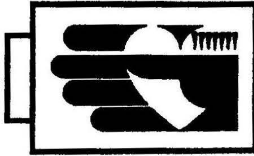

Ned H. Craft, D.D.S.

PATIENT REGISTRATION FORM

First Name: ______________________ Middle Initial: ______ Last Name: ______________________

Preferred Name: ______________ Birth Date: ______________ Social Security Number: ______________

Address: ____

City: ______________________ State: ______________ Zip: ______________

Home Phone: ______________ Work Phone: ______________ Cell Phone: ______________

Sex: Male____ Female____ Marital Status: Married____ Single____ Divorced____ Separated____ Widowed____

Employment Status: Full Time___ Part Time___ Retired___ Student Status: Full Time___ Part Time___

Spouse's Name: ______________________ Children's Names: ______________________

Responsible Party (if someone other than the patient)

First Name: ______________________ Middle Initial: ______ Last Name: ______________________

Address: ____

City: ______________________ State: ______________ Zip: ______________

Home Phone: ______________ Work Phone: ______________ Ext. ______ Cell Phone: ______________

Birth Date: ______________________ Social Security Number: ______________________

INSURANCE INFORMATION

Name of Insured: ______________________ Relationship to Patient: Self___ Spouse___ Child___ Other___

Insured Soc. Sec. #: ______________ Subscriber ID#: ______________ Insured Birth Date: ______________

Employer: ____

Emergency Contact: ______________________ Relationship to Patient: ______________

Phone Number: ______________________

DENTAL HISTORY

Chief Oral Concern: ____

Date of Last Dental Exam: ______________ Any Previous Major Dental Treatment? ❑ Yes ❑ No When: ______________

Describe: ____

Do you have or do you use any of the following:

Teeth sensitive to cold, heat, sweets or pressure ❑ Yes ❑ No
Bleeding gums, if yes, how long?________ ❑ Yes ❑ No
Food packs around teeth ❑ Yes ❑ No
Clenching or grinding ❑ Yes ❑ No
Swelling, lumps in mouth ❑ Yes ❑ No
Unfavorable dental experience ❑ Yes ❑ No
Frequent blisters on lips or mouth ❑ Yes ❑ No
Oral Habits: Fingernail biting, cheek biting, etc. ❑ Yes ❑ No
Use disclosing tablets or solution ❑ Yes ❑ No
How often do you brush?: ______________
How often do you floss?: ______________
Is your toothbrush (Circle One) Soft Medium Hard
Do you use a battery operated toothbrush? ❑ Yes ❑ No
Do you have pain opening/closing your jaw? ❑ Yes ❑ No

Unusual sounds in ears when eating ❑ Yes ❑ No
Very dry mouth ❑ Yes ❑ No
Bad breath ❑ Yes ❑ No
Unpleasant taste ❑ Yes ❑ No
Burning of tongue ❑ Yes ❑ No
Pain around ear ❑ Yes ❑ No
Complications from extractions ❑ Yes ❑ No
Periodontal Treatment ❑ Yes ❑ No
Mouth Breathing ❑ Yes ❑ No
Use a Fluoride Supplement ❑ Yes ❑ No
Use a Water Jet Device ❑ Yes ❑ No
Use Tobacco products ❑ Yes ❑ No
Use Rubber tip stimulators ❑ Yes ❑ No

MEDICAL HISTORY

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

Physician's Name: ______________________ Office Number: ______________

Are you under a physician's care now? ❑ Yes ❑ No If yes, please explain: ______________
Have you every been hospitalized or had a major operation? ❑ Yes ❑ No If yes, please explain: ______________
Have you ever had a serious head or neck injury? ❑ Yes ❑ No If yes, please explain: ______________
Do you use controlled substances? ❑ Yes ❑ No If yes, please explain: ______________
Are you taking bisphosphonates (bone density medication)? ❑ Yes ❑ No
Are you taking blood thinners? ❑ Yes ❑ No
Are you allergic to any of the following? Aspirin, Penicillin, Codeine, Sulfa, Acrylic, Metal, Latex,
Local Anesthetics or any other medication? ❑ Yes ❑ No If yes, please explain: ______________
For Women: Are you pregnant/trying to get pregnant? ❑ Yes ❑ No
Are you taking oral contraceptives? ❑ Yes ❑ No
Are you nursing? ❑ Yes ❑ No Are you Menopausal? ❑ Yes ❑ No

Do you have, or have you had, any of the following?

