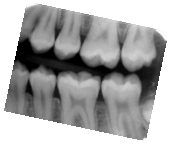
# Mooring & Mooring, DDS, PA

## Patient Information



(print) Patient Name: _____

Preferred Name: _____

Date of Birth: _____ Social Security #: _____-_____-_____

Gender: M / F Marital Status: _____

e-mail Address: _____

Address: _____

City/State/Zip: _____

Phone Numbers: Home: _____ Work: _____ ext _____

Cell: _____ Other: _____

Employer Name: _____

Address: _____ City/State/Zip: _____

Person to contact in case of emergency: _____

Phone Number: _____ Relationship: _____

### Referral Information

Name of person, office or other source referring you to our practice: _____

_____

### Spouse or Responsible Party Information

Name: _____

Date of Birth: _____ Social Security #: _____-_____-_____

Gender: M / F Marital Status: _____

e-mail Address: _____

Address: _____ City/State/Zip: _____

Phone Numbers: Home: _____ Work: _____ ext _____

Cell: _____ Other: _____

Employer Name: _____

### Insurance Information

Name of Insured: _____

ID#: _____ Group #: _____

Patient's relationship to insured: _____

Insurance Plan Name: _____

Address: _____ Insurance Phone: _____

### RELEASE

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dentist. I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me. I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payment in full of all accounts. By signing this statement, I revoke previous agreements to the contrary and agree to be responsible for payments of services not paid, in whole or in part by my dental care payor. I attest to the accuracy of the information on this page.

**Patient or Guardian's Signature** _____ **Date** ___/____/____

MOORING & MOORING, DDS, PA

# Dental Health

(print) Patient Name: _____

Previous Dentist Name: _____ Phone Number: _____

When was your last dental visit? ___/___/____ Last Professional Cleaning? ___/___/____

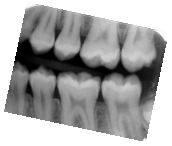
How often did you see your dentist? _____

Are you having any dental problems which require immediate attention? _____

Do any of the following cause tooth discomfort? Hot Cold Sweets Chewing

How often do you brush your teeth?_____ Floss? _____ Listerine? _____

Water Pik?_____ Other dental aids?_____



Is your water fluoridated? _____ Yes ○ No ○ Not Sure ○

Do your gums bleed when you brush your teeth? _____ Yes ○ No ◉

Do your gums ever feel tender or swollen? _____ Yes ○ No ◉

Have you ever had periodontal treatment? _____ Yes ○ No ○ When? _____

Do you clench or grind your teeth? _____ Yes ○ No ○ When? _____

Do your jaws ever feel tired or ache? _____ Yes ○ No ○ Click or pop? Yes ○ No ○

Can you chew on both sides of your mouth? _____ Yes ○ No ○ Comfortably? Yes ○ No ○

Do you have frequent headaches? _____ Yes ○ No ○ Earaches? Yes ○ No ○

Have you ever had orthodontic treatment (braces)? _____ Yes ○ No ○ When? _____

Do you have any areas where food traps in your teeth? Yes ○ No ○

Do you lose fillings or break fillings? _____ Yes ○ No ○

Do you usually have cavities? _____ Yes ○ No ○

Do you have any loose teeth? _____ Yes ○ No ○

Cracked or broken teeth? _____ Yes ○ No ○

Do you have any noticeable wear on teeth? _____ Yes ○ No ○

Do you have any missing teeth? _____ Yes ○ No ○

Have they been replaced? _____ Yes ○ No ○

If so, how? _____ Fixed Bridge Removable Partial Full Denture Dental Implant

Are you comfortable with the replacement? Yes No Please describe: _____

_____

How do you feel about the appearance of your smile? _____

_____

Is there anything about your smile you would change? _____

_____

Have you ever had any cosmetic dentistry done to improve your appearance? Yes No

If yes, are you pleased with the results? Yes No Please comment: _____

_____

How do you feel about your previous dental experiences? _____

_____

**Patient or Guardian's Signature** _____ **Date** ___/___/____

MOORING & MOORING, DDS, PA

# Medical History

(print) Patient Name: _____

Physician's Name: _____ Address: _____

Are you under a physician's care? Yes No

Since when? _____ Why? _____

When was your last complete physical exam? _____

Are you taking any medications or substances? Yes No

If yes, please list medications: _____

Do you routinely take health related substances? (vitamins, herbal supplements, natural products) Yes No

