Date: _____

PATIENT REGISTRATION

First Name: _____ Last Name: _____ Middle Initial: _____

Patient is: ☐Policy Holder ☐Responsible Party Preferred Name: _____

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ Address 2: _____

City: _____ State: _____ Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____ Soc Sec: _____ Drivers Lic: _____

○Responsible Party is also a Policy Holder for Patient ○Primary Insurance Policy Holder ○Secondary Insurance Policy Holder

Patient Information

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ Address 2: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Sex: ○Male ○Female Marital Status: ○Married ○Single ○Divorced ○Separated ○Widowed

Birth Date: _____ Age: _____ Soc Sec: _____ Drivers Lic: _____

E-mail: _____ ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ○Full Time ○Part Time ○Retired

Employer: _____

Student Status: ○Full Time ○Part Time

School: _____

Pref. Pharmacy: _____

Section 3

Who may we thank for referring you to us?

_____

Primary Insurance Information

Name of Insured: _____

Insured Soc Sec: _____

ID Number: _____

Employer: _____

Address: _____

Address 2: _____

City: _____ State: _____ Zip: _____

Rem. Benefits: .00_____ Rem. Deuct: .00_____

Relationship to Insured: ○Self ○Spouse ○Child ○Other

Insured Date of Birth: _____

Group Number: _____

Ins. Company: _____

Address: _____

Address 2: _____

City: _____ State: _____ Zip: _____

Secondary Insurance Information

Name of Insured: _____

Insured Soc Sec: _____

ID Number: _____

Employer: _____

Address: _____

Address 2: _____

City: _____ State: _____ Zip: _____

Rem. Benefits: .00_____ Rem. Deuct: .00_____

Relationship to Insured: ○Self ○Spouse ○Child ○Other

Insured Date of Birth: _____

Group Number: _____

Ins. Company: _____

Address: _____

Address 2: _____

City: _____ State: _____ Zip: _____

Time 1:58 PM

Lawrence Family Dentistry

Date 8/26/2015

Medical History Form (revised 8-20-15)

Patient Name: Birth Date: Date Created:

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 you will receive. Thank you for answering the following questions.

Are you under a physician's care now? If yes, list doctor's name.	Yes No	If yes
Have you ever been hospitalized or had a major operation?	Yes No	If yes
Have you ever had a serious head or neck injury?	Yes No	If yes
Are you taking any medications, pills, or drugs?	Yes No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	Yes No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes No	If yes
Are you on a special diet?	Yes No	
Do you use tobacco?	Yes No	
Have you ever required pre-medication prior to dental treatment?	Yes No	If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Do you use controlled substances?	Yes No	If yes
Other?	☐	If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive	Yes No	Cortisone Medicine	Yes No	Hemophilia	Yes No	Radiation Treatments	Yes No
Alzheimer's Disease	Yes No	Diabetes	Yes No	Hepatitis A	Yes No	Recent Weight Loss	Yes No
Anaphylaxis	Yes No	Drug Addiction	Yes No	Hepatitis B or C	Yes No	Renal Dialysis	Yes No
Anemia	Yes No	Easily Winded	Yes No	Herpes	Yes No	Rheumatic Fever	Yes No
Angina	Yes No	Emphysema	Yes No	High Blood Pressure	Yes No	Rheumatism	Yes No
Arthritis/Gout	Yes No	Epilepsy or Seizures	Yes No	High Cholesterol	Yes No	Scarlet Fever	Yes No
Artificial Heart Valve	Yes No	Excessive Bleeding	Yes No	Hives or Rash	Yes No	Shingles	Yes No
Artificial Joint	Yes No	Excessive Thirst	Yes No	Hypoglycemia	Yes No	Sickle Cell Disease	Yes No
Asthma	Yes No	Fainting Spells/Dizziness	Yes No	Irregular Heartbeat	Yes No	Sinus Trouble	Yes No
Blood Disease	Yes No	Frequent Cough	Yes No	Kidney Problems	Yes No	Spina Bifida	Yes No
Blood Transfusion	Yes No	Frequent Diarrhea	Yes No	Leukemia	Yes No	Stomach/Intestinal Disease	Yes No
Breathing Problems	Yes No	Frequent Headaches	Yes No	Liver Disease	Yes No	Stroke	Yes No
Bruise Easily	Yes No	Genital Herpes	Yes No	Low Blood Pressure	Yes No	Swelling of Limbs	Yes No
Cancer	Yes No	Glaucoma	Yes No	Lung Disease	Yes No	Thyroid Disease	Yes No
Chemotherapy	Yes No	Hay Fever	Yes No	Mitral Valve Prolapse	Yes No	Tonsillitis	Yes No
Chest Pains	Yes No	Heart Attack/Failure	Yes No	Osteoporosis	Yes No	Tuberculosis	Yes No
Cold Sores/Fever Blisters	Yes No	Heart Murmur	Yes No	Pain in Jaw Joints	Yes No	Tumors or Growths	Yes No
Congenital Heart Disorder	Yes No	Heart Pacemaker	Yes No	Parathyroid Disease	Yes No	Ulcers	Yes No
Convulsions	Yes No	Heart Trouble/Disease	Yes No	Psychiatric Care	Yes No	Venereal Disease	Yes No
Yellow Jaundice	Yes No						