Condition	Yes/No	Condition	Yes/No
AIDS/HIV Positive	❑ Yes ❑ No	Hepatitis A, B, or C	❑ Yes ❑ No
Alzheimer's Disease/Dementia	❑ Yes ❑ No	Herpes	❑ Yes ❑ No
Anaphylaxis	❑ Yes ❑ No	High Blood Pressure	❑ Yes ❑ No
Anemia	❑ Yes ❑ No	High Cholesterol	❑ Yes ❑ No
Angina	❑ Yes ❑ No	Hives or Rash	❑ Yes ❑ No
Arthritis/Gout	❑ Yes ❑ No	Hypoglycemia	❑ Yes ❑ No
Artificial Joint	❑ Yes ❑ No	Kidney Problems	❑ Yes ❑ No
Artificial Screws/Plates	❑ Yes ❑ No	Leukemia	❑ Yes ❑ No
Asthma	❑ Yes ❑ No	Low Blood Pressure	❑ Yes ❑ No
Blood Disease	❑ Yes ❑ No	Lung Disease	❑ Yes ❑ No
Blood Transfusion	❑ Yes ❑ No	Mitral Valve Prolapse	❑ Yes ❑ No
Breathing Problems	❑ Yes ❑ No	Neurological Problems	❑ Yes ❑ No
Bruise Easily	❑ Yes ❑ No	Osteoporosis	❑ Yes ❑ No
Cancer	❑ Yes ❑ No	Psychiatric Care	❑ Yes ❑ No
Chemotherapy	❑ Yes ❑ No	Radiation Treatments	❑ Yes ❑ No
Congenital Heart Disorder	❑ Yes ❑ No	Renal Dialysis	❑ Yes ❑ No
Cortisone Medicine	❑ Yes ❑ No	Scarlet Fever	❑ Yes ❑ No
Diabetes	❑ Yes ❑ No	Shingles	❑ Yes ❑ No
Emphysema	❑ Yes ❑ No	Sickle Cell Disease	❑ Yes ❑ No
Epilepsy/Seizures	❑ Yes ❑ No	Sinus Trouble	❑ Yes ❑ No
Excessive Bleeding	❑ Yes ❑ No	Stroke	❑ Yes ❑ No
Excessive Thirst	❑ Yes ❑ No	Swelling of Limbs	❑ Yes ❑ No
Fainting Spells/Dizziness	❑ Yes ❑ No	Thyroid Disease	❑ Yes ❑ No
Frequent Cough	❑ Yes ❑ No	Tuberculosis	❑ Yes ❑ No
Frequent Headaches/Migraines	❑ Yes ❑ No	Tumors or Growth	❑ Yes ❑ No
Hay Fever/Allergies	❑ Yes ❑ No	Ulcer	❑ Yes ❑ No
Heart Murmur	❑ Yes ❑ No	Venereal Disease	❑ Yes ❑ No
Heart Pace Maker	❑ Yes ❑ No	Yellow Jaundice	❑ Yes ❑ No
Heart Trouble/Disease	❑ Yes ❑ No		

Describe any medical condition listed yes: ______________
Any other medical condition not listed above? Please describe: ______________
Please list any prescriptions, over the counter medications or herbal supplements you are currently taking: ______________

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 my changes in medical status.

APPOINTMENTS: Once an appointment is made, remember that time has been reserved exclusively for you. If you break an appointment, it will be your responsibility to call us to reschedule. If a second appointment is broken, it is our policy to dismiss you as a patient from our practice.

INSURANCE: Your dental insurance contract is between you and your insurance company. We will help you obtain benefits by preparing necessary insurance reports. All professional services rendered are charged directly to the patient. Patients are responsible for the balance of their account and all associated collection fees.

CONSENT FOR TREATMENT: I hereby agree to diagnostic procedures, dental treatments, and methods as found necessary by Dr. Craft for the restoration and maintenance of my dental health.

RELEASE OF INFORMATION: I authorize the release of this information to my medical doctor of record and to my insurance company as needed for filing of my claims. I understand treatment plans and fees presented could change depending upon the extent of dental disease and the time elapsed since the initial examination.

Signature of Patient: ______________________ **Date:** ______

NED H. CRAFT, DDS

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 02/01/03, 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 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 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 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 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 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 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 $0.25 for each page, $10.00 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 Communication: 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 complaint 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: Mary Pat Langford

Telephone: 252-746-2801 Fax: 252-746-2804

Address: 219 Third Street, P.O. Box 189, Ayden, N.C. 28513

NED H. CRAFT, DDS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, ________________________________, have received a copy of this office's Notice of Privacy Practices.

____
{Please Print Name}

____
{Signature}

____
{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

____

____

____

Ned H. Craft, DDS
219 Third St.
Ayden, NC 28513
252-746-2801

I understand there are very strict guidelines for confidentiality. My desire for release of my dental information is as follows:

_____ RELEASE NO INFORMATION WITHOUT MY WRITTEN PERMISSION TO ANY PERSON OR ENTITY OTHER THAN SPECIFIED FOR INSURANCE PURPOSES

_____ My dental condition may be discussed with individuals as listed below:

Spouse/Significant Other: ______________________

Others: ______________________________________
Name Relationship

____
Name Relationship

____
Name Relationship

I agree to the release of any information Dr. Craft feels is necessary for my care to other health care professional involved in my care.

I realize it is my responsibility to make changes in my desire for release of dental information.

________________________ ________________________
Patient Witness

____
Date