601 Fayetteville Street
Suite 100
Durham, NC 27701
919-973-0178
Trophysmilesdurham@gmail.com

AW Reynolds Jr - Durham PLLC

WE ARE PLEASED TO WELCOME YOU TO OUR PRACTICE, PLEASE TAKE A FEW MINUTES TO FILL OUT THIS FORM AS COMPLETELY AS YOU CAN.

Patient Information

Date_____________________

Name___________________________________ Phone( )________________________

Sex M____ F____ Birthdate________________________

Soc. Sec. #__________________________________ Driver License#_______________________

Child_____ Single______ Married______ Widowed_____ Separated_____ Divorced_____

Address_____________________________ City________________ State____ Zip_______

Employed by__________________________ Occupation_____________________

Has any other family member been here before?_____ Name___________________________

Relationship___________________

If student, School name_________________________Address______________________
City____________________ State____ Zip__________

Insurance Name______________________________________ Telephone #___________________

Whom may we thank for referring you? _____________________________

In case of emergency who should be notified?____

Phone# ( )__________________________ Relationship__________________________

If patient is a child fill out next part

Responsible person_________________________ Relationship to Patient___________________

Birthdate_________________ Soc.Sec.#__________________________________

Sex M____ F___. Single____ Married____ Widowed___ Separated___ Divorced__

Driver License#_______________________ Phone #__________________________

Address_____________________________ City____________ State_______ Zip______

Employed by__________________________ Occupation_____________________________

Dental History

Reason for Today's Visit____

Date of last dental visit (mon/year)__________________________ Dentist Name:__________________________

Check if you have had problems with any of the following:

____Bad Breath ____Grinding teeth ____Sensitivity to hot____Bleeding gums ____Loose teeth ____Sensitivity to sweets____Clicking or popping jaw ____Broken fillings ____Sensitivity when biting

____Food collection between teeth ____Sensitivity to cold ____Sores or growths in your mouth

How often do you floss per week________________________ How often do you brush?___________________

Medical History

Physician's Name____ Date of Last Visit________________

Have you had any serious illnesses or operations? If yes, describe________________________________

____

List medications you are currently taking____

____

Are you allergic to any medications?____

____

(Women) Are you pregnant? __Yes __No Nursing?__Yes __No Taking birth control pills? __Yes __No

Check if you have or have had any of the following:

___Anemia ___Cortisone Treatments ___Hepatitis ___Shortness of breath___Stroke___Skin Rash

___Arthritis, Rheumatism ___ Persistent Cough ___High Blood Pressure ___HIV/AIDS___Asthma

___Artificial Heart Valves ___Diabetes___Swelling ___Jaw Pain___Epilepsy___Tonsillitis___Ulcer

___Artificial Joints ___Cancer ______Chemotherapy___Respiratory Disease___Tuberculosis

___Fainting ___Liver Disease ___Thyroid Problems___Radiation Treatment___Hemophilia

___Back Problems ___Glaucoma ___Kidney Disease ___Tobacco Habit____Pacemaker __

___Blood Disease ___Headaches ___Heart Murmur ___Heart Problems ___Circulatory Problems

___Rheumatic Fever _____STD

I understand that payment is due in full at time of treatment unless prior arrangements have been approved.

Signature_____________________________________ Date_________________________ (If patient is a child, parent signature is needed)

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Office Rules & Policies

1. All patients who are over 18 years of age must show their picture ID
2. If applicable, co-payments must be paid at time of visit.
3. All patients must show their current Insurance/ Medicaid Card
4. Patients must have their current health information with all prescribed medications.

For All Appointments

1. There is a $50 charge for short notice or less than 24 hour cancellations or no show appointments. If your appointment is more than 1 hour of time, we need 48 hour cancellation notifications. If you are scheduled to see the Hygienist and Doctor this is considered as two separate appointments. If you receive 3 or more broken appointments you will be dismissed from our office. **It is your responsibility to remember your appointment time.** However, we will remind you with a courtesy call.
2. If you must cancel, you must call at least 24 hours before your appointed time.
3. All appointments need **to be confirmed by 3 pm the day before your appointment** by calling the office. You may leave a phone message if after normal business hours. Your appointment many be cancelled if you do not call to confirm.
4. If you have small children and must bring them with you to your appointment, a responsible person must accompany you to care for the children during your appointment time to maintain our schedule and to respect other patients and staff.
5. If you change your phone number, address or Insurance information please call and provide our office with the updated information.
6. Any broken appointment on a Saturday (if applicable) will result in a six-month suspension.
7. There is a $30 charge for all returned checks. Our office has Check Track account through our bank that automatically debits your account for the face amount plus a $25 processing fee.
8. Any appointment **15 minutes later** or more may be rescheduled and charged a fee.
9. Any appointments that require more than an hour appointment time, that is broken, you may be required to pay an upfront deposit before the appointment is rescheduled.

Children under 18 will not be seen unless accompanied by a parent/guardian.
Children under 12 are not allowed in reception area without adult supervision.
Parents are not allowed in the treatment area while dental procedures are being performed due to limited space.

I have read and understood the clinic's rules and policies and do hereby agree to all above.

Signature: ____ Date:__________

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HIPAA PATIENT CONSENT FORM

As you may be aware, a new federal law went into effect on April 14, 2003. The Health Insurance Portability and Accountability Act (HIPAA) require Dr. Arthur Reynolds, Jr., PLLC to provide you with its Notice of Privacy Practices. It outlines your privacy rights as a patient.

We may use information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication with family:
Health professionals, using their best judgment, may disclose to a family member, other relatives, close personal friends, or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care. Health Professionals may discuss Protected Health Information (PHI) with parent of minor (under age of 18 or in school and covered by parent's insurance policy) unless specifically instructed not to do so.

Worker's Compensation or Disability Insurance:
We may disclose health information to extent authorized by the extent necessary to comply with laws relating to workers compensations or other similar programs established by law.

Public Health:
As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Law Enforcement:
We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

For the patient's review and signature:

I understand that, under the Health Insurance Portability Act of 1996 (HIPAA). I have certain rights to privacy regarding my protected health information. I understand that this information and will be used to: *Conduct, plan, and direct my treatment and follow-up among the multiple health care providers who may be involved in the treatment directly and indirectly.
***Obtain payment from third party payers.**
***Conduct normal healthcare operations, such as quality assessments and physician's certifications.**

I have been informed by you and your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right the change it's Notice

of Privacy Practices from time to time and that I may contact this organization at any time or come to our office to obtain a current copy of Notice of Privacy Practices. I understand that I may request in writing that restrict how my private information is used or disclosed to carry out treatment, payment on health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions. I understand that I may revoke the consent in writing at any time, except to the extent that you have action relying on this consent.

Patient Name (please print): ____

Signature: ____

Relationship to Patient: ____NP