Have you ever had any serious illness not listed	Yes No	If yes

Comments:

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 (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____

Authorization for Release of Information – Compound Release

Name of Patient _____ Date of Birth _____

Lawrence Family Dentistry is authorized to release protected health information about the above named patient in the following manner and to identified persons.

Entity to Receive Information. Check each person/entity that you approve to receive information.	**Description of information to be released.** Check each that can be given to person/entity on the left in the same section.
☐ Voice Mail	☐ Results of lab tests/x-rays ☐ Other_____
You may release information (dental/medical/financial)about me to: Name_____ Name Name_____	**MY EMERGENCY CONTACT IS:** **Name**_____ **Contact #(s)**_____ _____
☐ Email communication-Provide email address* _____ *For email communication to occur, please accept the disclosure below:	☐ Financial ☐ Medical ☐ Appointment reminders ☐ Breach notification
☐ Text communication – Provide number * _____ *For text communication to occur, accept the disclosure below:	☐ Appointment reminder ☐ Other: _____
☐ For **email and/or text communication** I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected.	

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization will remain in effect until revoked by the patient.

_____Date _____

Signature of Patient or Personal Representative

*Description of Personal Representative's Authority (attach necessary documentation)

Revised 5-12-15

LAWRENCE FAMILY DENTISTRY
Denard T. Lawrence, DDS, PA

FINANCIAL POLICY

A $25 Fee may be charged for Missed Appointments without a 24 hour cancellation notice.

We accept cash, check, VISA, Mastercard, Discover and American Express. Returned checks will be charged the amount of the check PLUS a $25 processing fee. **Full payment is DUE at time of service**. We offer Care Credit to those qualifying with no interest plans for amounts over $200. Please note the parent or guardian who accompanies a child to our office **is responsible for payment at the time of appointment.**

We file your insurance as a courtesy and do our best to maximize your benefits. Although we call for benefits on your behalf, we strongly suggest that you call your insurance company to reconfirm any waiting periods, deductibles or benefits payable concerning your treatment plan. Regardless of your coverage, we require **all deductibles and estimated patient portions be paid at the time of treatment**. If your insurance plan does not pay within 120 days of treatment, you must pay any outstanding balances and seek reimbursement from your dental plan. Our office participates with Regular DPPO CIGNA only!

You are legally responsible for all charges incurred on your account, as well as any costs associated with collecting the total account balance. Accounts over 90 days are subject to being forwarded to collections at which time you may be notified by mail, e-mail and any phone numbers listed on your account. Methods of contact may include using pre-recorded or artificial voice messages and/or the use of an automatic dialing device, as applicable.

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FINANCIAL POLICY RECEIVED

I have read and understood the above information:

Patient (Print Name)____

Patient/Parent or Guardian Signature____________________________________

Date____

Revised 11/21

LAWRENCE FAMILY DENTISTRY

Acknowledgement of Receipt Of Notice of Privacy Practices

Patient Name & Address: _____

_____

_____

I was offered or received a copy of the Notice of Privacy Practices for the above named practice.

