

PATIENT REGISTRATION

First Name: _____ Last Name: _____ Middle Initial: _____
Preferred Name: _____ Sex: Male Female **Are you?** Policy Holder Responsible Party
Whom may we thank for this referral? _____

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____
Preferred Name: _____ Policy Holder Responsible Party
Address: _____
City, State, Zip: _____
Home Phone: _____ Work Phone: _____ Ext: _____ Cell Phone: _____
Date of Birth: ____ / ____ / ____ Age: _____ Social Security: ____ - ____ - ____
 Primary Insurance Policy Holder Name: _____ Secondary Insurance Policy Holder Name: _____

Patient Information

Address: _____
City, State, Zip: _____
Home Phone: _____ Work Phone: _____ Ext: _____ Cell Phone: _____
Date of Birth: ____ / ____ / ____ Age: _____ Social Security: ____ - ____ - ____
Marital Status: Married Single Divorced Separated Widowed Spouse Name: _____
Email: _____ I would like to receive correspondences via e-mail
Employment Status: Full Time Part Time Retired Student Status: Full Time Part Time
Patient/Parent Employed By: _____ Present Position: _____ How long held: _____
Spouse Employed By: _____ Present Position: _____ How long held: _____
Method of Payment: Cash Credit Card Check

Emergency Contact

Someone to notify in case of emergency not living with you: _____
Home Phone: _____ Work Phone: _____ Ext: _____ Cell Phone: _____

PATIENT CONSENT

CONSENT:

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

I consent to the dentist's use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment.

I consent to the disclosure of my records (or my child's records) to the following persons who are involved in my care (or my child's care) or payment for that care.

My consent to disclosure of records shall be effective until I revoke it in writing.

I authorize payment directly to the dentist or dental group of insurance benefits otherwise payable to me. I understand that my dental care insurance carrier or payer of my dental benefits may be less than the actual bill for services, and that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, by my dental care payer.

I attest to the accuracy of the information on this page.

Patient/Legal Guardian Signature

Date

Adult Medical History 03/17((Use This Form))

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, c

Are you under a physician's care now? 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 If yes _____

Do you use tobacco? Yes No If yes _____

Do you take Premedication prior to your dental visits (i.e. antibiotics or sedatives)? If so, please explain: 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

Other? If yes _____

Do you use controlled substances? Yes No If yes _____

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

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

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

PATIENT NUMBER



Patient's Name _____
Last First Initial Date of Birth

1. Purpose of initial visit _____
 2. Are you aware of a problem? _____
 3. How long since your last dental visit? _____
 4. What was done at that time? _____
 5. Previous dentist's name _____
Address: _____ Tel. _____
 6. When was the last time your teeth were cleaned? _____
- CIRCLE THE APPROPRIATE ANSWER. IF YOU DON'T KNOW THE CORRECT ANSWER, PLEASE WRITE "DON'T KNOW" ON THE LINE AFTER THE QUESTION.
7. Have you made regular visits?YES NO
How often: _____
 8. Were dental x-rays taken?YES NO
 9. Have you lost any teeth or have any teeth been removed?YES NO
Why? _____
 10. Have they been replaced?YES NO
 11. How have they been replaced?
a. Fixed bridge _____ Age _____
b. Removable bridge _____ Age _____
c. Denture _____ Age _____
d. Implant _____ Age _____
 12. Are you unhappy with the replacement?YES NO
If yes, explain _____
 13. Would you like to know about permanent replacements?YES NO
 14. Have you ever had any problems or complications with previous dental treatment?YES NO
If yes, explain: _____
 15. Do you clench or grind your teeth?YES NO
 16. Does your jaw click or pop?YES NO
 17. Have you experienced any pain or soreness in the muscles or your face or around your ear?YES NO
 18. Do you have frequent headaches, neckaches or shoulder aches?YES NO
 19. Does food get caught in your teeth?YES NO
 20. Are any of your teeth sensitive to: Hot? Cold? Sweets? Pressure?
 21. Do your gums bleed or hurt?YES NO
When? _____
 22. Do you experience dry mouth?YES NO
 23. How often do you brush your teeth? _____ When? _____
 24. Do you use dental floss?YES NO
How often? _____
 25. Are any of your teeth loose, tipped, shifted or chipped?YES NO
 26. Are you unhappy with the appearance of your teeth?YES NO
 27. How do you feel about your teeth in general? _____
 28. Do you feel your breath is offensive at times?YES NO
 29. Have you ever had gum treatment or surgery?YES NO
What? _____
Where? _____
When? _____
 30. Have you had any orthodontic work? _____
 31. Have you had any unpleasant dental experiences or is there anything about dentistry that you strongly dislike? _____
 32. Do you have any questions or concerns?YES NO

COMMENTS

[Large empty box for patient comments]

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE
PATIENT'S / GUARDIAN'S SIGNATURE _____ DATE _____
DENTIST'S SIGNATURE _____ DATE _____

ANEST.

