TRIPLE S DENTAL

Patient Information

Patient Name *
First Name
Last Name

Date mm-dd-yyyy
Date

Birthday mm-dd-yyyy
Date

SS# or Insurance ID#

Sex ○ M ○ F

Address
Street Address
Street Address Line 2
City
State / Province
Postal / Zip Code

Home Tel | Work Tel | Mobile #

Occupation | Email | Marital Status

Referral Source | Notes

Emergency Contact

Emergency Contact Name

Address
Street Address
Street Address Line 2
City
State / Province
Postal / Zip Code

Phone | Relationship

Insurance Information

Responsible Party Name		Relationship to Patient		Insurance Company	
Subscriber Name		Group # *		SS#	
Birthday *		Other Coverage ○ Yes ○ No			

Dental History

Reason for today's visit					
Former Dentist					
Tel		Last X-Ray Date		Last Cleaning	
Last Dental Visit		Do you feel pain ○ Yes ○ No		if yes please describe	

Do you feel numbness, swelling, or any other sensitivity? ○ Yes ○ No

if yes please describe

Additional comments about your past dental history

Health History

Physician Name	
Physician Tel	

Have you ever taken any of the group of drags collectively referred to as "Fen-Phen"? These include combanations of Ionimin, Adepex, Fastin (brand names of phentennine), Pondimin (fenfluramine) and Redux (dexfenfluramine).

○ Yes ○ No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	○ Yes ○ No	Epilepsy	○ Yes ○ No	Radiation Treatment	○ Yes ○ No
Anemia	○ Yes ○ No	Fainting or dizziness	○ Yes ○ No	Respiratory Disease	○ Yes ○ No
Arthritis, Rheumatism	○ Yes ○ No	Glaucoma	○ Yes ○ No	Rheumatic Fever	○ Yes ○ No
Artificial Heart Valves	○ Yes ○ No	Headaches	○ Yes ○ No	Scarlet Fever	○ Yes ○ No
Artificial Joints	○ Yes ○ No	Heart Murmur	○ Yes ○ No	Shortness of Breath	○ Yes ○ No
Asthma	○ Yes ○ No	Heart Problems	○ Yes ○ No	Sinus Trouble	○ Yes ○ No
Back Problems	○ Yes ○ No	Hepatitis Type __	○ Yes ○ No	Skin Rash	○ Yes ○ No
Herpes	○ Yes ○ No	Special Diet	○ Yes ○ No	Bleeding abnormally, with extractions or surgery	○ Yes ○ No

High Blood Pressure	○ Yes ○ No	Stroke	○ Yes ○ No	Blood Disease	○ Yes ○ No
Jaundice	○ Yes ○ No	Swollen Feet or Ankles	○ Yes ○ No	Cancer	○ Yes ○ No
Jaw Pain	○ Yes ○ No	Swollen Neck Glands	○ Yes ○ No	Chemical Dependency	○ Yes ○ No
Kidney Disease	○ Yes ○ No	Thyroid Problems	○ Yes ○ No	Chemotherapy	○ Yes ○ No
Liver Disease	○ Yes ○ No	Tonsillitis	○ Yes ○ No	Circulatory Problems	○ Yes ○ No
Low Blood Pressure	○ Yes ○ No	Tuberculosis	○ Yes ○ No	Congenital Heart Lesions	○ Yes ○ No
Mitral Valve Prolapse	○ Yes ○ No	Tumor or growth on head or neck	○ Yes ○ No	Cortisone Treatments	○ Yes ○ No
Nervous Problems	○ Yes ○ No	Cough, persistent or bloody	○ Yes ○ No	Pacemaker	○ Yes ○ No
Ulcer	○ Yes ○ No	Diabetes	○ Yes ○ No	Psychiatric Care	○ Yes ○ No
Venereal Disease ○ Yes ○ No		Emphysema	○ Yes ○ No	Do you wear contact lenses?	○ Yes ○ No
Weight Loss, unexplained	○ Yes ○ No				
Women: Are you pregnant?	○ Yes ○ No	If yes due date:		Are you nursing?	○ Yes ○ No

Medication & Allergies

Please list all the medication you are currently taking

Please list any known allergies

Are you allergic to any of the following? ○ Yes ○ No

If yes please check

☐ Aspirin ☐ Barbiturates (Sleeping pills) ☐ Codeine ☐ Iodine ☐ Latex ☐ Local Anesthetic ☐ Penicillin

Any other allergies? ○ Yes ○ No

HIPPA Notice of Privacy Practices

HIPAA NOTICE OF PRIVACY PRACTICES

As required by the Privacy Regulations Promulgated Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by our organization, 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, to pay your health care bills, to support the operation of the organization, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for equipment or supplies coverage may require that your relevant protected health information be disclosed to the health plan to obtain approval for coverage.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of our organization. These activities include, but are not limited to, quality assessment activities, employee review activities, accreditation activities, and conducting or arranging for other business activities. For example, we may disclose your protected health information to accrediting agencies as part of an accreditation survey. We may also call you by name while you are at our facility. We may use or disclose your protected health information, as necessary, to contact you to check the status of your equipment.

We may use or disclose your protected health information in the following situations without your authorization: as Required By Law, Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Criminal Activity, Inmates, Military Activity, National Security, and Workers' Compensation. Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only with Your Consent, Authorization or Opportunity to Object, unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or this organization has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy

Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Our organization is not required to agree to a restriction that you may request. If our organization believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, e.g., electronically.

You may have the right to have our organization amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information, if you have any questions concerning or objections to this form, please ask to speak with our President in person or by phone at 252-744-2426.

Associated companies with whom we may do business, such as an answering service or delivery service, are given only enough information to provide the necessary service to you. No medical information is provided.

We welcome your comments: Please feel free to call us if you have any questions about how we protect your privacy. Our goal is always to provide you with the highest quality services.

Acknowledgement of Receipt of Privacy Practices Notice

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

Signature

Clear

Date mm-dd-yyyy

Date

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

Personal Representative's Name:

Relation to Individual:

How Did You Hear About Us?

- ☐ Friend
- ☐ Facebook
- ☐ Google
- ☐ Yelp
- ☐ Advertisement
- ☐ Blog
- ☐ Reference
- ☐ Other