dentistry of the queen city

Patient Information

Name _____ Male ___ Female___
Last First MI

Title: Dr.__ Mr.__Mrs.__ Ms.__ How do you wish to be addressed _____

Address_____
Mailing address City State Zip

Home Phone_____Work Phone_____Cell Phone_____

Email address_____

Date of Birth_____ Social Security Number_____ Employer_____

Who may we thank for referring you to our practice?_____

Dental Insurance Information

Employee/Subscriber Name_____
Last First MI

Date of Birth_____ Subscriber ID#_____

Group/Employer Name _____Group Number_____

Insurance Company Name _____

Claims Mailing Address _____

_____

Telephone Number _____

- ☐ I authorize the dentist (or dentist's employees) to perform diagnostic procedures and dental treatment as may be necessary for proper dental care.
- ☐ I understand that my dental insurance benefits may be less than the fees for dental services and may not pay the fee charged in full.
- ☐ I understand that I am responsible for and agree to pay the total fees for my/my child's dental treatment.
- ☐ I agree to pay any applicable deductibles and estimated copayments on the date the dental services are rendered. I understand that not all dental treatment received may be covered by my insurance plan and I agree to pay for any non-covered services on the date the dental services are rendered.
- ☐ I hereby authorize payment of insurance benefits directly to the dentist which otherwise may be payable to me.
- ☐ I agree to pay the total cost of dental services rendered on the date of service if I/my child do not have dental insurance benefits.

Patient/Guardian Signature_____Date_____

Medical History

Patient Name _____ Nickname _____ Birthdate _____ Age ____

Address _____ Phone _____ Email _____

Name of Physician/and their specialty _____

Most recent physical examination _____ Purpose _____

What is your estimate of your general health? (circle one) Excellent Good Fair Poor

DO YOU HAVE or HAVE YOU EVER HAD:

1. hospitalization for illness or injury _____ YES NO

2. an allergic reaction to
   - ☐ aspirin, ibuprofen, acetaminophen, codeine
   - ☐ penicillin
   - ☐ erythromycin
   - ☐ tetracycline
   - ☐ sulfa
   - ☐ local anesthetic
   - ☐ fluoride
   - ☐ metals (nickel, gold, silver, _____)
   - ☐ latex
   - ☐ other _____

3. heart problems, or cardiac stent within the last six months _____ YES NO
4. history of infective endocarditis _____ YES NO
5. artificial heart valve, repaired heart defect (PFO)_____ YES NO
6. pacemaker or implantable defibrillator_____ YES NO
7. artificial prosthesis (heart valve or joints) _____ YES NO
8. rheumatic or scarlet fever _____ YES NO
9. high or low blood pressure _____ YES NO
10. a stroke (taking blood thinners) _____ YES NO
11. anemia or other blood disorder _____ YES NO
12. prolonged bleeding due to a slight cut (INR >3.0)___ YES NO
13. emphysema, sarcoidosis _____ YES NO
14. tuberculosis _____ YES NO
15. asthma _____ YES NO
16. breathing or sleeping problems (i.e. snoring, sinus) YES NO
17. kidney disease _____ YES NO
18. liver disease _____ YES NO
19. jaundice _____ YES NO
20. thyroid, parathyroid disease, or calcium deficiency YES NO
21. hormone deficiency _____ YES NO
22. high cholesterol or taking statin drugs _____ YES NO
23. diabetes (A1c=_____) _____ YES NO
24. stomach or duodenal ulcer _____ YES NO
25. digestive disorders (i.e. gastric reflux) _____ YES NO
26. osteoporosis/osteopenia (i.e. taking bisphosphates__ YES NO
27. arthritis _____ YES NO
28. glaucoma _____ YES NO
29. contact lenses _____ YES NO
30. head or neck injuries _____ YES NO
31. epilepsy, convulsions (seizures) _____ YES NO
32. neurologic problems (attention deficit disorder) ___ YES NO
33. viral infections and cold sores _____ YES NO
34. any lumps or swelling in the mouth _____ YES NO
35. hives, skin rash, hay fever _____ YES NO
36. venereal disease _____ YES NO
37. hepatitis (type _____) _____ YES NO
38. HIV/AIDS _____ YES NO
39. tumor, abnormal growth _____ YES NO
40. radiation therapy _____ YES NO
41. chemotherapy _____ YES NO
42. emotional problems _____ YES NO
43. psychiatric treatment _____ YES NO
44. Osteoporosis medication _____ YES NO
45. alcohol/ drug dependency _____ YES NO

