Drs. Capps, Bowman, & Padgett

MEDICAL HISTORY

PATIENT NAME ______________________ Birth Date ______________

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

- Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: ______
- Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: ______
- Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: ______
- Are you taking any medication, pills, or drugs? ◯ Yes ◯ No If yes, please explain: ______
- Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No ______
- Are you on a special diet? ◯ Yes ◯ No ______
- Do you use tobacco? ◯ Yes ◯ No
- Do you use controlled substances? ◯ Yes ◯ No

Women: Are you

Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics

☐ Other If yes, please explain: ______

Do you have, or have you had, any of the following?

Condition	Yes	No
AIDS/HIV Positive	◯	◯
Alzheimer's Disease	◯	◯
Anaphylaxis	◯	◯
Anemia	◯	◯
Angina	◯	◯
Arthritis/Gout	◯	◯
Artificial Heart Valve	◯	◯
Artificial Joint	◯	◯
Asthma	◯	◯
Blood Disease	◯	◯
Blood Transfusion	◯	◯
Breathing Problem	◯	◯
Bruise Easily	◯	◯
Cancer	◯	◯
Chemotherapy	◯	◯
Chest Pains	◯	◯
Cold Sores/Fever Blisters	◯	◯
Congenital Heart Disorder	◯	◯
Convulsions	◯	◯
Cortisone Medicine	◯	◯
Diabetes	◯	◯
Drug Addiction	◯	◯
Easily Winded	◯	◯
Emphysema	◯	◯
Epilepsy/Seizures	◯	◯
Fainting Spells/Dizziness	◯	◯
Frequent Cough	◯	◯
Frequent Diarrhea	◯	◯
Frequent Headaches	◯	◯
Genital Herpes	◯	◯
Glaucoma	◯	◯
Hay Fever	◯	◯
Heart Attack/Failure	◯	◯
Heart Murmur	◯	◯
Heart Pace Maker	◯	◯
Heart Trouble/Disease	◯	◯
Hemophilia	◯	◯
Hepatitis A	◯	◯
Hepatitis B/C	◯	◯
Herpes	◯	◯
High Blood Pressure	◯	◯
Hives or Rash	◯	◯
Hypoglycemia	◯	◯
Irregular Heartbeat	◯	◯
Kidney Problems	◯	◯
Leukemia	◯	◯
Liver Disease	◯	◯
Low Blood Pressure	◯	◯
Lung Disease Mitral	◯	◯
Valve Prolapse	◯	◯
Pain in Jaw Joints	◯	◯
Parathyroid Disease	◯	◯
Psychiatric Care	◯	◯
Radiation Treatments	◯	◯
Recent Weight Loss	◯	◯
Renal Dialysis	◯	◯
Rheumatic Fever	◯	◯
Rheumatism	◯	◯
Scarlet Fever	◯	◯
Shingles	◯	◯
Sickle Cell Disease	◯	◯
Sinus Trouble	◯	◯
Spina Bifida	◯	◯
Stomach/Intestinal Disease	◯	◯
Stroke	◯	◯
Swelling of Limbs	◯	◯
Thyroid Disease	◯	◯
Tonsillitis	◯	◯
Tuberculosis	◯	◯
Tumors/Growths	◯	◯
Ulcers	◯	◯
Venereal Disease	◯	◯
Yellow Jaundice	◯	◯

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes, please explain: ______

List all medications that you are taking now:

Medications	Use	Medications	Use

Comments:

______

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT /GUARDIAN ______________ DATE ______________

DRS. CAPPS, BOWMAN, PADGETT AND ASSOCIATES

Our goal is to help you achieve and maintain optimum oral health. So that we may best serve you, please complete this form. We appreciate the confidence you have placed in us by selecting our team of dental professionals.

