TRIANGLE DENTISTRY

SMITH, TART & ASSOCIATES

PATIENT & GUARDIAN INFORMATION

Patient Name _____ Date _____

Name child would like to be called _____ Home Phone _____

Birthday _____ Age _____ Gender _____ Cell Phone _____

Guardian's Email _____

Home Address _____
Street City State Zip Code

School _____ Grade _____

Guardian 1 _____ Relationship to patient _____

Employer _____ Phone _____

Guardian 2 _____ Relationship to patient _____

Employer _____ Phone _____

Who has legal custody of patient? _____ Dental Insurance Check One ○ Yes ○ No

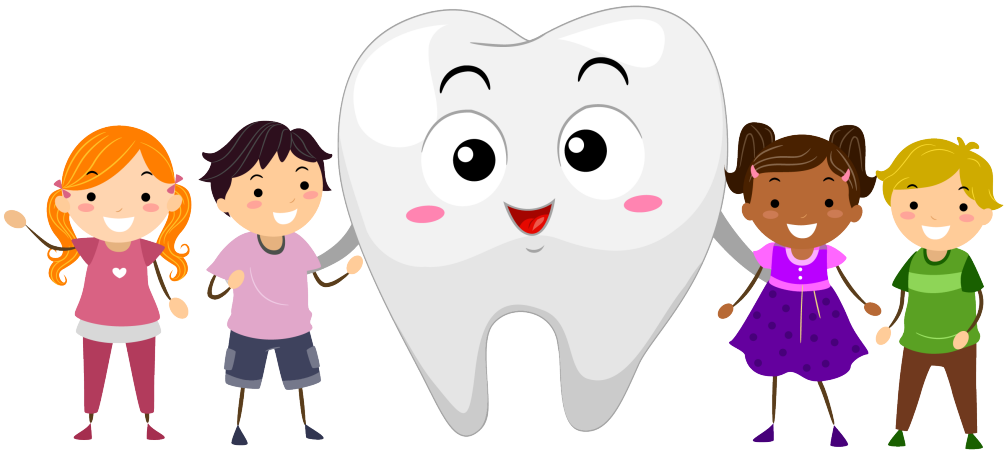
Person responsible for payment of account _____

Social Security # _____ Date of Birth (DOB) _____

Name of Child's physician/group _____ City/State _____ Phone _____

How did you hear about our practice? _____

What is the reason for your child's dental visit? _____



Phone (919) 847-6000 **Address** 120 Northway Court, Raleigh, NC 27615 **Website** www.triangledentistry.com

HEALTH HISTORY

A. CIRCLE YOUR ANSWERS (leave BLANK if you do not understand the question)

1. Yes No Is your child in good health? If no, please explain

_____

2. Yes No Has there been a change in your child's health within the last year? If yes, please explain

_____

3. Yes No Has your child been hospitalized or had a serious illness in the last 5 years? If yes, please explain

_____

4. Yes No Is your child allergic to anything? If yes, please explain

_____

5. Yes No Is your child taking any medications? If yes, please list medication name, dose, and reason

_____

Name of Child's Physician _____ Date of last Medical Exam _____

B. HAS YOUR CHILD EVER HAD...

6. Yes No Heart disease
7. Yes No Liver/GI disease
8. Yes No Speech/Hearing challenges
9. Yes No Physical Delays
10. Yes No Mental Delays
11. Yes No Personality/Social Delays
12. Yes No Congenital birth defects
13. Yes No Cleft lip/palate
14. Yes No Autism
15. Yes No Cerebral Palsy
16. Yes No Significant Injuries
17. Yes No HIV/AIDS-ARC
18. Yes No Cancer/Tumors
19. Yes No Endocrine/growth
20. Yes No Bleeding/transfusions
21. Yes No Rheumatic fever
22. Yes No Anemia
23. Yes No Hepatitis
24. Yes No Diabetes
25. Yes No Asthma/breathing challenges
26. Yes No Blood dyscrasias
27. Yes No Seizures

If any Yes's were circled, please explain

_____

_____

_____

Patient's Name _____ Birthdate _____

DENTAL HISTORY

28. ○ Yes ○ No Has your child ever been to the dentist? If yes, date of last x-rays taken _____

Name & Location of your Child's Dentist _____

29. ○ Yes ○ No Has your child ever experienced an unfavorable reaction from previous dental care?
If yes, please explain _____

30. ○ Yes ○ No Does your child suck a finger, thumb, or pacifier?