ARE YOU:

46. presently being treated for any other illness _____ YES NO
47. aware of a change in your general health _____ YES NO
48. taking medication for weight management _____ YES NO
49. taking dietary supplements _____ YES NO
50. often exhausted or fatigued _____ YE S NO
51. subject to frequent headaches _____ YES NO
52. a smoker or smoked previously _____ YES NO
53. often unhappy or depressed _____ YES NO
54. FEMALE = taking birth control pills _____ YES NO
55. FEMALE = pregnant _____ YES NO
56. MALE = prostate disorders _____ YES NO

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

_____

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

drug	purpose	drug	purpose
1. _____	_____	2. _____	_____
3. _____	_____	4. _____	_____
5. _____	_____	6. _____	_____

notes

Patient's Signature _____ date _____

Doctor's Signature _____ date _____

DENTAL HISTORY

Referred by _____ How would you rate your mouth? (circle one) Excellent Good Fair Poor

Previous Dentist _____ How long were you a patient? _____ Months/Years

Date of most recent dental exam _____/_____/_____ Date of most recent X-rays _____/_____/_____

Date of most recent treatment (other than a cleaning) _____/_____/_____

I routinely saw my previous dentist every (circle one) 3 months 4 months 6 months 12 months not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

PERSONAL HISTORY

1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [____] _____ YES NO
2. Have you had an unfavorable dental experience? _____ YES NO
3. Have you ever had complications from past dental treatment? _____ YES NO
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? _____ YES NO
5. Did you ever have braces, orthodontic treatment or had your bite adjusted? _____ YES NO
6. Have you had any teeth removed? _____ YES NO

SMILE CHARACTERISTICS

7. Is there anything about the appearance of your teeth that you would like to change? _____ YES NO
8. Have you ever whitened (bleached) your teeth? _____ YES NO
9. Have you felt uncomfortable or self conscious about the appearance of your teeth? _____ YES NO
10. Have you been disappointed with the appearance of previous dental work? _____ YES NO

BITE AND JAW JOINT

11. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____ YES NO
12. Do you/would you have any problems chewing gum? _____ YES NO
13. Do you/would you have any problems chewing bagels, baguettes, protein bars, or other hard foods? _____ YES NO
14. Have your teeth changed in the last 5 years, become shorter, thinner, or worn? _____ YES NO
15. Are your teeth crowding or developing spaces? _____ YES NO
16. Do you have more than one bite and squeeze to make your teeth fit together? _____ YES NO
17. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____ YES NO
18. Do you clench your teeth in the daytime or make them sore? _____ YES NO
19. Do you have any problems with sleep or wake up with an awareness of your teeth? _____ YES NO
20. Do you wear or have you ever worn a bite appliance? (i.e. night guard, bite splint) _____ YES NO

TOOTH STRUCTURE

21. Have you had any cavities within the past 3 years? _____ YES NO
22. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? _____ YES NO
23. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? _____ YES NO
24. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? _____ YES NO
25. Do you have grooves or notches on your teeth near the gum line? _____ YES NO
26. Have you ever broken teeth, chipped teeth, or had a toothache, or cracked filling? _____ YES NO
27. Do you get food caught between any teeth? _____ YES NO

GUM AND BONE

28. Do your gums bleed when brushing or flossing? _____ YES NO
29. Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____ YES NO
30. Have you ever noticed an unpleasant taste or odor in your mouth? _____ YES NO
31. Is there anyone with a history of periodontal disease/pyorrhea/gum disease in your family? _____ YES NO
32. Have you ever experienced gum recession? _____ YES NO
33. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple?___ YES NO
34. Have you experienced a burning sensation in your mouth? _____ YES NO

Patients Signature _____ Date _____

Doctors Signature _____ Date _____

dentistry of the queen city

Notice of Privacy Practices

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.