Patient Information

DATE_____/_____/_____

First Name: ______________________ **Last Name:** ______________________ **Middle Initial:** __________

Date of Birth:_____/_____/_____ **Age:** _____ **SSN:**________________ **DL#** ____________________

Residential Address: ________________ **City:**________________ **State:**_____ **Zip:** __________

Home Phone:________________ **Work Phone:** ________________ **Cell:** __________ **Pager:** __________

APPOINTMENT REMINDER CONTACT INFORMATION (How would you like us to contact you? Please circle:)

Phone call: home work cell   Text Message: Y / N   E-Mail: Yes ____________________ **/ no thanks**

PLEASE CIRCLE: Male Female   PLEASE CIRCLE: Single Married Widowed Divorced

Are you a full time student? _____ **If you are filing dental insurance, you must submit a student status form.**

Employer Information

Name of Employer: ________________________ **Occupation:** ________________________

Employer Address: ____________________ **City:**________________ **State:**_____ **Zip:** __________

Parent or Spouse Information

Whom is financially responsible for this account if different from patient?

Name: ________________ **Relationship:** ________________ **Employer:** ________________

SSN#: ____________________ **D/O/B:** _____/_____/_____ **DL#** ____________________

Billing Address: ____________________ **City:**________________ **State:**_____ **Zip:** __________

Contact home #:________________ **Contact Work #:**________________ **Contact Cell #:** ______________

Whom should we call in the event of an emergency? NAME: ______________________________

Contact home #:________________ **Contact Work #:**________________ **Contact Cell #:** ______________

Dental Insurance Information

Please have your insurance card available so a copy can be made for our records. No benefits will be applied without card.

Primary Carrier:

Insurance Company: ________________ **Policy Number:** ________________
Employer Name:________________ **Employee Name:**________________
Employee SSN: ________________ **Employee DOB:** ________________

Secondary Carrier:

Insurance Company: ________________ **Policy Number:** ________________
Employer Name:________________ **Employee Name:**________________
Employee SSN: ________________ **Employee DOB:** ________________

Additional Information

Whom may we thank for referring you to our office? ________________ **Relationship?**________________

Have any family members been treated in our office? YES / NO   Who? ________________

Why did you choose Capps, Bowman, Padgett and Associates for your dental needs? ________________

PLEASE READ AND SIGN THE BACK OF THIS PAGE

I understand that all information on this form is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge. I hereby authorize x-rays, study models, photographs, and/or other aids necessary to make a thorough diagnosis of my dental needs. I authorize Capps, Bowman, Padgett and Associates to perform needed treatments and dispense necessary medications that may be indicated. I understand the use of anesthetic agents involves risks. It is my responsibility to inform this dental office of any changes in my medical status.

I understand that if I am taking antibiotics, I may need some other form of birth control other than oral contraceptives.

I understand the responsibility for payment of dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered, UNLESS financial arrangements have been made. I understand that where appropriate, credit bureau reports may be obtained. I further understand that a statement fee will be added to any balance over 90 days. In the event of default, I (we) promise to pay this charge on the indebtedness, together with such collection cost, and reasonable attorney fees as may be required to effect collection.

I agree to assign insurance payments to Capps, Bowman, Padgett and Associates. I understand any overpayment by the insurance company will be reimbursed to me upon my request. I am also aware that my insurance may not cover the full professional fee. I hereby authorize release of any information relating to a claim and agree to promptly pay any outstanding balance to Capps, Bowman, Padgett and Associates within 90 days of rendering treatment; all fees are due and payable at that time.

I understand should I transfer to another dental practice, that the original chart and x-rays must remain at Capps, Bowman, Padgett and Associates. If I request a copy of my dental records to be forwarded to another dental practice I understand that a $25 duplication fee will be billed to my account.

I agree that the above information has been provided to me in a manner and language that I understand.

Signature of Patient or Legal Guardian: ______________________________ Date: ________________

Authorization for Release of Information

Name of Patient ____ Date of Birth ______________

Dr. Capps, Bowman, Padgett, & Associates is authorized to release protected health information about the above named patient in the following manner and to the identified persons.

