THANK YOU FOR SELECTING OUR DENTAL TEAM

To help us meet all your healthcare needs, please fill out this form completely in ink.
If you have any questions or need assistance, please ask us and we will be happy to help.

PATIENT INFORMATION (CONFIDENTIAL)

Patient Number _____

Name _____ Date _____

SS#/SIN _____ Birthdate _____ Home Phone _____

Address _____ City _____ State/Prov. _____ Zip/P.C. _____

Email _____ Cell Phone _____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

If Student, Name of School/College _____ City _____ State/Prov. _____ ☐ Full Time ☐ Part Time

Patient or Parent/Guardian's Employer _____ Work Phone _____

Business Address _____ City _____ State/Prov. _____ Zip/P.C. _____

Spouse or Parent/Guardian's Name _____ Employer _____ Work Phone _____

Whom May We Thank for Referring You? _____

Person to Contact in Case of Emergency _____ Phone _____

RESPONSIBLE PARTY

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone _____

Email _____ Cell Phone _____

Driver's License # _____ Birthdate _____ Financial Institution _____

Employer _____ Work Phone _____ SS#/SIN _____

Is this Person Currently a Patient in our Office? ☐ Yes ☐ No

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

☐ Cash ☐ Personal Check Credit Card ☐ VISA ☐ MasterCard ☐ I wish to discuss the office's payment policy.

INSURANCE INFORMATION

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS#/SIN _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Employer Address _____ City _____ State/Prov. _____ Zip/P.C. _____

Insurance Company _____ Group # _____ Policy/ID# _____

Ins. Co. Address _____ City _____ State/Prov. _____ Zip/P.C. _____

How Much is Your Deductible? _____ How Much Have You Used? _____ Max. Annual Benefit _____

Do You Have Any Additional Insurance? ☐ Yes ☐ No If Yes, Complete the Following

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS#/SIN _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Employer Address _____ City _____ State/Prov. _____ Zip/P.C. _____

Insurance Company _____ Group # _____ Policy/ID# _____

Ins. Co. Address _____ City _____ State/Prov. _____ Zip/P.C. _____

How Much is Your Deductible? _____ How Much Have You Used? _____ Max. Annual Benefit _____

Over Please

PATIENT MEDICAL HISTORY

Physician _____ Office Phone _____ Date of Last Exam _____

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? If yes, please explain _____	☐	☐
3. Are you taking any medication(s) including non-prescription medicine? If yes, what medication(s) are you taking? _____	☐	☐
4. Have you ever taken Fen-Phen/Redux?	☐	☐
5. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates?	☐	☐
6. Have you taken Viagra, Revatio, Cialis or Levitra in the last 24 hours?	☐	☐
7. Do you use tobacco?	☐	☐
8. Do you use controlled substances?	☐	☐

9. Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pains	☐	☐
Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Easily Winded	☐	☐
Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐
Swollen Ankles	☐	☐	Angina	☐	☐	Hay Fever/Allergies	☐	☐
Fainting/Seizures	☐	☐	Frequently Tired	☐	☐	Tuberculosis	☐	☐
Asthma	☐	☐	Anemia	☐	☐	Radiation Therapy	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Epilepsy/Convulsions	☐	☐	Cancer	☐	☐	Recent Weight Loss	☐	☐
Leukemia	☐	☐	Arthritis	☐	☐	Liver Disease	☐	☐
Diabetes	☐	☐	Joint Replacement or Implant	☐	☐	Heart Trouble	☐	☐
Kidney Diseases	☐	☐	Hepatitis/Jaundice	☐	☐	Respiratory Problems	☐	☐
AIDS or HIV Infection	☐	☐	Sexually Transmitted Disease	☐	☐	Mitral Valve Prolapse	☐	☐
Thyroid Problem	☐	☐	Stomach Troubles/Ulcers	☐	☐	Other _____	☐	☐

	Yes	No
10. Are you wearing contact lenses?	☐	☐
11. Are you allergic to or have you had any reactions to the following?		
Local Anesthetics (e.g. Novocain)	☐	☐
Penicillin or any other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (e.g. nickel, mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Other _____	☐	☐
12. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	☐	☐
13. Women Only:		
Are you pregnant or think you may be pregnant?	☐	☐
Are you nursing?	☐	☐
Are you taking oral contraceptives?	☐	☐

PATIENT DENTAL HISTORY

Name of Previous Dentist _____ Date of Last Exam _____

Previous Dentist's Location _____ Date of Last Cleaning _____

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have you ever experienced any of the following problems in your jaw?		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing	☐	☐

	Yes	No
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you ever had any difficult extractions in the past?	☐	☐
12. Have you ever had any prolonged bleeding following extractions?	☐	☐
13. Have you had any orthodontic treatment?	☐	☐
14. Do you wear dentures or partials?	☐	☐
If yes, date of placement _____		
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐
16. Do you like your smile?	☐	☐