MED. ALERT

DENTAL HISTORY



JULIE PATTERSON LEDFORD, DDS, PA

- COMPREHENSIVE FAMILY DENTISTRY -

FINANCIAL GUIDELINES

We are honored you have given our team the opportunity to assist you with your dental care. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering the following payment options.

- Cash, Check, Visa, MasterCard, Discover, American Express
- Payment plans through Care Credit, including 6 or 12 month no interest if paid in full within promotional period plans. (requires credit approval)
- For those patients who have a dental benefit plan, we are happy to file your claims and estimate your payment due at each appointment. Remember that your coverage is a contract between you and your company and we cannot guarantee the amount insurance will pay for any procedure.

The parent or guardian accompanying children will be responsible for payment at time of visit.

Accounts with balances over 90 days past due will accrue interest at the rate of 1.5% per month. Legal fees incurred due to collection proceedings will be the patient's/guardian's responsibility.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want and need.

I have read, understand, and accept these Financial Guidelines.

Patient Name (please print)

Patient/Legal Guardian Signature

Date

Authorization for Release of Information

Name of Patient _____ Date of Birth _____

Julie P. Ledford, DDS and staff are 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.
<input type="checkbox"/> Voice Mail	<input type="checkbox"/> Appointments <input type="checkbox"/> Dental or Medical Treatment <input type="checkbox"/> Financial
<input type="checkbox"/> Other person (s) (provide name and phone number)	<input type="checkbox"/> Appointments <input type="checkbox"/> Dental or Medical Treatment <input type="checkbox"/> Financial
<input type="checkbox"/> Email communication-Provide email address* _____ *For email communication to occur, please accept the disclosure below:	<input type="checkbox"/> Dental or Medical Treatment <input type="checkbox"/> Financial <input type="checkbox"/> Breach notification
<input type="checkbox"/> Text communication – Provide number * _____ *For text communication to occur, accept the disclosure below:	<input type="checkbox"/> Appointment reminder <input type="checkbox"/> Other: _____
<input type="checkbox"/> 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.	
<input type="checkbox"/> Photo of patient received by patient or legal guardian <input type="checkbox"/> Photo taken by staff (Example: pre/post procedures)	<input type="checkbox"/> May be posted in office <input type="checkbox"/> May be posted on website <input type="checkbox"/> May be posted on Facebook

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.

 Signature of Patient or Personal Representative

 Date

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

Julie P. Ledford, DDS, PA

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED BY [Practice Name] AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

YOUR RIGHTS: When it comes to your health information you have certain rights. This section explains your rights.

Upon written request:

- Ask to see or get an electronic or a paper copy of your health record or other information we have about you. We will also provide a summary of your health information if requested. We will charge a reasonable, cost based fee. We will provide this information as soon as possible but no later than 30 working days of the request.
- Ask us to correct your health information you think is incorrect or incomplete. We may say “no” but will tell you why in writing within 60 days.
- You can ask us to communicate with you in a certain way (for example, home or office phone) or to send mail to a different address. We will accommodate all reasonable requests.
- Ask us not to use or share certain health information for treatment, payment or our operations. We are not required to agree with your request and may say “no” if it would affect your care.
- If you pay for a service or health care item out of pocket in full and you ask us not to share that information for payment or our operations with your health insurer we will agree unless we are required by law to share that information.
- Ask us for a list or an accounting of the times we have shared your health information for reasons other than treatment, payment, healthcare operations, and when you have asked us to share information. We will provide a list for the past six years for the request. One request per year will be provided free of charge. For additional requests we will charge a reasonable, cost based fee.
- Revoke an authorization to use or disclose PHI at any time except where action has already been taken.