Entity to Receive Information: Check each person/entity that you approve to receive information.	**Description of information to be released.** Check each that can be given to person/entity on the left in the same section.
☐ Spouse (provide name and phone number) ________________	☐ Financial
☐ Parent (provide name and phone number) ________________	☐ Medical / Dental
☐ Other (provide name and phone number) ________________	
☐ Voicemail (excludes appointment confirmation)	☐ Results of lab tests/x-rays
☐ Fax (provide fax number)_________________	☐ Other______________________________
☐ Email communication (Provide email address ______________________	☐ Financial
*In order for email/fax communication to occur, please accept the disclosure below:	☐ Medical / Dental
	☐ Breach notification

☐ For email/fax communication, I understand that if the email/fax is not sent in an encrypted manner, there is a risk it could be accessed inappropriately. I still elect to receive email/fax communication.

Patient Rights:
- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and understand that my treatment will not be conditioned on signing.

The information is released at the patient's request and this authorization will remain in effect until revoked by the patient.

____ ____________________

Signature of Patient or Personal Representative Date

*Description of Personal Representative's Authority (attach necessary documentation)

Revised December 2014

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 the Privacy Officer. (252) 752-1891

Effective Date: April 14, 2003   Revised: August 1, 2013

We are committed to protect the privacy of your personal health information (PHI).

This Notice of Privacy Practices (Notice) describes how we may use within our practice or network and disclose (share outside of our practice or network) your PHI to carry out treatment, payment, or health care operations. We may also share your information for other purposes that are permitted or required by law. This Notice also describes your rights to access and control your PHI.

We are required by law to maintain the privacy of your PHI. We will follow the terms outlined in this Notice.

We may change our Notice at any time. Any changes will apply to all PHI. Upon your request, we will provide you with any revised Notice by:

- Posting the new Notice in our office.
- If requested, making copies of the new Notice available in our office or by mail.
- Posting the revised Notice on our website: **(www.cappsbowman.com)**.

Uses and Disclosures of Protected Health Information

We may use or disclose (share) your PHI to provide health care treatment for you.

Your PHI may be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you.

EXAMPLE: Your PHI may be provided to a physician to whom you have been referred for evaluation to ensure that the physician has the necessary information to diagnose or treat you. We may also share your PHI from time to time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

We may also share your PHI with people outside of our practice that may provide medical care for you, such as home health agencies.

We may use and disclose your PHI to obtain payment for services. We may provide your PHI to others in order to bill or collect payment for services. There may be services for which we share information with your health plan to determine if the service will be paid for.

PHI may be shared with the following:

- Billing companies
- Insurance companies, health plans
- Government agencies in order to assist with qualification of benefits
- Collection agencies

EXAMPLE: You are seen at our practice for a procedure. We will need to provide a listing of services, such as x-rays, to your insurance company so that we can get paid for the procedure. We may at times contact your health care plan to receive approval PRIOR to performing certain procedures to ensure the services will be paid for. This will require sharing of your PHI.

We may use or disclose, as needed, your PHI in order to support the business activities of this practice, which are called health care operations.

EXAMPLES:

- Training students, other health care providers, or ancillary staff (such as billing personnel) to help them learn or improve their skills.
- Quality improvement processes which look at delivery of health care and for improvement in processes which will provide safer, more effective care for you.
- Use of information to assist in resolving problems or complaints within the practice.

We may use and disclosure your PHI in other situations without your permission:

- If required by law: The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. For example, we may be required to report gunshot wounds or suspected abuse or neglect.
- Public health activities: The disclosure will be made for the purpose of controlling disease, injury or disability and only to public health authorities permitted by law to collect or receive information. We may also notify individuals who may have been exposed to a disease or may be at risk of contracting or spreading a disease or condition.
- Health oversight agencies: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.
- Legal proceedings: To assist in any legal proceeding or in response to a court order, in certain conditions in response to a subpoena, or other lawful process.
- Police or other law enforcement purposes: The release of PHI will meet all applicable legal requirements for release.
- Coroners, funeral directors: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law.
- Medical research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.
- Special government purposes: Information may be shared for national security purposes, or if you are a member of the military, to the military under limited circumstances.
- Correctional institutions: Information may be shared if you are an inmate or under custody of law which is necessary for your health or the health and safety of other individuals.
- Workers' Compensation: Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.

Other uses and disclosures of your health information.