Dentistry of the Queen City, hereafter referred to as "Practice," is committed to preserving the privacy and confidentiality of your health information. This Notice of Privacy Practices (NPP) describes how we may use and disclose your protected health information, hereafter referred to as "PHI," to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. 45 CFR§ 164.520. This Notice has been revised to conform to HIPAA's Final Rule referred to as the "Omnibus Rule" published 01/25/13. This notice replaces previous versions of the Notice and is effective 07/15/2014. You may access or obtain a copy according to the following options: 1) our website at www.drlmj.com 2) contact the office and request a copy to be sent to you by mail or email, 3) request a copy at the time of your next appointment.

1. USES & DISCLOSURES OF PHI. How We Use Your Information: Your PHI may be used and disclosed by our Practice's provider, administrative and or clinical staff and others outside of our Practice who are involved in your care and treatment for the purpose of providing healthcare services to you.

A) Treatment: We will use and disclose your PHI to provide, coordinate or manage your care and any related services. We may disclose PHI to other providers who may be treating you such as a specialist.

B) Payment: We will use your PHI to obtain payment for the services provided by this Practice. For example, if we are working with your insurance plan, we may verify eligibility or coverage for benefit determination. We may use or disclose your information so that a bill may be sent to you that may include services provided.

C) Healthcare Operations: The Practice may use or disclose, as needed, your PHI in order to support its business activities such as quality performance reviews regarding our services or the performance of our staff.

D) Business Associates: We may share your PHI with third party business associates such as answering services, transcriptionists, billing services, consultants, trainers and legal counsel. We obtain a written agreement with business associates to assure the protection and privacy of your PHI.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Agree or Object: We may use or disclose your PHI in the following situations without your authorization or providing you the opportunity to agree or object as follows:

E) Required or Permitted by Law: We may use or disclose your PHI as required by law. This may include public health activities such as controlling a communicable disease or compliance with health oversight agencies authorized by law. We may disclose PHI to a public health authority authorized to receive reports of child abuse or neglect. We may disclose your PHI if we believe you have been a victim of abuse, neglect or domestic violence to a governmental agency authorized to receive such information in compliance with state and federal law. We may disclose your PHI to the Food and Drug Administration for the quality, safety, or effectiveness of FDA-regulated products or activities. We may disclose your PHI in the course of a legal proceeding in response to a subpoena, discovery request or other lawful process. We may also disclose PHI to law enforcement providing applicable legal requirements are satisfied. We may disclose PHI to a coroner or medical examiner for identification purposes. We may disclose PHI to researchers when the information does not directly identify you as the source of the information and such research has been approved by an institutional review board to ensure the privacy of the PHI. We may disclose PHI as authorized to comply with workers' compensation laws. We may use and disclose your PHI if you are an inmate of a correctional facility and this information is necessary for your care.

Authorization for Other Uses and Disclosures of PHI: Use and disclosure of your PHI not addressed in this Notice of Privacy Practices will be made only with your written authorization. You may revoke this authorization in writing at any time. If you revoke this authorization, we will no longer use or disclose your PHI; however, we are unable to retrieve previous disclosures made with your prior authorization.

Other Permitted and Required Uses and Disclosures that Require Your Permission or Objection:

i) Students: We may share PHI with students working in our Practice to fulfill their educational requirements. If you do not wish a student to observe or participate in your care, please notify your provider.

ii) Appointment Reminders: We may contact you as a reminder of your appointment. Only limited information is provided on an answering machine or an individual other than you answering the call. We may issue a post card or letter notifying you that it is time to make an appointment. You may provide a preferred means of contact such as a mobile telephone number or email address. Reasonable requests will be accommodated.

iii) Family, Close Friends, Personal Representatives & Care Givers: Our staff may disclose to person involved in your care your PHI relevant to that person's involvement in your care or payment of the services providing you identify these individual(s) and authorize the release of information. If you are unable to agree or object to such disclosure, we may disclosure such information as necessary if we determine that it is in your best interest based on our professional judgment. If a young adult age eighteen (18) requests that his or her information not be released to a parent or guardian, we must comply with this request in compliance with state law. For minor children living in divided households, both parents (mother and father) have access to the PHI unless their parental rights have been terminated. Payment of services is addressed in your Final Divorce Decree; however, we obtain payment from the parent who brings the child in

interest based on our professional judgment. If a young adult age eighteen (18) requests that his or her information not be released to a parent or guardian, we must comply with this request in compliance with state law. For minor children living in divided households, both parents (mother and father) have access to the PHI unless their parental rights have been terminated. Payment of services is addressed in your Final Divorce Decree; however, we obtain payment from the parent who brings the child in for treatment. We will provide you a statement to send to the other parent for your reimbursement.
iv) Disaster Relief: If applicable, we may use or disclose your PHI to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your care.