Are you allergic to any medications or substances? Yes No

If yes, please list: _____

Do you have any other allergies or hives? _____

Do you have any problems with penicillin, antibiotics, anesthetics or other medications? _____

Are you sensitive to any metals or latex? _____ Yes No

Are you pregnant or suspect you may be? _____ Yes No

Do you use any birth control medications? _____ Yes No

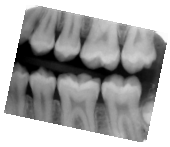
Have you ever been treated for or been told you might have heart disease? Yes No

Do you have a pacemaker or an artificial heart valve implant? _____ Yes No

Have you ever had rheumatic fever? _____ Yes No

Are you aware of any heart murmurs? _____ Yes No

Have you ever had radiation or chemotherapy? _____ Yes No



Have you ever taken Fosamax, Zometa, Aredia, Boniva or any other oral or intravenous treatment (bisphosphonates) for bone tumors, excessive calcium or osteoporosis? _____ Yes No

Do you have inflammatory disease, such as arthritis or rheumatism? _____ Yes No

Do you have any artificial joints/prosthesis? _____ Yes No

Do you have any blood disorders, such as anemia, leukemia, etc? _____ Yes No

Have you ever bled excessively after being cut or injured? _____ Yes No

Do you have any stomach, kidney, or liver problems? _____ Yes No

Are you a diabetic? _____ Yes No

Do you have fainting or dizzy spells? _____ Yes No

Do you have asthma? _____ Yes No

Do you have epilepsy or seizure disorders? _____ Yes No

Do you or have you ever had venereal disease? _____ Yes No

Do you have HIV/AIDS? _____ Yes No

Have you had or do you test positive for hepatitis? _____ Yes No

Do you or have you had T.B.? _____ Yes No

Do you smoke, chew, use snuff or any other forms of tobacco? _____ Yes No

Do you consume alcoholic beverages? _____ Yes No

Have you had psychiatric treatment? _____ Yes No

Are all immunizations up to date? (children under 18) _____ Yes No

Have you taken any prescription drugs fenfluramine, fen-phen, redux, or other weight loss products? _____ Yes No

Do you have any disease condition, or problem not listed? _____ Yes No

If so, please explain _____

Is there anything else we should know about your health that we have not covered in this form? _____ Yes No

Would you like to speak to the Doctor privately about any problem? _____ Yes No

*I certify that the above information is complete and accurate.*

**Patient or Guardian's Signature** _____ **Date** ___/___/____

Mooring & Mooring, DDS, PA

# Acknowledgement of Receipt of Privacy Practices Notice

Please complete Section A and Section B

### Section A: The Patient

Name: _____

Date of Birth: _____ Social Security #: _____-_____-_____

### Section B: Acknowledgement of Receipt of Privacy Practices Notice

I, _____, acknowledge that I have received a Notice of Privacy Practices from the above-named practice.

Signature: _____ Date: _____

If a personal representative signs this authorization on behalf of the individual complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

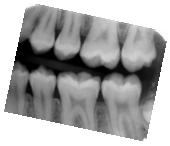
### Section C: Good Faith Effort to Obtain Acknowledgement of Receipt

Describe your good faith effort to obtain the individual's signature on this form:

_____

Describe the reason why the individual would not sign this form:

_____



### [To be completed by office personnel]

I attest that the above information is correct.

