

Huitt & Borders Family Dentistry  
222 North Lafayette Street Suite 13  
Shelby, North Carolina 28150  
704-487-8931

We would like to welcome you to our practice, and thank you for choosing us! Our goal is to give our patients the very best dental care possible. Therefore, we sincerely hope that your first visit will be pleasant, and that you will find our staff to be courteous and efficient.

Enclosed, you will find the following forms that should be completed prior to your first appointment: **Patient Registration, Medical History, Patient Authorization Form, Consent for Use and Disclosure of Health Information, Acknowledgement of Receipt of Notice of Privacy Practices, and Release of Dental X-Rays** (if needed). Please also include a list of all medications that you are currently taking, if not already stated on your Medical History form.

Be sure to bring these completed forms with you, as well as your **dental insurance card(s)**. If we do not have a copy of your current insurance information at the time of your appointment, you will be responsible for your balance of the services rendered. Our office will provide you with documentation for you to file your claim with your insurance company.

**Our office is currently in network with Delta Dental and Ameritas.** We are glad to file insurance for you as a courtesy; however, the patient/responsible party is ultimately responsible for all fees. All deductibles and co-pays are due at the time of your appointment.

Please be reminded that if you have not had x-rays taken at your previous dental office within the last twelve months, new x-rays will be taken at this first appointment to ensure a complete evaluation. If you would like for us to request any records from your previous dental office, we will be glad to do so.

As a new patient, an extended amount of time has been reserved for your first visit, so it is imperative that you make every effort to be at our office at the scheduled time. We send text messages and emails prior to your appt to remind you of the date and time. We will also call you the day before your appt, unless you have already confirmed your appointment. We know that a scheduling conflict may arise, and we ask that you contact our office as early as possible so that another patient can be scheduled at that appointment time.

We look forward to meeting you, and to welcoming you to our office as a new patient!

**PATIENT REGISTRATION**

ID: \_\_\_\_\_ Chart ID: \_\_\_\_\_  
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: _____
<input type="checkbox"/> Responsible Party is also a Policy Holder for Patient <input type="checkbox"/> Primary Insurance Policy Holder <input type="checkbox"/> Secondary Insurance Policy Holder		

Patient Information

Address: _____		Address 2: _____	
City: _____	State / Zip: _____	Pager: _____	
Home Phone: _____	Work Phone: _____	Ext: _____	Cellular: _____
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed		
Birth Date: _____	Age: _____	Soc Sec: _____	Drivers Lic: _____
E-mail: _____ <input type="checkbox"/> I would like to receive correspondences via e-mail.			
Section 2		Section 3	
Employment Status: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Retired	Emergency Contact # _____		
Student Status: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time	Physician Name & # _____		
Medicaid ID: _____	Pref. Dentist: _____	Referred by _____	
Employer ID: _____	Pref. Pharmacy: _____	Premed Needed? _____	
Carrier ID: _____	Pref. Hyg: _____	Blood Thinner? _____	
		Employer? _____	

Primary Insurance Information

Name of Insured: _____	Relationship to Insured: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other
Insured Soc. Sec: _____	Insured Birth Date: _____
Employer: _____	Ins. Company: _____
Address: _____	Address: _____
Address 2: _____	Address 2: _____
City, State, Zip: _____	City, State, Zip: _____
Rem. Benefits: _____	Rem. Deduct: _____

Secondary Insurance Information

Name of Insured: _____	Relationship to Insured: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other
Insured Soc. Sec: _____	Insured Birth Date: _____
Employer: _____	Ins. Company: _____
Address: _____	Address: _____
Address 2: _____	Address 2: _____
City, State, Zip: _____	City, State, Zip: _____
Rem. Benefits: _____	Rem. Deduct: _____

## 2014 Medical History Form(Copy)(Copy)(Copy)

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.

## General

Have you been out of the United States in the last 30 days? ☐ Yes ☐ No If yes

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

Do you use tobacco? ☐ Yes ☐ No

## 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

## General

Do you have any of the following symptoms? Fever, Muscle pain, Vomiting, Diarrhea, Stomach pain or ☐ Yes ☐ No If yes

## General

Are you currently taking any form of blood thinner? ☐ Yes ☐ No If yes

## General

Are you currently required to take a pre-medication? ☐ 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			

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

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: \_\_\_\_\_

Huitt & Borders Family Dentistry  
222 North Lafayette St. Suite 13  
Shelby, North Carolina 28150  
[hbdentistry222@gmail.com](mailto:hbdentistry222@gmail.com)  
phone: 704-487-8931  
fax: 704-487-8332

Date: \_\_\_\_\_

To: \_\_\_\_\_

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**Reference: Release of Dental X-Rays**

I, \_\_\_\_\_, request that any current x-rays that are available be released to Huitt & Borders Family Dentistry.

Please email x-rays to [hbdentistry222@gmail.com](mailto:hbdentistry222@gmail.com) if your office has that capability.

Thank you.

