Piedmont Regional Dental Clinic Patient Medical/Dental Health History

Patient Name_____ Date of Birth____/____/____ Age_____

Although dental personnel primarily treat the area in and around the mouth, your mouth is a part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the dentistry you receive. Thank you for answering the following questions.

Who is your primary care physician? (Name, phone number, and city): _____

Are you currently being treated by a specialist? YES / NO If yes, name and type of specialist _____

Have you ever been hospitalized or had a major operation? YES / NO If yes, please explain: _____

Are you taking any medications? YES / NO Please list all medications you are currently taking: _____

_____

Do you take bisphosphonates (e.g. Fosamax, Reclast, Zometa, Atonel, or Boniva)? YES / NO If yes, medication name _____

Dosage (mg)_____ Times Per Day_____

Are you allergic to any medications? YES / NO If yes, please list: _____

Do you have any allergies to anything other than medications? YES / NO If yes, please specify: _____

Are you pregnant, trying to become pregnant? YES / NO If yes, estimated due date: _____

Have you given birth within the past year? YES / NO Nursing? YES / NO

Taking oral contraceptives? YES / NO Do you use tobacco? YES / NO

Do you use controlled substances? YES / NO

Do you have, or have you had, any of the following? Please circle.

- ADD/ADHD
- AIDS/HIV Positive
- Alzheimer's/Parkinson's Disease
- Anaphylaxis
- Anemia
- Arthritis/Rheumatism
- Artificial Parts/Pins/Screws
- Asperger's Syndrome
- Asthma
- Breathing Problems/Lung Disease
- Autism
- Blood Disease
- Chemical Dependency
- Convulsions/Seizures
- Developmental Delay
- Diabetes/Hypoglycemia
- Fainting Spells/Dizziness
- Frequent Headaches
- Glaucoma
- Heart Condition
- Heart Valve Replacement
- Hemophilia
- Herpes
- High Blood Pressure
- High Cholesterol
- Hives and/or Rash
- Kidney Problems/Dialysis
- Liver Disease (hepatitis, cirrhosis)
- Psychiatric Care
  - Anxiety
  - Depression
  - PTSD
- Radiation
- Chemotherapy
- Recent Weight Loss/Gain
- Rheumatic Fever
- Sexually Transmitted Infection
- Shingles
- Sickle Cell Disease
- Stomach/Intestinal Disease
- Stroke
- Swelling of Limbs
- Take Blood Thinners (i.e. Coumadin, Heparin, Plavix)
- Thyroid Conditions
- Tumors or Growths
- Ulcers

Have you ever had any other illness(es) not listed above? If yes, please explain: _____

_____

Do you have a "Do Not Resuscitate Order"? YES / NO If yes, PRDC does require a copy to be on file.

Is this your first visit to a dentist? YES / NO

If no, how long has it been since you have visited a dentist?_____years _____months

Who was your previous dentist? _____

Do you like your smile? YES / NO If not, would you like information on how to enhance your smile? YES / NO

What are your current dental concerns? _____

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 _____ Date _____

Provider Signature_____ Date _____

To be completed by PRDC staff: Weight_____Blood Pressure_____

Piedmont Regional Dental Clinic Patient Registration

Patient's First Name_____ **MI**____ **Last Name** _____

Preferred Name_____ **Date of Birth**____/____/____ Age ___

Marital Status (circle one) Single / Married / Widowed / Divorced / Child **Gender** (circle one) Male / Female / Other

Street Address_____ **City**_____ **State** _____ **Zip** _____

P.O. Box_____ **City**_____ **State** _____**Zip**_____

Home Phone ( )_____Cell Phone ( )_____ Work Phone ( )_____

Email (required)_____ Is it ok to contact you and leave messages at the above numbers listed or email? YES / NO

Occupation_____ **Employer**_____

Responsible Party (if not the patient) ____ I affirm that I have the legal authority to provide consent for treatment for this patient.

