Patient Information (Confidential)

NAME _____ **DATE** _____
First Middle Last

ADDDRESS _____**CITY/STATE** _____ **ZIP** _____

HOME # _____ **WORK #** _____ **CELL #** _____

SS# _____ **BIRTHDATE** _____

MARITAL STATUS: **Single** **Married** **Divorced** **Widowed** **Partnered**

E-MAIL _____

OCCUPATION: _____

If College Student, FT / PT , Name of School _____

Patient's/ Parent's/Guardian's Employer _____ **Work #** _____

Spouse/Parent's/Guardian's Name_____ **Employer** _____ **Work #** _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

PERSON TO CONTACT IN CASE OF AN EMERGENCY _____ **PHONE**_____

REPSONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____**RELATIONSHIP** _____

ADDRESS _____ **Home #** _____

DRIVER'S LICENSE # - STATE _____**BIRTHDATE** _____**SS#**_____

EMPLOYER _____ **WORK #** _____

Is this person currently a patient in our office? YES NO

DENTAL INSURANCE INFORMATION

NAME OF INSURED _____ **Relationship to patient**_____

BIRTHDATE _____ **SS#** _____

NAME OF EMPLOYER _____ _____

INSURANCE CO._____ **INS GROUP #** _____

INSURANCE ADDRESS _____**CITY/STATE**_____**ZIP**_____

PHONE # _____ **POLICY / ID #** _____

DO YOU HAVE ANY ADDITIONAL DENTAL INSURANCE? YES NO IF YES, COMPLETE THE FOLLOWING.

NAME OF INSURED _____ **Relationship to patient**_____

BIRTHDATE _____ **SS#** _____

NAME OF EMPLOYER _____

INSURANCE CO._____ **INS GROUP #** _____

INSURANCE ADDRESS _____**CITY/STATE**_____**ZIP**_____

PHONE # _____ **POLICY / ID #** _____

X _____
SIGNATURE OF PATIENT OR PARENT/GUARDIAN, IF MINOR

Although we 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 medications that you may be taking, could have an important interrelationship with the dentistry that you will be receiving and your dental health.

Who is your General Dentist _____How many years with your dentist? _____

Are you in good health? Y N Are you under the care of a physician now? Y N For what? _____
Physician's Name/Address: _____
Physician's #: _____
Have you ever been hospitalized for any surgical operation or serious illness? Explain _____
_____

Are you allergic to any of the following? Aspirin Penicillin Codeine Dental Anesthetics Acrylic Metal Latex Sulfa Tetracycline Iodine Aleve Other _____

Please CIRCLE
anything below that pertains to you.

AIDS/HIV Infection? T Cell Count?	Excessive Thirst	Psychiatric Care
Alzheimer's Disease	Fainting Spells/Dizziness	Radiation Treatments
Anaphylaxis	Frequent Diarrhea	Recent Weight Loss
Anemia	Frequent Headaches	Renal Dialysis
Angina	Gastric Reflux	Rheumatic Fever
Arthritis / Gout	Genital Herpes	Rheumatism
Artificial Heart Valve	Glaucoma	Scarlet Fever
Artificial Joint	Hay Fever	Shingles
Asthma	Hearing Aids	Sickle Cell Disease
Blood Disease	Heart Attack / Failure	Sinus Problems
Blood Transfusion	Heart Trouble / Disease	Spina Bifida
Breathing Problem	Hemophilia	Stomach/Intestinal Disease
Bruise Easily	Hepatitis A – B - C	Stroke / TIA's
Cancer	Herpes	Swelling of Limbs
Chemotherapy	High Blood Pressure	Thyroid Disease
Chest Pains	Hives or Rash	Tuberculosis
Cold Sores / Fever Blisters	Hypoglycemia	Tumors or Growths
Congenital Heart Disorder	Irregular Heart Beat	Ulcers
Convulsions	Kidney Problems	Venereal Disease
Cortisone Medicine	Leukemia	Yellow Jaundice
Depression	Liver Disease	Use Tobacco
Diabetes	Low Blood Pressure	Using any Medications Now
Drug / Alcohol Dependency	Lung Disease	Use of Controlled Substances
Easily Winded	Mitral Valve Prolapse	Under the care of a physician
Emphysema / COPD	Pacemaker	
Epilepsy or Seizures	Pain in Jaw Joints	
Excessive Bleeding	Parathyroid Disease	

