

# HEALTH HISTORY & REGISTRATION

## PATIENT INFORMATION

NAME: Last \_\_\_\_\_ First \_\_\_\_\_ Middle Initial \_\_\_\_\_  
Sex: M F Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Social Security # \_\_\_\_\_  
If patient is a minor give Parent's or Guardian's name \_\_\_\_\_  
Whom may we thank for referring you to our office \_\_\_\_\_ Reason for this visit \_\_\_\_\_  
In order to confirm your appointments we must have a DAYTIME PHONE NUMBER from which you can be reached: # \_\_\_\_\_

## RESPONSIBLE PARTY INFORMATION

NAME: Last \_\_\_\_\_ First \_\_\_\_\_ Middle Initial \_\_\_\_\_  
RESIDENCE: Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Marital Status \_\_\_\_\_  
Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_ Relation to the patient \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Number of years employed \_\_\_\_\_

## RESPONSIBLE PARTY'S SPOUSE

Name \_\_\_\_\_ Home Phone \_\_\_\_\_  
Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_

## EMERGENCY INFORMATION: RELATIVE NOT LIVING WITH YOU.

Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Address \_\_\_\_\_ City, State \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

## DENTAL INSURANCE INFORMATION - PRIMARY COVERAGE

Insured's Name \_\_\_\_\_  
Insurance Company \_\_\_\_\_ E-Mail \_\_\_\_\_  
Insurance Company's Address \_\_\_\_\_  
Insured's Employer \_\_\_\_\_  
Insured's S.S. # \_\_\_\_\_ Group # \_\_\_\_\_ Local # \_\_\_\_\_

## SECONDARY INSURANCE COVERAGE-If you have double dental coverage, complete this for the second carrier

Insured's Name \_\_\_\_\_  
Insurance Company \_\_\_\_\_ E-Mail \_\_\_\_\_  
Insurance Company's Address \_\_\_\_\_  
Insured's Employer \_\_\_\_\_  
Insured's S.S. # \_\_\_\_\_ Group # \_\_\_\_\_ Local # \_\_\_\_\_



## OUR APPOINTMENT POLICY

Our practice is dedicated to quality care and exceptional dental services. We respect the importance of your time and work very hard to schedule appointments that accommodate the busy scheduling needs of all of our patients. In return, we ask that patients make every effort not to change reserved dental appointments or hygiene appointments.

We pride ourselves in providing promptly scheduled, excellent dental care for you and your family. We strive to ensure you are seen promptly and that you have no more than a 10 minute appointment wait. In the event that the doctor or hygienist is running behind due to an emergency, we will make every effort to contact you in advance so as to minimize the chances of any wait.

As we have pre-appointed and reserved time for you in the doctor or hygiene schedule, it goes without saying that other patients (who may have wanted that time) were not able to be accommodated. Thus, a broken and missed appointments creates scheduling problems for other patients as well as the practice. Without sufficient notification from you we are unable to offer this time to another patient.

If you find that you must change your pre-appointed time, we require a minimum of 48 hours notice so that we may offer this appointment time to another patient. Notification must be made directly to our staff. We generally do not accept messages left on the machine as notification, we require that you actually speak with one of our designated schedulers or front office staff.

A charge of \$35.00 will be applied to your account for broken and missed appointments without advance notification. If you are running late, we ask that you please call and give us your advised arrival time, so that we can do what we can to fit you into the schedule, while still accommodating other pre-scheduled patients.

As a courtesy to our patients we will confirm your appointment in advance by card, phone call or email. As a courtesy to our practice and other patients who may be waiting for an appointment, we appreciate a return call or notification from you that you will be at your appointment.

In the event that we do not receive a notification from you concerning your pre-appointed dental or hygiene visit, we may **not** be able to continue to reserve your scheduled time for your appointment. Oftentimes, because of the number of patients waiting for appointments, we are forced to release the appointment to another patient **unless** we hear back from you within 24 hours of the appointment.

In summary, we do understand that occasionally there are extenuating circumstances or emergencies that occur in life. We make every effort to accommodate our patients needs. We ask only that you make every effort to give us advance notice and work with us to re-schedule your appointment.

---

Patient

---

Date

**Sean M. Hamilton, D.D.S., P.L.L.C.**  
**1506-A Wayne Memorial Drive**  
**Goldsboro, NC 27534**

**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) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This act 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.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations

- ◆ Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include teeth cleaning services.
- ◆ Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- ◆ Health care operations include the business aspect of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost- management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individual identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

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 request, except to the extent that we have already taken action relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- ◆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 reasonably request to receive confidential communications of protected health information from us by alternative means or at alternative locations.
  
- ◆The right to inspect and copy your protected health information.
  
- ◆The right to amend your protected health information.
  
- ◆The right to receive an accounting of disclosures of protected health information.
  
- ◆The right to obtain and we have the obligation to provide to you a paper copy of this notice from us at your first service delivery date.
  
- ◆The right to provide and we are obligated to receive a written acknowledgement that you have received a copy of our Notice of Privacy Practices.

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.

This notice is effective as of April 14, 2003 and 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. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. 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, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

Sean M. Hamilton  
1506-A Wayne Memorial Drive  
Goldsboro, NC 27534  
919-731-4447

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  
202-619-0257  
toll free: 1-877-696-6775

**Sean M. Hamilton, D.D.S., P.L.L.C.**  
**1506-A Wayne Memorial Drive**  
**Goldsboro, NC 27534**

**NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT**

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- ◆ Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly
- ◆ Obtain payment from third-party payers
- ◆ Conduct normal healthcare operations such as quality assessments and physician certifications

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or 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.

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

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

---

**Office use only**

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date	initials	Reason