_____ _____

Signature Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- ❑ An emergency existed & a signature was not possible at the time.
- ❑ The individual refused to sign.
- ❑ A copy was mailed with a request for a signature by return mail.
- ❑ Unable to communicate with the patient for the following reason: _____
- ❑ Other:_____ _____

Prepared By _____

Signature _____

Date _____

L A W R E N C E

- FAMILY DENTISTRY-

3302 Bridges Street, Ste. H
Morehead City, NC 28557
252 247-3922 Office
252 222-3924 Fax

Patient's Name:_____ Birthdate:_____

I give consent for myself/my child to receive dental treatment deemed necessary by the providers at Lawrence Family Dentistry. These procedures include, but are not limited to; examinations, oral prophylaxes (cleanings), fluoride treatments, sealants, restorations (amalgam or composite fillings and crowns), periodontal (gum) treatments, endodontic (root canal) treatments, extractions, and the use of local anesthetics. I understand that the use of local anesthetics carries a small risk for swelling, bruising, allergic reaction, changes in pain perception, or prolonged anesthesia. This consent shall be considered in effect until rescinded or revoked.

_____ _____ _____

(print your name) (relationship) (date)

_____

(your signature)

THIS SECTION NEEDS TO BE COMPLETED FOR CHILDREN UNDER THE AGE OF 18 BY A PARENT OR LEGAL GUARDIAN ONLY

I affirm that I am the parent or legal guardian for the above named minor child(children). If I am unable to accompany my child, I give permission for the individuals named below to escort my child for dental treatments:

Name:_____ DOB_____ Relationship:_____

Name:_____ DOB_____ Relationship:_____

Name:_____ DOB_____ Relationship:_____

_____

(Signature of Parent or Legal Guardian)

Lawrence Family Dentistry
Denard T. Lawrence II, DDS, PA
3302 Bridges Street, Suite H
Morehead City, NC 28557
252-247-3922

We are bound by law to provide you with copies of your dental records at your request. In order to obtain any current radiographs from your previous dentist, please complete the following information.

Date: _____

Patient Name: _____ D.O.B. _____

Patient Name: _____ D.O.B. _____

Patient Name: _____ D.O.B. _____

Patient Name: _____ D.O.B. _____

Previous Dentist Name: _____

Location: _____ Phone/Fax# _____

___Please email to this address: _____

___Please mail to this address: 3302 Bridges Street, Suite H
Morehead City, NC 28557

___Patient will pick up x-rays.

_____ _____
Signature Date

_____ _____
Signature of parent or guardian Date

LAWRENCE FAMILY PRACTICE
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.

If you have any questions about this Notice please contact our Privacy Officer at 252 247-3922

Effective Date: April 1, 2015

We are committed to protect the privacy of your personal health information (PHI).

This Notice of Privacy Practices (Notice) describes how we may use within our practice or network and disclose (share outside of our practice or network) your PHI to carry out treatment, payment or health care operations. We may also share your information for other purposes that are permitted or required by law. This Notice also describes your rights to access and control your PHI.

We are required by law to maintain the privacy of your PHI. We will follow the terms outlined in this Notice.

We may change our Notice, at any time. Any changes will apply to all PHI. Upon your request, we will provide you with any revised Notice by:

- Posting the new Notice in our office.
- If requested, making copies of the new Notice available in our office or by mail.
- Posting the revised Notice on our website: **lawrencefamilydentistry.com**

Uses and Disclosures of Protected Health Information

We may use or disclose (share) your PHI to provide health care treatment for you.

Your PHI may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you.

EXAMPLE: Your PHI may be provided to a physician to whom you have been referred for evaluation to ensure that the physician has the necessary information to diagnose or treat you. We may also share your PHI from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

We may also share your PHI with people outside of our practice that may provide medical care for you such as home health agencies.

We may use and disclose your PHI to obtain payment for services. We may provide your PHI to others in order to bill or collect payment for services. There may be services for which we share information with your health plan to determine if the service will be paid for.

PHI may be shared with the following:

- Billing companies
- Insurance companies, health plans
- Government agencies in order to assist with qualification of benefits
- Collection agencies

EXAMPLE: You are seen at our practice for a procedure. We will need to provide a listing of services such as x-rays to your insurance company so that we can get paid for the procedure. We may at times contact your health care plan to receive approval PRIOR to performing certain procedures to ensure the services will be paid for. This will require sharing of your PHI.

We may use or disclose, as-needed, your PHI in order to support the business activities of this practice which are called health care operations.

EXAMPLES:

- Training students, other health care providers, or ancillary staff such as billing personnel to help them learn or improve their skills.
- Quality improvement processes which look at delivery of health care and for improvement in processes which will provide safer, more effective care for you.
- Use of information to assist in resolving problems or complaints within the practice.

