Teresa G. Conley, D.D.S.
FAMILY DENTISTRY

WELCOME

Thank you for selecting our dental healthcare team! 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 you.

Patient Information

Patient's Name:____
First Middle Last

Birthday:__________Social Security#:__________Male:______Female:______

Check Appropriate: Minor (Under 18):______Single:______Married:______Divorced/Separated:______Widowed:______

Address:__________City:__________State:______Zip:______

Phone Numbers: Please list at least two alternate numbers where you can be reached or receive messages!

Home: ( )__________Work: ( )__________Cell: ( )__________

Email:____

If Student, name of School or College:__________Location:__________

Name of Employer:__________Location:__________

For your safety please provide us with someone we can contact in the event of an emergency:

Contact:__________Relationship to Patient:__________Phone#: ( )__________

For Minor Patients (under 18 years old) Must be accompanied by a parent or guardian at EVERY appointment!

Name of Parent/Guardian:__________Relationship to Patient:__________

Birthdate:__________SS#:__________Work: ( )__________Cell: ( )__________

Name of Employer:__________Location:__________

Insurance Information (List only your insurance plans with DENTAL BENEFITS COVERAGE)

Primary Insurance:

Policy Holder's Name:__________Birthdate:__________Relationship to Patient:__________

Employer:__________Are You? Current:__________ or Retired:__________

Insurance Carrier:__________Phone#: ( )__________

Address:__________City:__________State:______Zip:______

SS#:__________Policy/ID#:__________Group#:__________

Secondary Insurance:

Policy Holder's Name:__________Birthdate:__________Relationship to Patient:__________

Employer:__________Are You? Current:__________ or Retired:__________

Insurance Carrier:__________Phone#: ( )__________

Address:__________City:__________State:______Zip:______

SS#:__________Policy/ID#:__________Group#:__________

Payments for deductibles and co-payments are due at the time of service.
For your convenience, we offer the following methods of payment:
Cash, Debit Card, Personal Check, Visa, MasterCard, Discover Card or American Express.
We also offer "No Interest Payment Plans" through CareCredit: Brochures can be provided.

We are always accepting new patients. Who may we thank for referring you?__________

Please return this form to our office via fax or email: Fax: 910-326-3192 / E-mail: apptscheduling@conleydentistry.com

Patient Name:______________________________ Birthdate:______________________________

PATIENT MEDICAL HISTORY

Physician:______________________ Office Phone#:______________________ Date of Last Exam:______________________

Please answer Yes or No to ALL of the following questions!

	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)? ______________________		
4. Have you ever taken Fen-Phen/Redux?	☐	☐
5. Have you ever taken Fosamax, Boniva, Actonel or any Cancer medication containing bisphosphonates?	☐	☐
If yes, how long? ______________________		
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. Are you wearing contact lenses?	☐	☐
11. Are you allergic to, or have you had any reaction to the following?		
Local Anesthetics (e.g. Novacain)	☐	☐
Penicillin or any other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives.	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (e.g. nickel, mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Other (please list) ______________________		
12. Do you have a persistent cough or throat clearing not associated with a known illness? (lasting more than 3 weeks).	☐	☐
13. Women Only:		
a. Are you pregnant or think you may be pregnant?	☐	☐
If yes, number of weeks ______________________		
b. Are you nursing?	☐	☐
c. Are you taking oral contraceptives?	☐	☐

Do you have or have you had any of the following? If you answer yes to any of the following please provide date of diagnosis or most recent occurrence!