You may also:

- Choose someone to act on your behalf. If you have given someone medical power of attorney or they are your legal guardian, that person can exercise your rights and make choices about your health information. We will ask for proof of this relationship before we take any action.
- Ask for a paper copy of this document even if you have agreed to receive the notice electronically. We will provide that copy promptly.
- File a complaint. If you feel your rights have been violated you may contact the designated Privacy Officer, [Practice officer, address, phone number and email address]
- File a complaint with the US Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Ave, S.W., Washington, D.C. 20201, calling 1.877.696.6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints.
- We will not retaliate for filing a complaint.

OUR RESPONSIBILITIES: The law requires us to:

- Maintain the privacy and security of your protected health information.
- Notify you promptly if a breach occurs that may compromise the privacy or security of your information.
- Follow the duties and privacy practices described in this notice and give you a copy of it.
- Not to use or share you information other what is described in this notice unless you tell us we can in writing. If you tell us we can and then change your mind, just let us know in writing you have changed your mind.

YOUR CHOICES - For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in situations described below, talk to us.

- In these cases you have both the right and the choice to tell us to: share information with your family, close friends, or others involved in your care and share information in a disaster relief situation.

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

- In these cases we never share your information unless you give us written permission:
 - Marketing purposes
 - Sale of your information
 - Most sharing of psychotherapy notes
 - In the case of fundraising, we may contact you for fundraising efforts, but you can tell us not to contact you again.

OUR USES AND DISCLOSURE – We typically use or share your health information in the following ways:

Treatment: We can use your health information and share it with other professionals who are treating you. Example: we may share your health information to an outside doctor for referral. We will also provide your health care providers with copies of various reports to assist them in your treatment.

Payment: We can use or share your health information to bill and get payment from health plans or other entities. Example: we give information about you to your health insurance plan so it will pay for your healthcare.

Health Care Operations: We can use and share your health information to run our practice, improve your care, and contact you when necessary. Example: we use health information about you to manage your treatment and services.

Other ways we can use or share your health information – We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

- **Help with public health and safety issues:** We can share health information about you for certain situations such as: preventing disease, helping with product recalls, reporting adverse reactions to medication, reporting suspected abuse, neglect, or domestic violence, and preventing or reducing a serious threat to anyone's health and safety.
- **Comply with the law:** We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see if we are complying with federal privacy law.
- **Respond to organ and tissue donation requests:** We will share health information about you with organ procurement organizations.
- **Work with a medical examiner or funeral director:** We can share health information with a coroner, medical examiner, or funeral director when you die.
- **Address workers' compensation, law enforcement, and other government requests:**
 - For workers' compensation claims
 - For law enforcement purposes or with a law enforcement official
 - With health oversight agencies for activities authorized by law
 - For special government functions such as military, national security, and presidential protective services
- **Respond to lawsuits and legal actions:** We can share your health information to respond to a court or administrative order, or in response to a subpoena.
- **Research:** We can use or share your information for health research.

CHANGES TO THIS NOTICE - We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office and on our website.

Privacy Officer Julie P. Ledford

drjulieledford@gmail.com

(828)389-8714

Effective date: April 14, 2003

Revision Date: March 26, 2013

Julie P. Ledford, DDS, PA – 36 Waldroup Road, Hayesville, NC 28904 – (828)389-8714

JULIE P. LEDFORD, D.D.S., PA

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: _____ Date of Birth: _____

I have 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: _____

Authorization to Release Health Information

Patient Information:

Name of Patient _____ Date of Birth _____

Address _____

City, State, Zip _____ Phone _____

At my request, _____ may release the following information:
(Name of the entity)

- | | | |
|--|---|-------------------------------------|
| <input type="checkbox"/> Entire record | <input type="checkbox"/> X-Rays or Photos | <input type="checkbox"/> Marketing* |
| <input type="checkbox"/> Financial Records | <input type="checkbox"/> Office Visit Notes | |
| <input type="checkbox"/> Other as listed | | |

*Financial compensation is received for this communication.

Entity or person who will receive the information:

Name _____

Address _____

City, State, Zip _____ Phone _____

 Send the information electronically. Email address: _____ For **email 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 move forward to allow email communications to occur.

This authorization shall be in effect until the information has been forwarded as requested or until the course of treatment is complete.

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 understand released information may include a communicable disease diagnosis such as HIV.

Signature of Patient or Personal Representative Date __________
Description of Personal Representative's Authority (attach necessary documentation)