Carrboro Family Dentistry

Adam J. Sturdevant, DDS, PA

Patient Registration

First Name: _____ Middle: _____ Last: _____

Sex: _____ Marital Status: _____ Preferred Title: _____

Date of Birth: _____

Home Street Address: _____

City:_____ State: _____ ZIP: _____

Cell Phone #: _____ Home #: _____ Work #: _____

Email: _____

Occupation: _____ Employer: _____

How did you hear about us?: _____

Emergency Contact

Name: _____ Relation: _____ Phone #: _____

Dental Insurance Company: _____

Policy Holder: _____Group #: _____ ID #: _____

If you are completing this form for another person what is your:

Full Name: _____ Relation: _____

If you are currently under the care of a doctor please provide their:

Name: _____ Practice Name: _____ Phone #: _____

Dental History

Do your gums bleed when you floss or brush?

YES NO

Are your teeth sensitive to cold, hot, sweets, or pressure?

YES NO

Is your mouth dry?

YES NO

Have you ever had problems with previous dental treatment?

YES NO

Is your tap water supply fluoridated (and do you drink it)?

YES NO

Are you currently experiencing dental/oral pain?

YES NO

Do you have any click, popping, or discomfort in your TMJ/jaw joint?

YES NO

Do you brux/grind/clench your teeth?

YES NO

Do you have sores or ulcers in your mouth?

YES NO

Have you ever had a serious injury/trauma to your head or mouth?

YES NO

Have you ever experienced dizziness or fainting from a medical or dental procedure?

YES NO

Do you have dental anxiety?

YES NO

How many times a day do you brush? _____

How many times a day do you floss? _____

Do you have an electric toothbrush?

YES NO

What oral care products do you use (toothpastes, mouth rinses, ulcer treatments, Waterpik, toothpicks, Proxabrush, etc.)?

_____

_____

When was your last dental visit?

_____

Name of dentist: _____

Name of practice: _____

When were your last dental x-rays?

_____

What is the reason for your visit today?

_____

_____

Medical History

Please mark YES or NO if you have ever been diagnosed with any of the following conditions:

YES NO Cardiovascular/heart diseases
YES NO Angina
YES NO Heart attack
YES NO Heart murmur
YES NO Congenital heart problems
YES NO Damaged heart valves
YES NO Artificial heart valve
YES NO Endocarditis
YES NO Rheumatic fever
YES NO Mitral valve prolapse
YES NO Heart surgery
YES NO Stroke
YES NO Low blood pressure
YES NO High blood pressure
YES NO Pacemaker
YES NO Abnormal/excess bleeding
YES NO Anemia
YES NO Hemophilia
YES NO AIDS or HIV
YES NO Arthritis
YES NO Asthma
YES NO Bronchitis
YES NO Emphysema
YES NO Cancer/chemotherapy/radiation
YES NO Diabetes Type I or II
YES NO Eating disorder
YES NO Gastrointestinal disease
YES NO Reflux/heartburn
YES NO Thyroid problems
YES NO Stroke
YES NO Glaucoma
YES NO Hepatitis or liver disease
YES NO Epilepsy
YES NO Fainting or seizures
YES NO Neurological disorders
YES NO Sleep disorders
YES NO Mental health disorders
YES NO Kidney problems
YES NO Osteoporosis
YES NO Sexually transmitted disease
YES NO Joint replacement

Other conditions not listed above:

_____

_____

_____

_____

_____

Allergies:

YES NO Local Anesthetics (caines)
YES NO Sulfite
YES NO Aspirin
YES NO Penicillin
YES NO Opioids
YES NO Latex
YES NO Metals
YES NO Benzodiazepines
YES NO Other (list or explain):

_____

_____

Medical History

Has a doctor ever told you that you need to premedicate before a dental procedure?

YES NO

Are you currently pregnant?

YES NO

Number of weeks: _____

Are you currently breast feeding?

YES NO

Have you ever taken bisphosphonates or RANKL inhibiting drugs like FOSAMAX, Boniva, Zometa, Prolia, XGEVA, or others?

YES NO

Do you use tobacco products?

YES NO

Do you use any recreational drugs?

YES NO

Do you drink alcohol?

YES NO

Amount: _____

Have you ever experienced drug or alcohol abuse?

YES NO

Have you been hospitalized in the last 5 years?

YES NO

Explain: _____

List all current medications and dosages below. Include prescription, over the counter, and any supplemental products:

_____

_____

_____

_____

_____

_____

Is there anything not covered by this form that you would like the doctor to be aware of?:

_____

_____

_____

_____

By signing here, I certify that I am the patient, or a representative of the patient authorized to provide the information on this form. I understand all the questions on this form and this information has been filled out with no omissions. I will not hold Carrboro Family Dentistry responsible for complications arising from omissions or errors on this form.

Signature: _____ Date: _____

Notice of Privacy Practices

Carrboro Family Dentistry
Adam J. Sturdevant, DDS, PA

610 Jones Ferry Road, Suite #206
Carrboro, NC 27510
919-929-5160
CarrboroFamilyDentistry@gmail.com
CarrboroFamilyDentistry.com

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.**

LAYERED SUMMARY
Your Rights
You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices
You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures
We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.
Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days.

Request confidential communications
- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say “yes” to all reasonable requests.

Ask us to limit what we use or share
- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information.

Get a list of those with whom we’ve shared information
- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice
You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you
- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated
- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.
In these cases, you have both the right and choice to tell us to:
- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:
- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:
- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**
Changes to the Terms of this Notice
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.
EFFECTIVE DATE: April 14, 2003, UPDATED: August 8, 2018

Carrboro Family Dentistry
Acknowledgements and Consents

- I have received, read, and understand the Notice of Privacy Practices for Carrboro Family Dentistry.
- I understand that I am solely responsible for full payment for services at the time they are rendered.
- I give consent for Carrboro Family Dentistry to use my Protected Health Information (PHI) for my treatment, payment, and health care operations.

Signature: _____ Date: _____

Authorizations

This section is not required

This section authorizes who we can speak with and in what fashion about your care.

I authorize my protected health information (PHI) to be released in the following fashion:

Individuals/Entities PHI can be released to:

Parent/Guardian (Name & Phone): _____

Spouse/Partner (Name & Phone): _____

Other (Name & Phone): _____

Type of PHI that can be released to the above authorized individuals/entities:

☐ Medical/Treatment information ☐ Financial/Insurance information

Manner information can be delivered:

☐ Text Message ☐ Phone ☐ E-mail ☐ Voice Mail ☐ Mail

- I understand I am not required to fill out or sign this section of this form
- I understand I can revoke this authorization at any time

By signing here, I certify that I am the patient, or a representative of the patient authorized to provide the information on this form. I understand all the questions on this form and this information has been filled out with no omissions. I will not hold Carrboro Family Dentistry responsible for complications arising from omissions or errors on this form.

Signature: _____ Date: _____