2. YOUR RIGHTS. The following is a statement of your rights regarding PHI we gather about you:
A) Copy of this Notice: You have the right to a copy of this notice including a paper copy.
B) Inspect and Copy PHI: You have the right to inspect and obtain a copy of PHI about you maintained by our Practice to include patient and billing records. You must submit a written request and indicate whether you prefer a paper or electronic copy. According to state and federal law, we may charge you a reasonable fee to copy your records. Our Practice does not transmit unsecure PHI via email. However, if you prefer this information emailed to you with encryption or security measures, we will comply with your request and will verify your email address. We suggest sending our Practice an email and we will reply with the attachment. (Note: Under federal law, you may not inspect or copy psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding. Please contact the Privacy Officer for more details).
C) Amendment: You have the right to have your provider amend your PHI about you in a designated record set. Please consult with the Privacy Officer. We may deny this request and you may respond with a statement. We may include a rebuttal statement in your record. Reasons we may deny amending such information, but not limited to these reasons, is if we did not create the information, or if the individual who created the information is no longer available to make the amendment or it is not part of the information maintained at our Practice.
D) Restrictions: You have the right to request a restriction of your PHI. If you paid out-of-pocket for a service or item, you have the right to request that information not be disclosed to a health plan for purposes of payment or health care operations and we are required to honor that request. You may request in writing to our Privacy Officer not to use or disclose any part of your PHI for the purposes of treatment, payment or health care operations such as to family members or friends involved in your care or for notification purposes as described in this Notice of Privacy Practices. However, your provider is not required to agree to this restriction. You may discuss restrictions with the Privacy Officer.
E) Confidential Communications: You have the right to request to receive confidential communications from our Practice by alternative means or at an alternative location. For example, you may prefer our Practice to use your mobile telephone or email rather than a residential line. Please make this request in writing to the Privacy Officer. Our staff will not ask personal questions regarding your request.
F) Disclosures: You have the right to request an accounting of disclosures of your PHI including those made through a Business Associate as set forth in CFR 45 § 164.528. The HITECH Act removed the accounting of disclosures exception to PHI to carry out treatment, payment and healthcare operations if such disclosures are made through the EHR. To request an accounting, submit your request in writing to the Privacy Officer.
G) Breach Notification: According to the HITECH Act, you have the right to be notified following a breach of unsecured PHI that affects you. "Unsecured" is information that is not secured through the use of technology or methodology identified by the Secretary of the U.S. Department of Health and Human Services to render the PHI unusable, unreadable and undecipherable to unauthorized users. Breach notification applies to our Business Associates who are obligated to notify our Practice if a breach of unsecured PHI occurs that affects you.
H) Fundraising: If PHI is used for fundraising which is considered "health care operations," basic requirements must be satisfied to include notice to you and a process for you to opt-out. If the individual consents, only specific parts of PHI may be used for fundraising. Note: Your PHI will not be used in this manner.

3. COMPLAINTS. You have the right to file a complaint if you believe your privacy rights or that of another individuals' have been violated. You may contact our Privacy Officer and your issue will be addressed. You may also file a complaint with the Secretary of Health and Human Services at: U.S. Department of Health & Human Services, Office of Civil Rights, 200 Independence Avenue, SW, Washington, D.C. 20201. Your complaint must be filed in writing, either on paper or electronically, by mail, fax, or e-mail; name the covered entity or business associate involved and describe the acts or omissions you believe violated the requirements of the Privacy, Security, or Breach Notification Rules; and be filed within 180 days of when you knew that the act occurred. Visit the Office of Civil Rights website at www.hhs.gov/ocr/hipaa/ for more information.