Have you ever had any serious illness not listed above? _____

Grind or clench your teeth?	Cold Sensitivity?	Heat Sensitivity?	Sweet Sensitivity?
Food wedged between your teeth?	Bleeding Gums?	Automatic or Manual Brush ?	
Are you having any discomfort as this time?			

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 health. It is my responsibility to inform the dental office of any changes in medical status.

Signature _____ **Date** _____

Are you allergic to or have you had any reaction to:

Dental Anesthetics **Penicillin** **Sulfa** **Codeine** **Aspirin** **Minocycline** **Iodine** **Aleve**

Tetracycline **Latex / Rubber** **Barbituates, Sedatives or Sleeping Pills**

Any Metals (Nickel, Mercury) **Other (Please List): _____**

Have you ever been told that you need to be premedicated with antibiotics prior to dental procedures? Yes No
Heart Murmur / Mitral Valve Replacement Artificial Joint – Knee Hip Other _____

Pharmacy Name, Address & Phone # _____

_____

Please list all Medications, including Non-prescription medications and Supplements:

Medication Name / Dosage Purpose Medication Name / Dosage Purpose

_____

_____

_____

_____

_____

_____

_____

_____

_____

Date of Visit: _____ **Changes**: _____ _____
_____
Patient Signature: _____

Date of Visit: _____ **Changes**: _____ _____
_____
Patient Signature: _____

Date of Visit: _____ **Changes**: _____ _____
_____
Patient Signature: _____

Date of Visit: _____ **Changes**: _____ _____
_____
Patient Signature: _____

Date of Visit: _____ **Changes**: _____ _____
_____
Patient Signature: _____

Patient Name: _____ Birthdate: _____

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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 (04/14/2003), 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 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 can also give us written authorization to use your health information or to disclose it to as needed to persons you choose. 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 $0.0 for each page, $0.0 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.

Information Contact Person: Kathy Phone: 489-3204 Fax: 489-0756 Address: 3001 Academy Road Suite 250, Durham, NC 27707

Complaints Contact Person: Cheryl- Phone: 489-3204 Fax: 489-0756 Address: 3001 Academy Road Suite 250, Durham, NC 27707

This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).

MICHAEL R. RICHTER, DDS, MS
PERIODONTICS & DENTAL IMPLANTS
www.drmichaelrichter.com

Consent For Use & Disclosure of Health Information

I have had full opportunity to read and consider the consent form and Notice of Privacy Practices. I understand that by signing this consent form, I am giving consent for your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Printed Name _____ Date _____

Signature _____

Consent for Treatment

1. I hereby authorize Dr. Michael Richter, DDS, MS or designated staff to take x-rays, study models, photographs and any other diagnostic aids deemed appropriate by him to make a thorough diagnosis of _____'s dental needs.

2. Upon diagnosis, I authorize Dr. Michael Richter, DDS, MS to perform all recommended treatment mutually agreed upon by me to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

Patient Printed Name _____ Date _____

Patient Signature _____

Parent or Responsible Party _____

Relationship to Patient _____

Patient Name _____ Chart # _____

Appointment Policy

So that we maintain the operation of our office on sound principles and to assure you and other patients of uninterrupted treatment, it is necessary for all patients to accept and adhere to a definite arrangement of appointments. Once you have made an appointment, remember this time is reserved for you.

In the event of an unforeseen need to change your appointment or cancellation is *absolutely necessary*, we do require 48 hours notice for appointments and 72 hours notice for surgery to reschedule your reserved time. A FEE MAY BE CHARGED IF APPOINTMENTS ARE CHANGED OR CANCELLED WITH LESS THAN 48 HOURS NOTICE OR 72 HOURS FOR SURGERY.

Signature _____ Date _____
Patient or Guarantor