Parent/Guardian Name_____ Phone ( )_____

Relationship_____

Are there children under 12 in your household? YES / NO
If yes, what school(s) do they attend?_____

PRDC in a non-profit organization. PRDC is required to report the following information. Please answer/circle.

Race: White Black/African American American Indian or Alaska Native Asian Native Hawaiian or Pacific Islander Other Unknown

Ethnicity: Hispanic or Latino Not Hispanic or Latino

Veteran Status: YES / NO If yes, please ask about free care on Veterans Day.

Homeless Status: YES / NO If yes, please choose one: Doubling up Transitional Shelter Street

Would you like to know about PRDC's Affordable Care Program for income-eligible households? YES / NO

Emergency Contact Information: In case of an emergency, PRDC requires contact information for at least one person to be listed.

Name_____ Relationship_____Phone ( ) _____

Medicaid covered patients: ID Number (12 digits)__ __ __ __ __ __ __ __ __ __ __ __ Name of Plan _____

If you are covered by any dental insurance other than Medicaid, please fill in the following information:

Name of Insurance Plan _____ Subscriber Name _____

Employer _____

Subscriber Address_____ City_____State _____ Zip_____

Subscriber Date of Birth____/____/___Relationship to Patient_____ Subscriber Phone ( ) _____

Insurance Group #_____ Subscriber ID_____ Subscriber SS# _____

How did you hear about PRDC? Did someone refer you to us? Please tell us so we can thank them. _____

Do you use Facebook? YES / NO

Consent for Services and Care: I authorize PRDC to treat the above named patient and disclosed, when requested, any and all information for any illness or injury, medical history consultation, prescription or treatment and copies of all medical records. I assign or authorize direct payment to the designated practice toward any medical procedures performed and authorized PRDC to file Medicaid and Insurance Claims on my behalf. I agree that this authorization shall be valid until rescinded in writing or replaced by one of a later date. A photocopy of this authorization shall be considered effective and valid as the original. I understand I am responsible for services not covered by Medicaid/Insurance Plan or if my Medicaid/Insurance Plan is not in effect at the time of service. I understand that PRDC renders services without regard to race, creed, color, or national origin. By my signature I acknowledge that I have been informed of Virginia state law regarding blood testing: In the event that a health care provider or employee is exposed to a patient's bodily fluids in a manner which may transmit disease, the patient will be deemed to have consented to testing for HIV and hepatitis and to release or disclosure of the test results to that health care provider or employee. I consent to all dental treatment deemed necessary by the provider.

Signature of Patient, Parent or Guardian _____ Date _____

Printed Name_____ Relationship _____

Piedmont Regional Dental Clinic HIPAA Form

Patient Name_____ Date of Birth____/____/__

PRDC may release my health information to my primary care physician, other licensed medical professionals, and any third party paying for my treatment in order to coordinate care. PRDC also has the right to release information to the following organizations and/or persons regarding your treatment, care, or appointments:

Name_____ Relationship_____ Phone ( ) _____

Name_____ Relationship_____ Phone ( ) _____

Name_____ Relationship_____ Phone ( ) _____

HIPAA requirements and the Affordable Care Act allow and sometimes require PRDC to communicate with our patients via email. PRDC uses certified encryption programs to ensure your information remains private and only you, or your authorized representatives, can see it. I understand I may receive appointment reminders and timely reports after dental care.

I understand at times it may be necessary in coordinating care or for insurance purposes for PRDC to share or release my dental health record.

I understand if I wish to have my dental health records transferred to another office or location I will need to sign a Release of Records.

PRDC considers a patient's dental health record to be the following information:

Clinical Notes	Patient Registration	Medication History
Radiographs	Treatment Plan	HIPAA Form
Account Ledger	Medical History Intake	PRDC Patient Acknowledgment Form

Signature of Patient, Parent or Guardian _____ Date _____

Printed Name_____ Relationship _____

PRDC Acknowledgment of Receipt of Notice of Privacy Practices and Office Policies

I acknowledge by signing this document I have been given a copy, read, been informed, and understand all office policies and the Notice of Privacy Practices. I also acknowledge it is my responsibility, should I have any questions now and/or in the future, to contact PRDC staff for clarification. I further understand that there are instances when PRDC is legally obligated to disclose some or all of my health information.