If you have any questions, would like additional information or want to report a problem regarding the handling of your PHI, you may contact the Privacy Officer at:

Gregory S. Reece, DMD, PLLC
3014 Baucom Road, Suite 100
Charlotte, North Carolina 28269
TEL: (704) 596-6767
FAX: (704) 596-7790

You will not be penalized for filing a complaint.

dentistry of the queen city

Your Privacy Is Important to Us

Acknowledgement of Receipt of Notice of Privacy Policies

I have received a copy of the Notice of Privacy Practices of Dentistry of the Queen City. I hereby authorize, as indicated by my signature below, Dentistry of the Queen City to use and to disclose my protected health information for any necessary clinical, financial, and insurance purpose, as authorized in the Patient Consent form.

Print Name _____ Address _____

Signature _____ Date _____

Please check your preferred means of communication:

- ☐ You may contact me at my home telephone number _____
- ☐ You may contact me on my mobile telephone number _____
- ☐ *You may contact me on my work telephone number* _____
- ☐ You may send me an unencrypted email/text message at: _____
- ☐ Other _____

Please list authorized persons with whom we may discuss your Protected Health Information (PHI) in addition to custodial parents and legal guardians:

1. _____ Date Added / Removed: _____
2. _____ Date Added / Removed: _____
3. _____ Date Added / Removed: _____
4. _____ Date Added / Removed: _____

* * *

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
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining the acknowledgement
- ☐ Other (Please Specify) _____

Staff Person Initials _____

Special Authorization
Gregory S. Reece, DMD, PLLC

I, _____, consent to allow Gregory S. Reece, DMD, PLLC to use my (check all that apply):

- ☐ dental / medical photos
- ☐ radiographs
- ☐ study models
- ☐ TMJ score
- ☐ and other information (please describe): _____

from my dental record for (check all that apply):

- ☐ Website/social media marketing
- ☐ scientific papers
- ☐ lectures
- ☐ demonstrations and other educational events
- ☐ other (please describe): _____

I have been informed that I am not required to sign this consent.

I understand I am not financially compensated for this authorization.

This consent may be revoked by written notice delivered to Gregory S. Reece, DMD, PLLC within 30 days of signature. This special authorization expires on _____.

Gregory S. Reece, DMD, PLLC
Name of Practice

By: _____
Authorized Staff Member Date

_____
Patient Date

_____
Print Patient Name

_____
Guardian / Parent Date

dentistry of the queen city

Financial Policy Acknowledgment

The following information is to inform you of our office's financial policy. If at any time, you have questions regarding this policy, please do not hesitate to ask any member of our business team.

We are committed to providing you with the highest quality of care. Our fees are a reflection of the quality of care we provide. We continue our commitment by offering a variety of financial options to enable you to received the dental care you need. We accept cash, check, VISA, Mastercard, Discover and American Express. We have also partnered with third-party companies to offer the flexibility of deferred interest and extended payment options. If you choose to pay with a check and your check is returned for any reason, we will electronically debit your account for the amount of the check plus a processing fee of $25.

We will communicate all recommended treatment options and associated fees, prior to the start of treatment. Payment is expected at the time of treatment. A delinquent account impedes our ability to provide you with the quality dental care that you deserve. Any account accruing a balance for whatever reason will be subject to a $10 per month statement fee. It is our policy that the parent or guardian who accompanies a child to our office for treatment is responsible for payment of all services rendered.

We are committed to respecting your time and ask that you make every effort to keep the appointment time reserved exclusively for you. We understand there may be times when you are unable to keep your scheduled appointment, however, any appointment missed may be subject to a missed appointment fee of $50. Should you find it necessary to reschedule an appointment, please provide us with a notice of 24 business hours to avoid being charged a missed appointment fee.

As a courtesy to our patients with dental insurance benefits, we will submit your claim and provide any necessary information to assist you in receiving your dental benefits. We require that any applicable deductibles and estimated patient portion be paid at the time treatment is rendered. We do accept assignment of insurance benefits as a form of payment to help reduce your immediate out-of-pocket expense.

Important Facts About Your Dental Insurance

- Dental insurance is a contract between the patient and the insurance company. It is a benefit to assist you with the cost of dental care. At no time should insurance benefits compromise your doctor's diagnosis or affect your choice of treatment.
- It is your responsibility to understand the type of dental insurance you have (i.e., Traditional, PPO, or DMO, etc) and the benefits selected by you and your employer.

Patient/Parent/Guardian Signature:_____ Date:_____