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

PATIENT DENTAL HISTORY

Name of Previous Dentist:______________________ Location:______________________ Date of Last Exam:______________________

	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 in 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	☐	☐
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 Patient is a minor) **Date**

Please return this form to our office via fax or email: Fax: 910-326-3192 / E-mail: apptscheduling@conleydentistry.com

Teresa G. Conley, D.D.S.
FAMILY DENTISTRY

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRACTICE POLICY AND NOTICE OF PRIVACY PRACTICE AND PATIENT DISCLOSURES

(PLEASE PRINT) Concerning Myself, ______________________________, and/or my following

dependents,_______________________ /_________________________ /_________________________

_______________________ /_________________________ /_________________________

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual. NOTE: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

I have received a copy of this office's Notice of Practice Policy and Notice of Privacy Practices explaining the Policies of this Practice and the Use and Disclosures of Health Information and the Patient's Rights. I have read and understand the practice's appointment policy.

_________________________________ ___________________________
Signature Date

You are entitled to a copy of this consent after you have signed it. Original is for Patient's Chart.

For Office Use Only: We attempted to obtain written acknowledgement of receipt but could not because
___Communication barriers prohibited us from obtaining.
___An emergency situation prevented us from obtaining.
___Other: Please specify:____

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FAMILY DENTISTRY

Radiograph Release Authorization

I, the undersigned, am hereby requesting duplication of any current and/or relevant radiographs to be forwarded as stated and for the following reason(s):

☐ Moving to a new area ☐ Changing Dentist ☐ Second Opinion ☐ Other, please specify______________
____

Please forward all radiographs:

From

____
(Dentist's Name)
____
(Address)
____
____
____
(Phone#) (Fax#)

To

____
(Dentist's Name)
____
(Address)
____
____
____
(Phone#) (Fax#)

This request is to include the following patients:

Patient's Name	Date of Birth	Office Use: X-Rays Provided

________________________________ ________________
(Authorizing Signature) **(Date)**

*Office Use Only: Status of X-rays released/requested:*________________________________
____
____

Please return this form to our office via fax or email: Fax: 910-326-3192 / E-mail: apptscheduling@conleydentistry.com

Teresa G. Conley, D.D.S.
FAMILY DENTISTRY

PRACTICE POLICY NOTICE TO ALL NEW PATIENTS

In order that we may serve our patients in the most efficient manner, the following policies are in effect:

1) Payment of estimated deductible and co-pay amounts are due at the time of each visit.
2) When a dental claim has been filed to your insurance carrier, we allow 60 days for the payment to be received. If no payment has been received by the 60 days then the balance due will become your responsibility.
    a. Please note: While we try to estimate your insurance deductible and/or co-pay amounts per visit, knowledge of your insurance coverage is YOUR responsibility. Please review Your Insurance Policy before beginning any major dental treatment and address any questions you may have to that company.

   Finance and billing charges may apply to all accounts unpaid after 30 days.
3) When a patient arrives for their appointment more than 10 minutes late they risk the chance of not being seen on that day. Exceptions are only made when our schedule will allow for the delay.
4) A 24 hour notice is required for canceled or re-scheduled appointments. Please note: A $50.00 Broken Appointment Fee may be applied.
5) Patients who have missed two appointments without the 24 hour notice or have been consistently late for appointments will be seen on a stand-by basis only.
6) Children under the age of 18 MUST be accompanied on each visit by a parent or guardian. (NO Exceptions Allowed)!

NOTICE TO MEDICAID PATIENTS
PATIENTS WITHOUT THEIR CURRENT MONTH'S MEDICAID CARD WILL NOT BE SEEN UNLESS VERIFICATION CAN BE OBTAINED FROM EDS.
FAILING TO DISCLOSE OTHER DENTAL INSURANCE IS A VIOLATION OF THE NORTH CAROLINA STATE LAW

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.

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual. NOTE: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are 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 01/01/11, 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 in 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 and 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 for 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 your 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 and 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 our 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 by 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 information 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 officials 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 that 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, we will charge you $1 for each page, $5 per hour for staff time to 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 also may submit a written complain to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. 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 U.S. Department of Health and Human Services.

Contact Officer: Angela Rawlins
Telephone: 910-326-2030, Fax: 910-326-3192
E-mail: teresaconley@conleydentistry.com
Address: 1306 W. Corbett Ave., Swansboro, NC 28584

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(Keep this page for your records)