	☐
History of infective endocarditis _____	☐	☐
Artificial heart valve, repaired heart defect (PFO) ___	☐	☐
Pacemaker or implantable defibrillator _____	☐	☐
Artificial prosthesis (heart valve or joints) _____	☐	☐
Rheumatic or scarlet fever _____	☐	☐
High or low blood pressure_____	☐	☐
A stroke (taking blood thinners) _____	☐	☐
Anemia or other blood disorder _____	☐	☐
Prolonged bleeding due to a slight cut (INR>3.5)____	☐	☐
Emphysema, sarcoidosis _____	☐	☐
Tuberculosis _____	☐	☐
Asthma _____	☐	☐
Breathing or sleep problems (i.e. snoring, sinus)____	☐	☐
Kidney disease _____	☐	☐
Liver disease _____	☐	☐
Jaundice _____	☐	☐
Thyroid, parathyroid disease, or calcium deficiency _	☐	☐
Hormone deficiency _____	☐	☐
High cholesterol or taking statin drugs _____	☐	☐

	YES	NO
Diabetes (HbA1c = _____)	☐	☐
Stomach or duodenal ulcer _____	☐	☐
Digestive disorders (i.e. gastric reflux) _____	☐	☐
Osteoporosis/Osteopenia (bisphosphonates)___	☐	☐
Arthritis _____	☐	☐
Glaucoma _____	☐	☐
Contact lenses _____	☐	☐
Head or neck injuries _____	☐	☐
Epilepsy, convulsions (seizures) _____	☐	☐
Neurologic problems (attention deficit disorder)	☐	☐
Viral infections and cold sores _____	☐	☐
Any lumps or swelling in the mouth _____	☐	☐
Hives, skin rash, hay fever _____	☐	☐
Hepatitis (type____) _____	☐	☐
HIV/AIDS _____	☐	☐
Tumor, abnormal growth	☐	☐
Diagnosis of cancer (type_____)	☐	☐
Radiation therapy_____	☐	☐
Chemotherapy _____	☐	☐
Anxiety _____	☐	☐
ARE YOU:		
Presently being treated for any other illness ___	☐	☐
Aware of a change in your general health _____	☐	☐
Taking dietary supplements_____	☐	☐
Often exhausted or fatigued _____	☐	☐
Subject to frequent headaches _____	☐	☐
A smoker or smoked previously _____	☐	☐
FEMALE – taking birth control pills_____	☐	☐
FEMALE – pregnant _____	☐	☐
Taking steroidal meds_____	☐	☐
Alcohol/chemical dependency _____	☐	☐

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment.

_____

_____

_____

Phone: 919.847.6000 **Fax**: 919.847.3159 **Mail**: 120 Northway Court, Raleigh, NC 27615 **Web**: www.triangledentistry.com

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Patient's Name:_____ Birthdate: _____

Please list all medications, supplements, and or vitamins taken within the last two years

Drug	Purpose	Drug	Purpose

Ask for an additional sheet if you are taking more medications.

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature_____ Date _____

Patient's Signature_____ Date _____

Patient's Signature_____ Date _____

Patient's Signature_____ Date _____

Patient's Signature_____ Date _____

Patient's Signature_____ Date _____

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To Our Patients:

***What is HIPAA?* The Health Insurance Portability and Accountability Act**

Why? 1. HIPAA protects you and the privacy of your health information.

2. This permits us to file your electronic insurance claims which protects the privacy of your information and allows for faster reimbursement.

3. This is required by law.

Attached:

- **Notice of Privacy Practices - at your leisure please read the complete explanation of HIPAA**

- **Acknowledgement of Receipt of Notice of Privacy Practices – please complete & give to a staff member**

** It is of note: Your signature simply states that you have received this Notice of Privacy Practices.

TRIANGLE DENTISTRY

SMITH, TART & ASSOCIATES

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)

_____

_____

_____

TRIANGLE DENTISTRY

SMITH, TART & ASSOCIATES

Patient Financial Policy

Thank you for choosing Triangle Dentistry for your dental needs. Your dental health is important to us, and we want to ensure that you receive the treatment you need. We realize that every person's financial situation is different. For this reason, we have the following payment options from which you may choose.

Cash or Check
MasterCard, Visa, Discover or American Express
Care Credit

Insurance Filing

We may accept assignment of your insurance benefits; however, we require that your estimated portion and deductible be paid at time of service. Since your insurance policy is an agreement between you and your insurance company, please realize that it is your responsibility to follow up on claims and payments. We will send a statement to you each month your account has an outstanding balance. Payment in full is appreciated on all statements.

The patient is responsible for payment of all fees not covered by insurance regardless of any insurance company's arbitrary determination of usual and customary fees.

I have read, understand and agree to the payment terms of this financial policy.

_____ _____

Date **Patient or Responsible Party Signature**

Note: A 1.5% finance charge per month will be assessed on all balances over 60 days old. All accounts over 120 days past due will be forwarded to our collection service. All fees and costs associated with the collections process (including all legal fees) will be the responsibility of the patient.

PAYMENT IS EXPECTED AT TIME OF SERVICE

Please give us a minimum of 48 hours' notice to cancel your appointment. Failure to do so may result in a $48 cancellation fee.

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Request for Release of Dental Records

DATE: _____

PATIENT NAME: _____

DATE OF BIRTH: _____

I HEREBY REQUEST RELEASE OF MY DENTAL RECORDS FROM THE OFFICE:

_____

_____

_____

Phone: _____ **BWX:** _____ **Panorex:** _____ **FMX:** _____

We prefer jpeg attachments sent via email.

Please include the date they were taken.

To avoid repeat requests, please email us if the patient does not have current records at your office.

PLEASE SEND TO: **Triangle Dentistry**
Smith, Tart, & Associates
120 Northway Court
Raleigh, NC 27615

EMAIL ADDRESS: Triangledentistry@mindspring.com

PATIENT AUTHORIZATION: _____

TRIANGLE DENTISTRY

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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 and 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 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 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 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 judgement in 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 emails).

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 charge you per page and for staff time per hour 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.

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 Web site 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 alternative locations, you may complain to use 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.

Contact Officer:	James E. Smith, DMD
Telephone:	(919) 847-6000 Fax: (919) 847-3159
Email:	triangledentistry@mindspring.com
Address	120 Northway Court Raleigh, NC 27615