CONFIDENTIAL

Patient Registration Information

Date:_____

Name:_____ SS #:_____

First Middle Last

Welcome to Our Practice!

Thank you for selecting our dental healthcare team. Please fill out this form completely (front and back) in ink. If you have any questions or concerns do not hesitate to ask for assistance. We will be happy to help.

Home (Physical) Address:_____City:_____State:_____

Zip:_____

Mailing Address:_____City:_____State:_____ZIP:_____

Birthdate:_____ Home Phone:_____ Work:_____**Cell:_____

Email:_____ Are you: Minor:___ Single:___ Married:___ Divorced:___ Widowed:___

You or your parent's employer:_____ Occupation:_____

Work Address:_____City:_____ State:_____ Zip:_____

Spouse Name:_____ Employer:_____Work#:_____

Parents Name (if minor child): _____Employer:_____Work#:_____

If you are a student, name of school/college:_____ City:_____State:_____

Whom may we thank for referring you?:_____

**Our office uses a service that confirms by email and texting. If you do not wish to receive this service, please notify the front office. Please be aware that standard texting fees may apply.

Emergency Contact Person/Relationship: _____ Phone:_____

Responsible Party

Person responsible for this account:_____ Relationship:_____

Address: _____ City:_____ State:_____ Zip:_____

Home Phone:_____ Work#:_____Cell#:_____

Social Security #:_____ Birthdate:_____

Employer :_____ Is this person currently a patient in our office? :_____

Insurance Information

Name of Insured:_____Relationship:_____

Social Security #:_____ Birthdate: _____

Employer :_____ Work #:_____

Address of

Employer: _____ City:_____State:_____Zip:_____

Insurance

Company:_____ Group#:_____

Insurance Co.

Address :_____ City:_____ State:_____ Zip:_____

Authorization, Release and Agreement to Pay For Serviced Rendered

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such Dental care to third party payers and/or other health practitioners.

I hereby consent to and authorize the use and reproduction by D.W. Norwood, D.D.S. and T. W. Hamilton, D.D.S. of any and all photographs taken of me for my education, for other patient's education and for seminars that this office would attend. I understand these photographs will never be used for commercial purposes. All films become property of D.W. Norwood and T.W. Hamilton

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents.

Co-payment is due when services are rendered. If my insurance company refuses to pay my dentist directly, I will pay for services in full.

X_____

(Signature of patient or parent if minor)

Date: _____

Financial Arrangements and Information

Payment is required in full at each appointment, less any estimated insurance payment.

For your convenience, we offer the following methods of payment:

Cash, Personal Check, MasterCard, Visa, Discover, American Express and Third Party

Credit Plans for Qualified Applicants

If you have any questions concerning financial arrangements or need special arrangements, please feel

free to ask for assistance.

Thank you for filling out this form completely. The information you have provided will help us serve your dental healthcare needs more effectively and efficiently. If you have any questions at any time, please ask us. We are always happy to help.

PATIENT QUESTIONNAIRE CONFIDENTIAL

NAME_____ BIRTHDATE_____ DATE_____

DENTAL HISTORY

1. Reason for visit? _____
2. When was your last dental visit? _____
3. How often do you brush your teeth? _____
4. What texture brush do you use? ☐ Soft ☐ Medium ☐ Hard

	Yes	No
5. Do your gums bleed while brushing?	☐	☐
6. Do your gums bleed while flossing?	☐	☐
7. Do you feel pain to any of your teeth when brushing or flossing them?	☐	☐
8. Are your teeth sensitive to hot, cold sweet or sour foods/liquids?	☐	☐
9. Have you noticed any loosening of your teeth?	☐	☐
10. Does food tend to become caught between your teeth?	☐	☐
11. Do you have any sore or lumps in or near your mouth?	☐	☐
12. Have you ever experienced any of the following problems in your jaw?		
a) Clicking?	☐	☐
b) Pain (joint, ear, side of face)?	☐	☐
c) Difficulty in opening or closing?	☐	☐
d) Difficulty in chewing?	☐	☐

	Yes	No
13. Have you had any head, neck or jaw injuries?	☐	☐
14. Do you have frequent headaches?	☐	☐
15. Do you clench or grind your teeth while asleep or awake?	☐	☐
16. Do you bite your lips or cheeks frequently?	☐	☐
17. Have you ever had:		
Orthodontic treatment (braces)?	☐	☐
Oral Surgery?	☐	☐
Gum treatment?	☐	☐
Your teeth ground or bite adjusted?	☐	☐
18. Are you satisfied with the appearance of your teeth?	☐	☐
19. Have you ever had an upsetting experience in the dental office?	☐	☐
20. Is there anything about having dental treatment that bothers you?	☐	☐

MEDICAL HISTORY

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 that you will be receiving. Thank you for answering the following questions.

