

CAROLINA DENTAL ASSOCIATES

Catherine A. Ha, DMD, PA

“Creating Beautiful Smiles”

5400 S. Miami Blvd., Suite 116, Durham, NC 27703

919.941.5549 office 919.941.5569 fax

Welcome to our Practice!

Please help us by providing us with the following confidential information.

PATIENT INFORMATION: Today’s Date _____

E-mail Address: _____ Last Name: _____ First Name: _____ Middle: _____

Preferred to be called: _____ Mailing Address: _____ City, State, Zip: _____

Date of Birth (MM/DD/YYYY): _____ Age: _____ Married Partnered Separated Divorced Single Widowed Minor

Cell Phone: () _____ Work Phone: () _____ Home Phone: () _____

SS#: _____ Driver’s License: _____ Sex: M F Occupation: _____

Employer: _____ Address, City State, Zip _____

Emergency Contact Name: _____ Relationship: _____ Phone #: _____

Spouse’s Name: _____ Spouse’s Birthdate: _____ Spouse’s SS#: _____

Spouse’s Address (if different than above): _____ City, State, Zip: _____

Spouse’s Employer: _____ Address, City, State, Zip: _____

In the event that we must contact you for scheduling changes, etc., please indicate the best PHONE NUMBER during business hours to call you:

Phone number: _____ **Place:** _____ **Time:** _____

How did you hear about our office? Please check: _____ Dental Insurance Website _____ Internet Search (Google, Yahoo!, MSN, etc) _____ Yellow Pages
_____ Direct Mailing/Postcards _____ Patient referral (Name of Patient) _____ _____ Location/Walk-In

INSURANCE INFORMATION:

Primary Insurance Company : _____ **Address:** _____

City, State, Zip _____ Phone #: _____

Policy Holder Name: _____ SS#: _____ Birth date: _____

Group# or Policy # _____

Insurance Assignment: I certify that I, and/or my dependent(s), have insurance coverage with the above named insurance company and assign directly to Catherine A. Ha, DMD, PA all insurance benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative

Date

MEDICAL HEALTH HISTORY

PATIENT NAME: _____

CHECK YOUR ANSWERS:

Are you in good health? Yes No

Has there been a change in your health within the last year? Yes No Explain: _____

Have you been hospitalized or had a serious illness in the last 5 years? Yes No Explain: _____

Are you being treated by a physician now? Yes No For what? _____

Name of your physician: _____ Date of last Medical Exam: _____

HAVE YOU EVER EXPERIENCED?

- | | | | | | |
|-----|----|---|-----|----|--------------------------------|
| Yes | No | Chest Pains | Yes | No | Dizziness |
| Yes | No | Swollen Ankles | Yes | No | Ringling in ears |
| Yes | No | Shortness of breath | Yes | No | Frequent Headaches |
| Yes | No | Recent weight loss, fever, night sweats | Yes | No | Fainting spells |
| Yes | No | Persistent cough, coughing up blood | Yes | No | Blurred Vision |
| Yes | No | Bleeding problems, bruising easily | Yes | No | Seizures |
| Yes | No | Sinus Problems | Yes | No | Excessive thirst |
| Yes | No | Difficulty swallowing | Yes | No | Frequent urination |
| Yes | No | Constipation, blood in stools | Yes | No | Dry Mouth |
| Yes | No | Frequent vomiting, nausea | Yes | No | Jaundice |
| Yes | No | Difficulty urinating, blood in urine | Yes | No | Joint pain, stiffness |
| | | | Yes | No | Sleep apnea or chronic snoring |

DO YOU HAVE OR HAVE YOU HAD?

- | | | | | | |
|-----|----|--|-----|----|----------------------------|
| Yes | No | Heart disease | Yes | No | HIV positive or AIDS-ARC |
| Yes | No | Heart attack, heart defects | Yes | No | Tumors, Cancer |
| Yes | No | Heart murmur | Yes | No | Arthritis, rheumatism |
| Yes | No | Rheumatic fever | Yes | No | Eye disease |
| Yes | No | Stroke, hardening of arteries | Yes | No | Skin disease |
| Yes | No | High Blood Pressure | Yes | No | Anemia |
| Yes | No | TB, emphysema or other lung diseases | Yes | No | VD (syphilis or gonorrhea) |
| Yes | No | Hepatitis, A B C | Yes | No | Herpes |
| Yes | No | Stomach problems, ulcers | Yes | No | Kidney, bladder diseases |
| Yes | No | Diabetes | Yes | No | Thyroid, adrenal diseases |
| Yes | No | Family History of diabetes, heart problems, cancer | | | |

DO YOU HAVE OR HAVE YOU HAD?

- | | | | | | |
|-----|----|--------------------|-----|----|--|
| Yes | No | Surgeries | Yes | No | Radiation Treatments |
| Yes | No | Blood Transfusions | Yes | No | Chemotherapy |
| Yes | No | Artificial Joint | Yes | No | Prosthetic heart valve |
| Yes | No | Contact Lenses | Yes | No | Pacemaker |
| Yes | No | Psychiatric Care | Yes | No | Women only: Birth Control Pills |
| | | | Yes | No | Women only: Pregnant or nursing |

DO YOU USE OR HAVE USED?

