PATIENT REGISTRATION AND HEALTH HISTORY

DATE _____

PATIENT'S NAME _____ DATE OF BIRTH _____

☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED S.S. # _____

NAME OF SPOUSE _____

IF A CHILD, PARENT'S NAME _____

PERSON RESPONSIBLE FOR THIS ACCOUNT _____

RESIDENCE ADDRESS _____ PHONE _____

CITY _____ STATE _____ ZIP _____

EMPLOYED BY _____ PHONE _____

BUSINESS ADDRESS _____

PRESENT POSITION _____ HOW LONG HELD _____

SPOUSE EMPLOYED BY _____

REFERRED BY _____

DENTAL INSURANCE (IF ANY) _____

CASH ☐ TERMS ☐ DENTAL INSURANCE ☐

PATIENT'S NAME

DENTAL HISTORY

PURPOSE OF THIS APPOINTMENT _____

APPROXIMATE DATE OF LAST DENTAL EXAM _____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING _____

☐ TEETH SENSITIVE TO COLD, HEAT, SWEETS
☐ BLEEDING GUMS
☐ FOOD IMPACTION
☐ SWELLING OR LUMPS IN MOUTH
☐ LOOSE TEETH
☐ COMPLICATIONS FROM EXTRACTIONS
☐ PERIODONTAL TREATMENT
☐ ORTHODONTIC TREATMENT

Drs. Dickey, Singleton, Lynch, and Farr

Name_____ Sex_____ Date of Birth_____

Address_____

Telephone Landline_____ Cell_____ Work_____

Dental Insurance_____ Email _____
(Company Name)

Emergency Contact_____ Date_____

DIRECTIONS

Please read questions carefully. Answer all questions by circling either YES or NO and filling in all blanks when indicated. Dental procedures may complicate or be complicated by conditions elsewhere in the body. It is important to have a complete and accurate health history to assist the dental staff in evaluating your general health. Answers to the following questions are for the records of this office and will be considered confidential.

1. What is the impression of your present health?
   Excellent Good Fair Poor

   a. Has there been a change in your general health in the past year? YES NO
2. If yes, what is the condition(s) being treated?
   _____
3. Are you presently under the care of a physician? YES NO
4. Name and address of physician _____
   _____
5. Have you been hospitalized or had a serious illness within the past 5 years? YES NO
6. Do you presently have or have had any of the following illnesses, diseases or problems?

   a. Heart disease (heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, congenital heart disease) YES NO
      1. Do you have chest pain when you exercise? YES NO
      2. Do you ever become short of breath after mild exercise? YES NO
      3. Do you get short of breath when lying down? YES NO
      4. Do you use an extra pillow to help you sleep? YES NO

   b. Artificial heart valve or pace maker? YES NO
   c. Cancer (tumors, cysts, growths) YES NO
   d. Allergies (i.e. - hayfever) YES NO
   e. Asthma or bronchitis YES NO
   f. Hives or skin rashes YES NO
   g. Fainting spells, seizures, epilepsy YES NO
   h. Diabetes YES NO
      1. Do you have to urinate (pass water) more than 6 times a day? YES NO
      2. Are you thirsty much of the time? YES NO
      3. Does your mouth frequently become dry? YES NO

4. Unexplained weight gain or loss of more than 10 pounds? YES NO
5. Slow healing? YES NO
6. Have you taken any medications for osteoporosis, osteopenia, or low bone density? YES NO

i. Hepatitis, jaundice or liver disease YES NO
j. Arthritis, bursitis, or rheumatism YES NO
k. Stomach or duodenal ulcers YES NO
l. Kidney trouble YES NO
m. Tuberculosis - positive TB tine or IPPD test YES NO
If yes, when were you treated and what was the date of your last chest x-ray?_____
n. Do you cough a lot or cough up blood? YES NO
o. High or Low blood pressure YES NO
p. Venereal disease - syphilis, gonorrhea, etc. YES NO
q. Oral herpes/cold sores/fever blisters YES NO
r. Joint replacement implants YES NO
s. Acquired Immune Deficiency Syndrome? YES NO
t. Nervous system disorders (epliepsy, cerebral palsy, etc.) YES NO
u. Emotional or mental system disorders YES NO
v. Drug or alcohol addiction YES NO
w. Do you smoke? If yes, how much a day?_____
x. Are you currently on any anticoagulants or blood thinners? YES NO