	Yes	No
1. Are you in good health?	☐	☐
2. Have there been any changes in your general health within the past year?	☐	☐
3. Date of your last physical exam: _____		
4. Physician's name: _____ Address/Phone: _____		
5. Are you under the care of a physician?	☐	☐
6. Have you ever been hospitalized for any surgical operation or serious illness? Please explain. _____	☐	☐
7. Are you taking any medicine(s), including non-prescription medicine(s)? If yes, what medicine(s) are you taking? _____	☐	☐
8. Have you had any abnormal bleeding?	☐	☐
9. Do you bruise easily?	☐	☐
10. Have you ever required a blood transfusion?	☐	☐

	Yes	No
11. Have you had a recent weight loss?	☐	☐
12. Do you use tobacco?	☐	☐
13. Are you interested in quitting smoking?	☐	☐
14. Do you use alcohol?	☐	☐
15. Do you use cocaine or other illegal drugs?	☐	☐
16. Are you wearing contact lenses?	☐	☐
17. Do you have any disease, condition or problem not listed above that you think I should know about?	☐	☐

WOMEN ONLY:

1. Are you pregnant or think you may be pregnant?	☐	☐
2. Are you nursing?	☐	☐
3. Are you taking birth control pills?	☐	☐

(OVER)

MEDICAL HISTORY CONTINUED...

	Yes	No
Are you allergic to or have you had reactions to:		
1. Latex?	☐	☐
2. Metals—Jewelry etc?	☐	☐
3. Local anesthetics like Novocain?	☐	☐
4. Penicillin or other antibiotics?	☐	☐
5. Sulfa drugs?	☐	☐
6. Barbiturates, sedatives or sleeping pills?	☐	☐
7. Aspirin?	☐	☐
8. Iodine?	☐	☐
9. Other?		
Do you have or have you ever had the following:		
1. Rheumatic heart disease or rheumatic fever?	☐	☐
2. Scarlet fever?	☐	☐
3. Heart defect or heart murmur?	☐	☐
4. Heart trouble, heart attack or angina?	☐	☐
A. Do you have pain in your chest upon exertion?	☐	☐
B. Are you ever short of breath after mild exercise?	☐	☐
C. Do your ankles swell?	☐	☐
D. Do you get short of breath when you lie down?	☐	☐
E. Do you require extra pillows when you sleep?	☐	☐
5. Pacemaker?	☐	☐
6. Heart surgery?	☐	☐
7. High blood pressure?	☐	☐
8. Low blood pressure?	☐	☐
9. Hepatitis, jaundice or liver disease?	☐	☐
10. Sinus trouble?	☐	☐

	Yes	No
11. Lung or breathing problems?	☐	☐
12. Asthma or hay fever?	☐	☐
13. Hives or skin rash?	☐	☐
14. Fainting spells or seizures?	☐	☐
15. Diabetes?	☐	☐
16. AIDS or HIV infection?	☐	☐
17. Thyroid problems?	☐	☐
18. Allergies?	☐	☐
19. Arthritis or rheumatism?	☐	☐
20. Joint replacement or implant?	☐	☐
21. Stomach ulcer?	☐	☐
22. Kidney trouble?	☐	☐
23. Tuberculosis?	☐	☐
24. Persistent cough?	☐	☐
25. Cough that produces blood?	☐	☐
26. Cancer?	☐	☐
27. Sexually transmitted disease?	☐	☐
28. Epilepsy?	☐	☐
29. Anemia?	☐	☐
30. Leukemia?	☐	☐
31. Glaucoma?	☐	☐

I certify that the information listed is complete and accurate.

X _____ _____

(PATIENT, PARENT OR GUARDIAN) DATE

SIGNATURE

FOR COMPLETION BY THE DENTIST:

SUMMARY OF DENTAL HISTORY

SUMMARY OF MEDICAL HISTORY

MEDICAL HISTORY UPDATE:

DATE	COMMENTS	INITIALS PATIENT	DENTIST	HYGIENIST

DW Norwood DDS TW Hamilton DDS

100 Beverly Hanks Centre Hendersonville, NC 28792
E-mail: willowcreek@att.net
Fax: 828-697-5365
Phone: 828-697-2387

X-Ray and Records Release

Expires upon one time release

Patient Information:

Name of Patient_____ Date of Birth_____

Address_____

City, State, Zip_____

I authorize the practice below to release my x-rays and records:

_____

_____

_____

Please forward/release my health information to:

_____

_____

_____

This authorization shall be in effect until the information has been forwarded as requested.

Patient Information

I understand that my treatment will not be conditioned on signing this authorization and that I have the right to refuse to sign this authorization. I understand that information disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to revoke this authorization by sending a written notification to the address above and that a revocation is not effective if the information has already been disclosed but will be effective going forward.

I understand that I have the right to inspect or copy the protected health information as described in this document. I can do the by written notification to the above address.

Signature:_____Date:_____

If a personal representative is signing please provide the necessary documentation.

Authorization for Release of information

Name of Patient: _____ Date of Birth: _____

DW Norwood DDS/TW Hamilton DDS is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Entity to Receive Information. (Check each person/entity that you approve to receive information).

◯ Voice Mail

_____

◯ Spouse (provide name & phone number)

_____

◯ Parent (provide name & phone number)

_____

◯ Other (provide name & phone number)

_____

Description of information to be released. (Check each that can be given to person/entity)

◯ Results of exams/x-rays

◯ Financial

◯ Other: _____

Patient Information

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to Re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on sighing. **This authorization shall be in effect until revoked by the patient.**

Signature _____ Date _____

** If signed by a Personal Representative the necessary documentation must be provided.

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 4/16/2003, 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 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 the 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 an 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 must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: 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 a 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 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.

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 officials 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 letters).

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 $0.___ for each page, $___ per hour for staff time 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 us 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.

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.

Contact Officer:

Kim Stepp

Telephone: 828-697-2387

Fax: 828-697-5365

Email: willowcreek@att.net

Address: 100 Beverly Hanks Centre, Hendersonville, NC 28792