We may use and disclosure your PHI in other situations without your permission:

- If required by law: The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. For example, we may be required to report gunshot wounds or suspected abuse or neglect.
- Public health activities: The disclosure will be made for the purpose of controlling disease, injury or disability and only to public health authorities permitted by law to collect or receive information. We may also notify individuals who may have been exposed to a disease or may be at risk of contracting or spreading a disease or condition.
- Health oversight agencies: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.
- Legal proceedings: To assist in any legal proceeding or in response to a court order, in certain conditions in response to a subpoena, or other lawful process.
- Police or other law enforcement purposes: The release of PHI will meet all applicable legal requirements for release.
- Coroners, funeral directors: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law
- Medical research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.
- Special government purposes: Information may be shared for national security purposes, or if you are a member of the military, to the military under limited circumstances.

- Correctional institutions: Information may be shared if you are an inmate or under custody of law which is necessary for your health or the health and safety of other individuals.
- Workers' Compensation: Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.

Other uses and disclosures of your health information.

Business Associates: Some services are provided through the use of contracted entities called "business associates". We will always release only the minimum amount of PHI necessary so that the business associate can perform the identified services. We require the business associate(s) to appropriately safeguard your information. Examples of business associates include billing companies or transcription services.

Health Information Exchange: We may make your health information available electronically to other healthcare providers outside of our facility who are involved in your care.

Treatment alternatives: We may provide you notice of treatment options or other health related services that may improve your overall health.

Appointment reminders: We may contact you as a reminder about upcoming appointments or treatment.

We may use or disclose your PHI in the following situations UNLESS you object.

- We may share your information with friends or family members, or other persons directly identified by you at the level they are involved in your care or payment of services. If you are not present or able to agree/object, the healthcare provider using professional judgment will determine if it is in your best interest to share the information. For example, we may discuss post procedure instructions with the person who drove you to the facility unless you tell us specifically not to share the information.
- We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death.
- We may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts.

The following uses and disclosures of PHI require your written authorization:

- Marketing
- Disclosures of for any purposes which require the sale of your information

All other uses and disclosures not recorded in this Notice will require a written authorization from you or your personal representative.

Written authorization simply explains how you want your information used and disclosed. Your written authorization may be revoked at any time, in writing. Except to the extent that your doctor or this practice has used or released information based on the direction provided in the authorization, no further use or disclosure will occur.

Your Privacy Rights

You have certain rights related to your protected health information. All requests to exercise your rights must be made in writing. Contact our privacy officer for a written request document.

You have the right to see and obtain a copy of your protected health information.

This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. If requested we will provide you a copy of your records in an electronic format. There are some exceptions to records which may be copied and the request may be denied. We may charge you a reasonable cost based fee for a copy of the records.

You have the right to request a restriction of your protected health information.

You may request for this practice not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. We are not required to agree with these requests. If we agree to a restriction request we will honor the restriction request unless the information is needed to provide emergency treatment.

There is one exception: we must accept a restriction request to restrict disclosure of information to a health plan if you pay out of pocket in full for a service or product unless it is otherwise required by law.

You have the right to request for us to communicate in different ways or in different locations.

We will agree to reasonable requests. We may also request alternative address or other method of contact such as mailing information to a post office box. We will not ask for an explanation from you about the request.

You may have the right to request an amendment of your health information.

You may request an amendment of your health information if you feel that the information is not correct along with an explanation of the reason for the request. In certain cases, we may deny your request for an amendment at which time you will have an opportunity to disagree.

You have the right to a list of people or organizations who have received your health information from us.

This right applies to disclosures for purposes other than treatment, payment or healthcare operations. You have the right to obtain a listing of these disclosures that occurred after April 14, 2003. You may request them for the previous six years or a shorter timeframe. If you request more than one list within a 12 month period you may be charged a reasonable fee.

Additional Privacy Rights

- You have the right to obtain a paper copy of this notice from us, upon request. We will provide you a copy of this Notice the first day we treat you at our facility. In an emergency situation we will give you this Notice as soon as possible.
- You have a right to receive notification of any breach of your protected health information.

Complaints

If you think we have violated your rights or you have a complaint about our privacy practices you can contact:

Vicki Simpson, HIPAA Privacy Officer, Lawrence Family Dentistry, 3302 Bridges Street, Ste. H, Morehead City, NC 28557, 252 247-3922

You may also complain to the United States Secretary of Health and Human Services if you believe your privacy rights have been violated by us.

If you file a complaint we will not retaliate against you for filing a complaint.

This notice was published and becomes effective on April 1, 2015.