7. Have you had abnormal bleeding or severe bleeding after a tooth extraction, surgery or injury? YES NO
a. Do you bruise easily? YES NO
b. Have you ever required a blood transfusion? YES NO
If yes, please explain the circumstances._____
_____
8. Do you have an anemia or other type of blood disorder?
9. Have you had surgery or radiation treatment for a cancer, tumor or growth, especially in the head/neck region? YES NO
10. Have you had medical x-rays in the last five years? YES NO
11. Are you taking any of the following medications?
a. Antibiotics or sulfa drugs YES NO
b. Anticoagulants (blood thinners) YES NO
c. High blood pressure medication YES NO
d. Cortisone (steroids) YES NO
e. Tranquilizers YES NO
f. Aspirin YES NO
g. Insulin or an oral hypoglycemic (i.e. - Orinase) YES NO
h. Digitalis or other drugs for heart trouble YES NO
i. Nitroglycerin YES NO
j. Antihistamines YES NO
k. Oral contraceptives or hormonal therapy YES NO

12. Are you taking any other drug or medicine? YES NO
If so, what and for what condition?_____
_____
13. Have you taken any medication in the past six months? YES NO
If yes, what and for what condition?_____
_____

14. Are you allergic or have you adversely reacted to:

a. Local anesthetics	YES	NO
b. Penicillin or other antibiotics	YES	NO
c. Sulfa drugs	YES	NO
d. Barbiturates, sedatives, or sleeping pills	YES	NO
e. Aspirin	YES	NO
f. Iodine	YES	NO
g. Codeine/narcotics	YES	NO
h. Other_____		

15. Are you employed in any situation which exposes you regularly to x-rays or other ionizing radiation? YES NO

16. Do you have any disease, condition, or problem not listed that you think the dentist or hygienist should be aware of? YES NO
If so, please explain_____

WOMEN ONLY

18. Are you pregnant? YES NO
If yes, what trimester?_____

19. Do you have any problems associated with your menstrual cycle? YES NO

I certify that this information is correct to the extent of my knowledge on this date_____.

_____
Patient or Guardian signature

Drs. Lynch, Dickey and Singleton Dentists, Inc

I have received a copy of this office's Notice of Privacy Practices.

You May Refuse to Sign This Acknowledgment

Print Patient Name: _____

Signature/ Guardian: _____

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)

_____

_____

Drs. Lynch, Dickey and Singleton

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Name: _____

Address: _____ City ST: _____ Zip: _____

Telephone: _____ Email: _____

Date of Birth: _____ Social Security Number: _____

SECTION B: TO THE PATIENT- PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry our treatment, payment activities and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Laura Bondurant
Telephone: 540-343-5521
Address: 1510 Franklin Road SW, Roanoke, VA 24016

Right to Revoke: you will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE:

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment: payment activities and healthcare operations.
Signature: _____ Date: _____

If a personal representative on behalf of the patient signs this Consent, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

REVOCATION OF CONSENT
I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____

Drs. Lynch, Dickey and Singleton Dentists, Inc.

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.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow privacy practices that are described in this Notice while it is in effect. This Notice takes effect March 30,2015 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and applicable law permits the terms of this Notice at any time, provided such changes, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new notice 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.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV- related information, genetic information, alcohol and/ or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you ,we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.

Required by Law. We may use or disclose your health information when we are required to do so by law.

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

*Prevent or control disease, injury or disability;
*Report reactions to medications or problems with products or devices;
*Notify a person who may have been exposed to a disease or condition;
*Report child abuse or neglect;
*Notify a person of a recall, repair, or replacement of products or devices;
*Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence

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 the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the U. S, Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

OTHER USES AND DISCLOSURES OF PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI except to the extent that we have already taken action in reliance on the authorization.

YOUR HEALTH INFORMATION RIGHTS

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain electronically, you have the right to an electronic copy. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation o our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. 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 the additional requests.

Right to Request a Restriction. You have a right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the privacy official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. **We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment** or health care operations. And the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

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. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

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 if 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 the 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 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: Laura Bondurant
Telephone (540) 343-5521 fax (540) 343-0923
1510 Franklin Road, SW, Roanoke, VA 24016
lds3inc@aol.com

Financial Assignment/ Agreement and Policy:

Drs. Lynch, Dickey and Singleton, Inc.

1. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance.

2. In order to control your cost of billing, we request that your charges for offices visits be paid at the conclusion of each visit unless prior financial plans have been established.

3. A finance charge will be added to accounts after 60 day at 18%. In the event your account is sent to collections you would be responsible for all court cost, collection fees and attorney fees.

4. Due to the high cost of overhead there may be a charge of **$35 or more for broken appointments** and appointments not cancelled 24 hours before time. Payment of these charges will be required before other appointments are scheduled.

5. There will be a $25 charge for all returned checks.

6. State law requires blood testing of any patient if a dentist/ employee is exposed to any body fluids that could cause risk of infection.

Print Patient's Name:

_____

Patient's Signature:

_____

If minor, Parent of Guardian Signature:

_____

Date: _____