Signature: _____ Date: _____

Print Name: _____ Title: _____

Include this acknowledgement of receipt in the individual's records.

# 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 carefully, the privacy of your health information is important and our legal duty.**

Federal and state law requires us to maintain the privacy of your health information. That law also requires us 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 we describe in this notice while it is in effect. This notice takes effect April 14, 2003, 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 applicable law permits the changes. 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 health care operations. For example:

**Treatment:** We may use your health information for treatment or disclose it to a dentist, physician or other health care provider providing treatment to you.

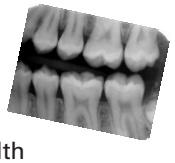
**Payment:** We may use and disclose your health information to obtain payment for services we provide to you. We may also disclose your health information to another health care provider or entity that is subject to the federal Privacy Rules for its payment activities.

**Health Care Operations:** We may use and disclose your health information for our health care operations. Health care operations include quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities. We may disclose your health information to another health care provider or organization that is subject to the federal privacy rules and that has a relationship with you to support some of their health care operations. We may disclose your information to help these organizations conduct quality assessment and improvement activities, review the competence or qualifications of health care professionals, or detect or prevent health care fraud and abuse.

**On Your Authorization:** You may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any uses 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 disclose your health information to a family member, friend or other person to the extent necessary to help with your health care or with payment for your health care. Before we disclose your health information to these people, we will provide you with an opportunity to object to our use or disclosure. If you are not present, or in the event of your incapacity or an emergency, we will disclose your medical information based on our professional judgment of whether the disclosure would be in your best interest. We may use our professional judgment and 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. We may use or disclose information about you to notify or assist in notifying a person involved in your care, of your location and general condition.

**Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters.)



**Disaster Relief:** We may use or disclose your health information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

**Public Benefit:** We may use or disclose your medical information as authorized by law for the following purposes

deemed to be in the public interest or benefit:
As required by law;
For public health activities, including disease and vital statistic reporting, child abuse reporting, FDA oversight, and to employers regarding work-related illness or injury,
To report adult abuse, neglect, or domestic violence;
To health oversight agencies;
In response to court and administrative orders and other lawful processes;
To law enforcement officials pursuant to subpoenas and other lawful processes, concerning crime victims, suspicious deaths, crimes on our premises, reporting crimes in emergencies, and for purposes of identifying or locating a suspect or other person; to Coroners, medical examiners, and funeral directors;
To an organ procurement organizations;
To avert a serious threat to health or safety;
In connection with certain research activities;
To the military and to federal officials for lawful intelligence counterintelligence, and national security activities;
To correctional institutions regarding inmates; and
As authorized by state worker's compensation laws.

## 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 request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge you a reasonable cost-based fee that may include labor, copying costs, and postage. 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 may—but are not require to—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 more information about fees.

**Disclosure Accounting:** You have the right to receive a list of instances in which we or our business associates disclosed your health information over the last 6 years (but not before April 14, 2003). That list will not include disclosures for treatment, payment, health care operations, as authorized by you, and for certain other activities. 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. Contact us using the information listed at the end of this notice for more information about fees.

**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 addition restrictions, but if we do, we will abide by our agreement (except in an emergency). Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. Your request is not binding unless our agreement is in writing.

**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. You must specify in your request the alternative means or location, and provide satisfactory explanation how you will handle payment 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 we should amend the information. We may deny your request under certain circumstances.

## Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us using the information listed at the end of this notice. If you believe that:
We may have violated your privacy rights,
We made a decision about access to your health information incorrectly,
Our response to a request you make to amend or restrict the use or disclosure of your health information was incorrect, or
We should communicate with you by alternative means or alternative locations,
you may contact us using the information listed below. 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.

## Provider Contact Office

Mooring & Mooring, DDS, PA.
Contact: Shannon Mooring
Telephone: (919) 550-5611
Fax: (919) 550-5211
e-mail: info@mooringdental.com
Address: 304 Tew Court  Clayton, NC  27520