Sincerely,

\_\_\_\_\_



## **Patient Authorization Form**

### Authorization to Release Information to Family Members

Many of our patients allow their family members (such as a spouse or significant other, a parent, or a child) to call and request personal information. This may include information about an appointment date/time, x-ray, treatment plan, results of an exam, or an account. Under the requirements for HIPAA, we are not allowed to give this information to anyone without the patient's consent. If you wish to have your personal information, including financial information, released to family members, you must sign this form.

You also have the right to revoke this consent, in writing, except after which we have already disclosed information in reliance on your prior consent.

**I authorize *Huitt & Borders Family Dentistry* to release my records, as well as any other information requested, to the following individual(s):**

- |          |                            |
|----------|----------------------------|
| 1. _____ | Relation to Patient: _____ |
| 2. _____ | Relation to Patient: _____ |
| 3. _____ | Relation to Patient: _____ |
| 4. _____ | Relation to Patient: _____ |
| 5. _____ | Relation to Patient: _____ |

### **Authorization Regarding Messages**

*(Please check **all** that apply)*

\_\_\_\_\_ I authorize you to leave a detailed message on the number provided regarding appointments.

\_\_\_\_\_ I authorize you to leave a detailed message on the number provided regarding dental treatment, dental care, test results, or financial information.

\_\_\_\_\_ I authorize you to leave a message with anyone who answers the number provided.

\_\_\_\_\_ I authorize you to only leave messages with \_\_\_\_\_.

\_\_\_\_\_  
**Patient Name**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Patient Signature**

## CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

### SECTION A: PATIENT GIVING CONSENT

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Telephone: \_\_\_\_\_ E-mail: \_\_\_\_\_  
Patient #: \_\_\_\_\_ Social Security #: \_\_\_\_\_

### SECTION B: TO THE PATIENT — PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

**Purpose of Consent:** By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

**Notice of Privacy Practices:** You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Kristin Brackett  
Telephone: 704-487-8931 Fax: 704-487-8332  
E-mail: hbdentistry222@gmail.com  
Address: 222 N.Lafayette Street Shelby, NC 28150

**Right to Revoke:** You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

### SIGNATURE

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

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

**YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.**  
**Include completed Consent in the patient's chart.**

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## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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\* You May Refuse to Sign This Acknowledgement\*

I, \_\_\_\_\_, have received a copy of this  
office's Notice of Privacy Practices.

\_\_\_\_\_  
Please Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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### For Office Use Only

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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 prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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written approval of the American Dental Association.

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



# 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.**

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information (protected health information) used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. Examples of treatment would include crowns, fillings, teeth cleaning services, etc.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be billing your dental plan for your dental services.
- **Health Care Operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would include a periodic assessment of our documentation protocols, etc.

In addition, your confidential information may be used to remind you of an appointment (by phone or mail) or provide you with information about treatment options or other health-related services including release of information to friends and family members that are directly involved in your care or who assist in taking care of you. We will use and disclose your protected when we are required to do so by federal, state or local law. We may disclose your PROTECTED HEALTH INFORMATION to public health authorities that are authorized by law to collect information, to a health oversight agency for activities authorized by law included but not limited to: response to a court or administrative order, if you are involved in a lawsuit or similar proceeding, response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested. We will release your PROTECTED HEALTH INFORMATION if requested by a law enforcement official for any circumstance required by law. We may release your PROTECTED HEALTH INFORMATION to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs. We may release PROTECTED HEALTH INFORMATION to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor. We may use and disclose your PROTECTED HEALTH INFORMATION when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat. We may disclose your PROTECTED HEALTH INFORMATION if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities. We may disclose your PROTECTED HEALTH INFORMATION to federal officials for intelligence and national security activities authorized by law. We may disclose PROTECTED HEALTH INFORMATION to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations. We may disclose your PROTECTED HEALTH INFORMATION to correctional institutions or law enforcement HIPAA/Notice of Privacy Practices.doc officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to

you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals or the public. We may release your PROTECTED HEALTH INFORMATION for workers' compensation and similar programs.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have certain rights in regards to your PROTECTED HEALTH INFORMATION, which you can exercise by presenting a written request to our Privacy Officer at the practice address listed below:

- The right to request restrictions on certain uses and disclosures of PROTECTED HEALTH INFORMATION, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to request to receive confidential communications of PROTECTED HEALTH INFORMATION from us by alternative means or at alternative locations.
- The right to access, inspect and copy your PROTECTED HEALTH INFORMATION.
- The right to request an amendment to your PROTECTED HEALTH INFORMATION.
- The right to receive an accounting of disclosures of PROTECTED HEALTH INFORMATION outside of treatment, payment and health care operations.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your PROTECTED HEALTH INFORMATION and to provide you with notice of our legal duties and privacy practices with respect to PROTECTED HEALTH INFORMATION.

We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all PROTECTED HEALTH INFORMATION that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office.

You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

**For more information about our Privacy Practices, please contact:**

**Dental Care Alliance**  
6240 Lake Osprey Dr.  
Sarasota, FL 34240  
Ph #: 941-955-3150

**For more information about HIPAA or to file a complaint:**

The U.S. Department of Health & Human Services  
Office of Civil Rights  
200 Independence Avenue, S.W.  
Washington, D.C. 20201  
877-696-6775 (toll-free)