31. ○ Yes ○ No Does your child experience pain when chewing, yawning, or opening wide?

32. ○ Yes ○ No Does your child's jaw make noise & is the pain associated with those sounds?

C. HAS YOUR CHILD EVER HAD...

33. ○ Yes ○ No Cavities
34. ○ Yes ○ No Dental trauma
35. ○ Yes ○ No Orthodontics
36. ○ Yes ○ No Toothache
37. ○ Yes ○ No Sensitivity
38. ○ Yes ○ No Tooth discoloration
39. ○ Yes ○ No Jaw Sounds

D. FLOURIDE HISTORY

40. ○ Yes ○ No Is your home water supply flouridated?
41. ○ Yes ○ No Does your child use fluoride toothpaste?
42. ○ Yes ○ No Does your child participate in a school fluoride rinse program?
43. ○ Yes ○ No Do you give your child any other form of flouride? If so, what? _____

OFFICE USE ONLY ○ Flouridated City Water ○ Private well ○ Public well

CONSENT FOR DENTAL TREATMENT

I request & authorize Triangle Dentistry to examine, clean, and provide dental treatment on my child's teeth. This treatment may include sealants, restorations (fillings) or crowns, *if necessary*. I further request & authorize the taking of dental x-rays as may be considered necessary by Triangle Dentistry to diagnose and/or treat my child's dental challenges. I understand that dental treatment for children includes individualized efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. Triangle Dentistry will provide an environment that will assist children in learning to cooperate during treatment by using praise, explanation, demonstration of procedures & instruments, and using variable voice tone. I am responsible for any charges incurred on this child for dental treatment.

Signature _____ Date _____

Signature _____ Date _____

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.

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

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Your signature states that you have received this 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)

_____

_____

PATIENT FINANCIAL POLICY

Your dental health is important to us and we want to ensure that you receive the gentle, compassionate care necessary. We realize that every person's financial situation is different. For this reason, we offer 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 the 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.

Our staff will file your claims with your insurance provider on your behalf. If we are contracted with your insurance company, we will accept the negotiated rate.

I have read, understand and agree to the payment terms of this financial policy. I agree to allow Triangle Dentistry to file my insurance on my behalf and be paid directly by aforementioned insurance company.

_____ _____

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 $50 cancellation fee.

REQUEST RELEASE OF DENTAL RECORDS

Date _____ Birthdate _____

Patient Name _____

Last First Middle

I hereby request release of my dental records from the office of

_____

_____

_____

Phone _____ BWX _____ Panoramic _____ FMX _____

***Please include date all x-rays were taken and attach via email in JPEG format. To avoid repeat requests, please contact us immediately 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

hello@triangledentistry.com

_____

PATIENT AUTHORIZATION

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 official's 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:	Privacy Officer
Telephone:	(919) 847-6000
Email:	hello@triangledentistry.com
Address	120 Northway Court Raleigh, NC 27615

TRIANGLE DENTISTRY
SMITH, TART & ASSOCIATES

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

1. Patient Name _____
First Name Middle Name Last Name

2. **Date of Birth** ____/____/____ 3. **SSN** ____-____-____ 4. **Date authorization initiated** ___/____/____

5. **Authorization initiated by** _____
Name (client or provider) (If provider, please specify relationship to client)

6. **Information to be Used or Disclosed**

☐ My dental information relating to the following treatment or condition: _____

☐ Most recent ____ years of record

☐ Entire Dental Record

○ Include ○ Exclude: My health information related to drug and/or alcohol abuse

○ Include ○ Exclude: My health information related to HIV/AIDS

Other information to be used or disclose (describe information in detail) _____

_____

_____

7. **Purpose of Use or Disclosure**

☐ Treatment, Payment or Health Care Operations

☐ Disclosure to Life Insurer for Coverage Purposes

☐ Disclosure to Employer of results of pre-employment physical or lab tests

☐ Marketing Purposes

☐ To the Following Family Members: _____

☐ Other (describe each purpose of the requested use and disclosure in detail): _____

_____

_____

8. Person(s) Authorized to make this Disclosure: _____

9. **Person(s) Authorized to Receive the Disclosure**: _____

Authorization and Signature: I authorize the release of my confidential protected dental information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be re-disclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected dental information. The authorization of the release of these records does not expire until written notice is given to Smile Forever Family Dentistry.