Initial_____

I agree to abide by PRDC's policy prohibiting weapons inside the Clinic building including both permitted and unpermitted, open carry and concealed weapons of all types.

Initial_____

PRDC Insurance and Financial Policy

- I understand that PRDC will bill my insurance as a courtesy. I may be responsible for any balance left unpaid by my insurance carrier.
- I understand I will be responsible for any fees not covered by my insurance if payment is denied due to ineligibility and/or inactive status.
- I understand I cannot qualify for both PRDC's Affordable Care Program and use my dental insurance benefits.
- I understand that if any portion of my bill remains unpaid PRDC will refer my balance to a collection agency. Should this become necessary, I agree to be responsible for attorney's fees of 33 1/3% and all court costs.

Patient, Parent or Guardian Initial_____

PRDC Media Release Acknowledgment

I hereby allow the Piedmont Regional Dental Clinic and its agents or assigns, the irrevocable right to use forever any film, video, audio, slides, photographs, digital media, interview material, or combination thereof, for inclusion in any promotional, educational, or advertising purposes, and I am waiving all rights to fees and compensation for any use, replication, publication, and distribution of any such materials.

Patient, Parent or Guardian Initial_____

Piedmont Regional Dental Clinic

Patient Rights and Responsibilities

1. As a PRDC patient, you have rights. You have the right to:

- Receive considerate and respectful care regardless of your race, gender, national origin, religion or economic status.
- Understand your diagnosis, treatment options.
- Know how much the services you request will cost.
- Know the name and credentials of the providers caring for you
- Demand privacy for your personal and medical records.
- Receive quality dental care which takes into consideration your psychological, spiritual, and cultural values as well as your economic situation.
- Express grievances in an appropriate manner and have them addressed directly.

As a PRDC patient, you also have responsibilities. It is your responsibility to:

- Provide accurate and complete contact information and medical history.
- Ask questions if you do not understand a diagnosis, a cost, or treatment options.
- Pay for your services promptly.
- Be respectful to our dentists, staff and other patients.
- Refrain from using phones and cameras in the treatment areas.
- Arrive on-time for your appointments.
- Cancel appointments no less than 2 business days prior unless you are unable to attend due to illness or an emergency.
- Accept the consequences of missing scheduled appointments. (See the Missed Appointment Policy)

2. Financial Policy: PRDC accepts patients of all economic levels. Patients at or below 250% of the Federal Poverty Level can apply for our Affordable Care Plan and may receive a significant discount on treatment.

Patients whose treatment is not covered by Medicaid, Delta Dental Premier or a specific grant must pay for their treatment at the time of service by cash, credit card, Health Savings Account or Care Credit.

3. Preventative Care: We encourage all patients to follow through with their proposed treatment plan. If treatment is not completed within six months of your last exam, you will be required to have a periodic exam before further treatment will be completed.

4. Concerns or Suggestions: We expect that each patient will be treated with dignity, respect and high quality dentistry. With that in mind, we expect our patients to treat our employees with respect and courtesy as well. If you have any concerns, please let us know. We welcome and encourage suggestions to better serve you. You may direct any concerns or suggestions to the Director.

5. Snow Dates: PRDC will update its phone message, send emails or tests, post to Facebook and the website if closed or opening late due to inclement weather.

Piedmont Regional Dental Clinic
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 May 1, 2011, 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 you 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 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 be 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 in formation 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 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 $ for each page, $ 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 Communications: 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 may also submit a written complaint with the US Department of Health and Human Services. We will provide you with the address to file your complaint with the US 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 US Department of Health and Human Services.

Contact Officer: Shari Landry, Director
Telephone: 540-661-0008 Fax: 540-9661-1070
Address: 13296 James Madison Highway, Orange, VA 22960
Email: officemanager@vaprdc.org