AUTHORIZATION AND RELEASE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____

Signature of patient (or parent/guardian if minor)

Doctor's Comments _____

_____

_____ Signature _____ Date _____

Halifax Plantation Dental Group
Dr. Jennifer L. Fraser

Patient name_____

Legal Guardian (if patient is under 18 yrs of age) _____

I request Jennifer L. Fraser D.M.D., assistants and dental hygienists to perform the following treatment/procedures:

- **FOR ALL NEW PATIENTS:** Oral evaluations, prophylaxis/cleaning, radiographs.
- I further request and authorize the taking of dental x-rays and the use of such anesthetics as may be considered necessary and/or advisable by the doctor.
- I have fully disclosed all health problems, including but not limited to: Heart conditions, high/low blood pressure, diabetes, the need for antibiotics prior to dental treatment (due to prosthetic valves, joints or heart conditions), medications taken/prescribed, bleeding problems, and allergies. **Yes**___ or **NO**___ If you are receiving dental treatment other than an exam, dental cleaning and radiographs, please read and initial beside the description of the treatment/procedure(s).

*Scaling and Root Planing _____
* Extraction of Tooth _____
* Root Canal Therapy _____
* Fillings, Bridges, Crowns _____
* Complete or Partial Dentures _____

*For Oral Surgery: The extraction of a tooth is an irreversible process and whether routine or difficult, it is a surgical procedure. In any surgery, there are some risks. These risks include, but not limited to, the possibility of pain or discomfort during and after the following treatment, swelling, infection, bruising, dry socket (due to dislodged blood clot), bleeding, injury to adjacent teeth, (especially with large fillings, decay or crowns), and surrounding tissue, TMJ disorder, limited jaw opening, displacement of a tooth or portion thereof into the sinus (especially with upper back teeth), or other anatomic location requiring additional surgery (and possible referral to Oral Surgeon) to close the opening or recover the tooth structure, temporary or permanent numbness, jaw fracture and allergic reactions. In addition, the decision to leave a small piece of root in the jaw when it's removed would require extensive surgery may-be necessary. To avoid injury to vital structures such as nerve or the sinus, small root tips may be left in place. Sharp ridges, or bone splinters may form later at the edge of the socket and may require another surgery or smooth or remove. The usual and most frequent risks and complications occurring from the planned treatment have been explained to me and by signing this form: I consent to the extraction of the above tooth/teeth.

*For Dentures and Partial Dentures: I realize that full or partial dentures are artificial and the problems of wearing these appliances have been explained to me (including, but not limited to, looseness, soreness and possible breakage). I realize the final opportunity to make changes in my new dentures (including shape, size, placement and color of the teeth), will be the "teeth in wax", try-in visit. I understand the appliance may need to be relined 3-15 months after the fabrication and the cost for this is not included in the initial denture. There may be additional charges for denture/partial adjustments in the future.

* For Crown and Bridges: I understand it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand I will be wearing temporary crowns and will ensure that they are kept on the tooth until the definite crown/bridge is cemented. I will verify the shape, color and size at the first appointment as the crown will be ready to cement at the following appointment. Endodontic procedures (root canals) are sometimes necessary after the preparation for the crown; root canals are a separate procedure and you may need to see a specialist if a root canal is needed. For implant crowns, we are not responsible for the successful placement and guarantee of the implant as we did not perform the implant placement.

* For Endodontic Treatment (Root Canal): I realize there is no guarantee that root canal treatment will save my tooth, and that a complication can occur from the treatment that may necessitate the extraction of the tooth. Occasionally metal objects are cemented in the tooth or extend through the root, which may/may not necessarily affect the success of the treatment. I understand there is considerable risk of instrument separation during root canal treatment in which referral to an Endodontist may be necessary to evaluate the situation, complete root canal treatment and/or perform surgical procedures to increase the root canal success. I understand that occasionally that additional surgical procedures may be necessary following root canal treatment, root canals may have to be retreated, referral to an Endodontist (Ex: complicated root canal anatomy, inability to locate canals, calcified canals) may be necessary. If a tooth fracture is present, it may not be visually detected but may lead to the loss of the tooth, even after a root canal is performed.

* Children: Should at anytime a child/dependent, become uncooperative during treatment with movement of the head, arms and/or legs, it may be necessary to terminate treatment. If a decision is made to terminate care, the current procedure being performed will be brought to a logical closure. Logical closure requires the cooperation of the patient in order to prevent pain and infection that can result from open teeth. During disruptive behavior incidents, it may be necessary for the assistant(s) to hold the patients hands, stabilize the head, and/or control leg movement in order to close a tooth. A bite block may be necessary to maintain mouth opening.