Signature of Patient _____

Signature of Personal Representative _____

Relationship to Client if Personal Representative

_____

Date of Signature: ____/____/____

PATIENT RIGHTS AND HIPAA AUTHORIZATIONS

The following specifies your rights about this authorization under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time ("*HIPAA*").

1. Tell your provider if you do not understand this authorization, and the provider will explain it to you.
2. You have the right to revoke or cancel this authorization at any time, except: (a) to the extent information has already been shared based on this authorization; or (b) this authorization was obtained as a condition of obtaining insurance coverage. To revoke or cancel this authorization, you must submit your request in writing to provider at the following address (insert address of provider):

☐ **Revoke Authorization** _____

Patient Signature

3. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment, payment, enrollment or your eligibility for benefits. However, you may be required to complete this authorization form before receiving treatment if you have authorized your provider to disclose information about you to a third party. If you refuse to sign this authorization, and you have authorized your provider to disclose information about you to a third party, your provider has the right to decide not to treat you or accept you as a patient in their practice.
4. Once the information about you leaves this office according to the terms of this authorization, this office has no control over how it will be used by the recipient. You need to be aware that at that point your information may no longer be protected by HIPAA. If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations.
5. You may inspect or copy the protected dental information to be used or disclosed under this authorization. You do not have the right of access to the following protected dental information: psychotherapy notes, information compiled for legal proceedings, laboratory results to which the Clinical Laboratory Improvement Act ("CLIA") prohibits access, or information held by certain research laboratories. In addition, our provider my deny access if the provider reasonably believes access could cause harm to you or another individual. If access is denied, you may request to have a licensed health care professional for a second opinion at your expense.
6. If this office initiated this authorization, you must receive a copy of the signed authorization.
7. *Special Instructions for completing this authorization for the use and disclosure of Psychotherapy Notes.* HIPAA provides special protections to certain medical records known as "Psychotherapy Notes." All Psychotherapy Notes recorded on any medium by a mental health professional (such as a psychologist or psychiatrist) must be kept by the author and filed separate from the rest of the client's medical records to maintain a higher standard of protection. "Psychotherapy Notes" are defined under HIPAA as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint or family counseling session and that are separate from the rest of the individual's medical records. Excluded from the "Psychotherapy Notes" definition are the following: (a) medication prescription and monitoring, (b) counseling session start and stop times, (c) the modalities and frequencies of treatment furnished, (d) the results of clinical tests, and (e) any summary of: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date. Except for limited circumstances set forth in HIPAA, in order for a medical provider to release "Psychotherapy Notes" to a third party, the client who is the subject of the Psychotherapy Notes must sign this authorization to specifically allow for the release of Psychotherapy Notes. Such authorization must be separate from an authorization to release other dental records.
8. You have a right to an accounting of the disclosures of your protected dental information by provider or its business associates. The maximum disclosure accounting period is the six years immediately preceding the accounting request. The provider is not required to provide an accounting for disclosures: (a) for treatment, payment, or dental care operations; (b) to you or your personal representative; (c) for notification of or to persons involved in an individual's dental care or payment for dental care, for disaster relief, or for facility directories; (d) pursuant to an authorization; (e) of a limited data set; (f) for national security or intelligence purposes; (g) to correctional institutions or law enforcement officials for certain purposes regarding inmates or individuals in lawful custody; or (h) incident to otherwise permitted or required uses or disclosures. Accounting for disclosures to dental oversight agencies and law enforcement officials must be temporarily suspended on their written representation that an accounting would likely impede their activities.