Business Associates: Some services are provided through the use of contracted entities called "business associates." We will always release only the minimum amount of PHI necessary so that the business associate can perform the identified services. We require the business associate(s) to appropriately safeguard your information. Examples of business associates include billing companies or transcription services.

Health Information Exchange: We may make your health information available electronically to other healthcare providers outside of our facility who are involved in your care.

Fundraising activities: We may contact you in an effort to raise money. You may opt out of receiving such communications.

Treatment alternatives: We may provide you notice of treatment options or other health related services that may improve your overall health.

Appointment reminders: We may contact you as a reminder about upcoming appointments or treatment.

We may use or disclose your PHI in the following situations UNLESS you object.

- We may share your information with friends or family members, or other persons directly identified by you at the level they are involved in your care or payment of services. If you are not present or able to agree/object, the healthcare provider using professional judgment will determine if it is in your best interest to share the information. For example, we may discuss post procedure instructions with the person who drove you to the facility unless you tell us specifically not to share the information.
- We may use or disclose protected health information to notify or assist in notifying a family member, personal representative, or any other person that is responsible for care of your location, general condition, or death.
- We may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts.

The following uses and disclosures of PHI require your written authorization:

- Marketing
- Disclosures for any purposes which require the sale of your information

All other uses and disclosures not recorded in this Notice will require a written authorization from you or your personal representative.

Written authorization simply explains how you want your information used and disclosed. Your written authorization may be revoked at any time, in writing. Except to the extent that your doctor or this practice has used or released information based on the direction provided in the authorization, no further use or disclosure will occur.

Your Privacy Rights

You have certain rights related to your protected health information. All requests to exercise your rights must be made in writing.

You have the right to see and obtain a copy of your protected health information.

This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. If requested, we will provide you a copy of your records in an electronic format. There are some exceptions to records which may be copied and the request may be denied. We may charge you a reasonable cost based fee for a copy of the records.

You have the right to request a restriction of your protected health information.

You may request for this practice not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. We are not required to agree with these requests.

If we agree to a restriction request we will honor the restriction request unless the information is needed to provide emergency treatment.

There is one exception: We must accept a restriction request to restrict disclosure of information to a health plan if you pay out of pocket in full for a service or product unless it is otherwise required by law.

You have the right to request for us to communicate in different ways or in different locations.

We will agree to reasonable requests. We may also request an alternative address or other method of contact, such as mailing information to a post office box. We will not ask for an explanation from you about the request.

You may have the right to request an amendment of your health information.

You may request an amendment of your health information if you feel that the information is not correct along with an explanation of the reason for the request. In certain cases, we may deny your request for an amendment at which time you will have an opportunity to disagree.

You have the right to a list of people or organizations who have received your health information from us.

This right applies to disclosures for purposes other than treatment, payment or healthcare operations. You have the right to obtain a listing of these disclosures that occurred after April 14, 2003. You may request them for the previous six years or a shorter timeframe. If you request more than one list within a 12 month period you may be charged a reasonable fee.

Additional Privacy Rights

- You have the right to obtain a paper copy of this notice from us, upon request. We will provide you a copy of this Notice the first day we treat you at our facility. In an emergency situation we will give you this Notice as soon as possible.
- You have a right to receive notification of any breach of your protected health information.

Complaints

If you think we have violated your rights or you have a complaint about our privacy practices, you can contact:

Privacy Officer - (252) 752-1891

You may also complain to the United States Secretary of Health and Human Services if you believe your privacy rights have been violated by us.

If you file a complaint, we will not retaliate against you for filing a complaint.

This notice was published and becomes effective on April 13, 2003.

Capps, Bowman, Padgett and Associates

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name & Address: ____
____
____

___I have received a copy of the Notice of Privacy Practices for the above named practice.
___I declined a copy of the Notice of Privacy Practices for the above named practice.

________________________________ ______________________
Signature Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- ❑ An emergency existed & a signature was not possible at the time.
- ❑ The individual refused to sign.
- ❑ A copy was mailed with a request for a signature by return mail.
- ❑ Unable to communicate with the patient for the following reason:
  ____
- ❑ Other:____
  ____

Prepared By: ____________________________________

Signature: ____________________________________

Date: ____________________________________