* During any course of treatment, complications may arise that may necessitate additional procedures or after the propose course of treatment. Such complications may include, but are not limited to, the need for a root canal or extraction. I acknowledge the practice of dentistry is not an exact science and offers no guarantees. When administering anesthetic, there is a rare but unavoidable risk of possible nerve damage, paralysis, and/or dysesthesia. These complications may be temporary or permanent.

Signature of person consenting to treatment: I have had sufficient opportunity to discuss the treatment plan, the benefits to be reasonable expected from this treatment, as well as the alternative approaches, including no treatment. All of my questions have been answered to my satisfaction, and I consent to the treatment and procedures prescribed. I confirm I have read this form or it was read to me.

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill of services. I agree to be responsible to payment of all services rendered on my or my dependants' behalf.

Patient or Guardian Signature_____

Print Name_____

Relationship_____

Dentist Signature_____Date_____

HIPPA Notice of Privacy Practices

Halifax Plantation Dental Spa
Dr. Jennifer L. Fraser

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you, and that relates to your past, present or future physical or mental health or condition and related health care services.

1. **Uses and Disclosures of Protected Health Information**

Your PHI may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice and any other use required by law.

Treatment: We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your PHI, as necessary, to a home health agency that provides care to you. For example, your PHI may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your PHI will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant PHI be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your PHI in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose you PHI to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and include your physician. We may also call your name in the waiting room when your physician is ready to see you. We may use or disclose you PHI, as necessary, to contact you to remind you of your appointment.

We may use or disclose your PHI in the following situations without your authorization. These situations include: as required by law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity: National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in this authorization.

Your Rights
Following is a statement of your rights with respect to your PHI.

You have the right to request a restriction of your PHI. Under federal law, however, you may not inspect or copy the following records; psychotherapy note; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and PHI that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your PHI. This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment, or health operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction and to whom you want the restriction apply.

Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. You then have the right to use another heath care professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your PHI. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints, You may complain to us or the Secretary of Health and Humane Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint**.

This notice was published and becomes effective on/before **April 14, 2003**.

We are required by law to retain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to PHI. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone at our main phone number.

Signature below is only acknowledgement that you have received this Notice of Privacy Practices:

Print name _____

Signature: _____ Date: _____

Official Financial Policy

Welcome to Halifax Plantation Dental Spa. We are happy to have you as a patient and look forward to offering you and your family the finest dental care available.

Before treatment is performed, we will discuss treatment and financial options. This estimate may require modification on the date your treatment is performed if further treatment becomes necessary. Our fees are based on the quality materials we use and the time, effort and skill required in performing your needed treatment. We charge what is usual and customary for our area. We will assist you with your benefit eligibility before treatment to help you calculate your costs and maximize your insurance. Payment is due at the time services are rendered. For your convenience we accept cash, checks, Visa, Mastercard, Discover and American Express. Care Credit may also be available to you. There will be a $25.00 charge for any returned check.

Emergency clients, new to our practice, should expect to make a payment at the time of service. Once established as an active patient, we will be happy to discuss other payment options.

Insurance benefits are determined by your employer, not your dentist. Your insurance policy is a contract between you and your insurance company. Your insurance coverage, and benefits is your responsibility. Insurance is not a guarantee of payment; it often does not cover all cost involved in treatment. As a courtesy, we will be happy to file your claim for you if you present your dental insurance card and all required employer information. You will be expected to pay for services rendered if this office is unable to verify your insurance information before treatment.
Any deductible or estimated co-payment amount will be due at the time of treatment.

If payment for services already rendered has not been paid in full within 45 days, either by you or your insurance company, the remaining balance for your treatment is considered due and must be paid by you.

RESCHEDULING/CHANGE IN SCHEDULING POLICY

Our practice is dedicated to quality care and exceptional service. Our doctors and team spend extensive amounts of time preparing for your visit. Broken and missed appointments create scheduling problems for our team as well as other patients.
Appointments are reserved exclusively for you. As a benefit to you, our valued patient, we may offer to move your appointment to an earlier time if openings arise. We reserve the right to charge and collect 35.00 for any broken appointments. Broken appointments are considered those that are missed (no-show) and cancelled with less than 24 hour advance notice.
Separated or divorced parents of minors, who are responsible for ½ of the cost of a child's/children's dental care: The parent who brings the child in to the dental appointment is responsible for paying the copayment or full fee. If it is necessary, we are happy to hold a credit/debit number from the non custodial parent on file.
Payment plans and financial arrangements are available for comprehensive dental treatment. Please speak to us to make arrangements prior to commencing treatment.

I have read and understand this financial policy.

_____	_____	_____
Printed Name	Signature	Date