- Yes No Recreational drugs
 Yes No Alcohol
 Yes No Tobacco in any forms
 Yes No Phen Phen diet Pills or any other diet pills
 Yes No Fosamax (for treatment of Osteoporosis)
 Yes No Blood Thinners (Coumadin, Warfarin)

VITAMINS & MEDICATIONS you are taking now:

_____, _____, _____
 _____, _____, _____
 _____, _____, _____

ALLERGIES: (to drugs, food, medications, metals, jewelry, acrylics, etc.) **List the following allergies:**

Do you have or have you had any other diseases or medical problems NOT listed on this form? Yes No If so, please explain:

Have you ever been told by a physician or dentist that you need to pre-medicated prior to any dental treatment? Yes No

DENTAL HEALTH HISTORY

Patient Name: _____

Reason for today's visit: _____

Name of your Former Dentist: _____ **City/State:** _____ **Date of Last Visit:** _____

Is keeping your teeth important to you? Yes No If yes, why? _____

On a scale of 1-10, 10 being the best, where would you rate your smile? _____

On a scale of 1-10, 10 being the best, where would you rate your oral health? _____

Have you ever experienced any of the following?

- | | |
|---|--|
| Yes No Bleeding gums | Yes No Sensitivity to hot & cold |
| Yes No Bad Breath or bad taste in mouth | Yes No Snoring |
| Yes No Burning sensations in mouth | Yes No Food catching between teeth |
| Yes No Soreness in jaw | Yes No Clenching or grinding of teeth |
| Yes No Difficulty opening wide | Yes No Pain/soreness around ears, eyes, face |
| Yes No Clicking or popping in jaw | Yes No Stiff neck muscles |
| Yes No History of or family history of gum disease | Yes No History of or family history of wearing dentures/partials |
| Yes No History of orthodontic treatment (braces) | Yes No Mouth or head injury |
| Yes No History of jaw surgery or wisdom teeth extractions | Yes No Smoke or chew tobacco |

Does having dental treatment make you afraid or nervous? Yes No If yes, what specific things bother you? _____

If you could change anything about your smile, which of the following would you want?

- | | | |
|-------------------------------------|------------------------------|---|
| Yes No Whiter teeth | Yes No Close space or spaces | Yes No Replace chipped teeth |
| Yes No Replace missing teeth | Yes No Replace old crowns | Yes No Remove silver fillings |
| Yes No Remove Stains/Spots on teeth | Yes No Less teeth showing | Yes No Replace old tooth-colored fillings |
| Yes No Straighter teeth | Yes No Less Gum showing | Yes No Reshape/resize my teeth |

Where do you see your overall oral health and/or your smile in the next 5 to 10 years? _____

Which of the following are important to you and your family when making dental health care decisions? Check any or all that applies:

- | | | |
|--|-------------------------------------|--|
| <input type="checkbox"/> Convenience | <input type="checkbox"/> Appearance | <input type="checkbox"/> Relationship with Dental Team |
| <input type="checkbox"/> Finances | <input type="checkbox"/> Time | <input type="checkbox"/> Quality of care |
| <input type="checkbox"/> What insurance covers | <input type="checkbox"/> Health | <input type="checkbox"/> Detailed treatment explanations |
| <input type="checkbox"/> Fear or Anxiety | <input type="checkbox"/> Comfort | <input type="checkbox"/> Technology |

HIPAA PRIVACY FORM

Purpose: This form, Notice of Privacy Practices, presents the information that federal law requires us to give our patients regarding our privacy practices.

We must provide this Notice to each patient beginning no later than the date of our first service delivery to the patient, including service delivered electronically, after April 14, 2003. We must make a good-faith attempt to obtain written acknowledgement of receipt of the Notice from the patient. We must also have the Notice available at the office for patients to request to take with them. We must post the Notice in our office in a clear and prominent location where it is reasonable to expect any patients seeking service from us to be able to read the Notice. Whenever the Notice is revised, we must make the Notice available upon request on or after the effective date of the revision in a manner consistent with the above instructions. Thereafter, we must distribute the Notice to each new patient at the time of service delivery and to any person requesting a Notice. We must also post the revised Notice in our office as discussed above.

CAROLINA DENTAL ASSOCIATES 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 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 \$1.00 for each page, \$25.00 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: Catherine A. Ha, DMD

Telephone: 919.941.5549 Fax: 919.941.6289

Address: 5400 S. Miami Blvd., Suite 116, Durham, NC 27703

HIPAA PRIVACY FORM

Acknowledgement of Receipt of Notice of Privacy Practices

Authorization to Release Protected Health Information: I understand that there may be a need to consult with other health care providers. I voluntarily authorize Catherine A. Ha, DMD or her associates to use and/or disclose my Protected Health Information (PHI) . I authorize Catherine A. Ha, DMD and associates to receive and use the information. This authorization will end when my current treatment plan is completed or one year from the date signed below. I understand that once the information is released it may be redisclosed by the recipient and may no longer be protected by federal privacy regulations. I understand that I may revoke this authorization at any time by notifying, in writing, the above-named doctor disclosing the PHI. However, if I do revoke this authorization, it will not have any effect on any actions taken by the above-named doctor disclosing the PHI prior to their receipt of the revocation. I understand that my treatment cannot be conditioned on whether I sign this authorization.

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

****You may refuse to sign this acknowledgement****

I, _____, have received a copy/explanation of this office's Notice of Privacy Practices.

Signature of Patient, Parent, Guardian or Personal Representative

Date

Relationship to Patient: Self Parent Guardian Personal Representative

For Office Use Only (DO NOT FILL OUT)

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 (such as a language barrier) prohibited obtaining the acknowledgment
 - An emergency situation prevented us from obtaining acknowledgement at time of service
 - Other, please specify: _____
- _____