TAYLOR POPE, DMD

PATIENT REGISTRATION

Welcome to our office. We are pleased that you have chosen us to assist you with your dental care. In order to care for you and communicate better, please fill out both sides of this form completely.

About You

Today's Date: _____

Name: Mr. Mrs. Ms. Dr. _____
(LAST) (FIRST) (MI)

I prefer to be called: _____ Driver's License # _____

Birthdate: _____ Age: _____ S.S. # _____

Street Address Necessary: _____ P.O. Box: _____

City: _____ State: _____ Zip: _____ County: _____

❑ Male ❑ Female ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Home Phone #: _____ Email Address: _____

Work Phone #: _____ Ext. _____ Cell # _____

Where and when are the best times to reach you from 8 am - 4 pm? _____

Choose preferred method of confirming appointment: ❑ Email ❑ Text ❑ Telephone

Employer: _____

Employer's Address : _____

Occupation: _____

Is another family member or relative a patient in our office? _____

Name: _____ Relationship: _____

Account Information

Person Financially Responsible for Account: _____

Relationship to Patient: _____ S.S. #: _____

Billing Address: _____

Home Phone #: _____ Work Phone #: _____ Ext: _____

Employer: _____

If 18 or older and you are not responsible for acct., authorize permission to discuss treatment/acct. with person responsible.

Signature _____

(Over)

Emergency Contact

In the event of an emergency, whom should we contact? _____

Relation: _____ Home Phone #: _____ Work Phone #: _____

2nd contact (not living with you): _____

Relation: _____ Home Phone #: _____ Work Phone #: _____

Referral Source

Our practice is fortunate to receive referrals from friends (patients and colleagues) who have been pleased with the services that we provide. Whom may we thank for referring you to us? _____

Dental Insurance

Please bring your Insurance Card with you to your appointments.

Insurance Co. Name: _____

Ins. Co. Address: _____

Ins. Co. Phone #: _____

Group #: _____ ID # _____

Name of Policy Holder: _____ Relation: _____

Birthdate of Policy Holder: _____ Policy Holder's S.S. #: _____

Policy Holder's Employer: _____ Date Employed: _____

Are you eligible for direct reimbursement benefits? ❑ Yes ❑ No

The services that we provide for you are based on an agreement between you and our office. Your dental insurance relationship constitutes an agreement between you, your employer and your insurance carrier. Please carefully review our policy regarding dental insurance and your responsibilities as the insured. Our dental team is here to help you and will be happy to answer any questions that you may have.

TAYLOR POPE, DMD
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.

Primary Care Physician: _____ Phone: _____

Are you under a physician's care now other than routine visits? ❍ Yes ❍ No If yes, please explain: _____

Have you ever 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 take, or have you taken, Phen-Fen or Redux? ❍ Yes ❍ No If yes, please explain: _____

Are you on a special diet? ❍ Yes ❍ No If yes, please explain: _____

Do you use tobacco or vape products? ❍ Yes ❍ No If yes, please explain: _____

Do you use controlled substances? ❍ Yes ❍ No

Have you ever been told your require premedication prior to dental treatment ❍ Yes ❍ No

Are you taking any medications, pills, or drugs? ❍ Yes ❍ No If yes, please explain: _____

_____

_____

Women: Are you

Pregnant/Trying to get pregnant? ❍ Yes ❍ No Taking oral contraceptives? ❍ Yes ❍ No Nursing? ❍ Yes ❍ No

Are you allergic to any of the following?

❍ Aspirin ❍ Penicillin ❍ Codeine ❍ Acrylic ❍ Metal ❍ Latex ❍ Local Anesthetics

❍ Other If yes, please explain: _____

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

AIDS/HIV Positive	❍ Yes ❍ No	Cortisone Medicine	❍ Yes ❍ No	Hemophilia	❍ Yes ❍ No	Renal Dialysis	❍ Yes ❍ No
Alzheimer's Disease	❍ Yes ❍ No	Diabetes	❍ Yes ❍ No	Hepatitis A	❍ Yes ❍ No	Rheumatic Fever	❍ Yes ❍ No
Anaphylaxis	❍ Yes ❍ No	Drug Addiction	❍ Yes ❍ No	Hepatitis B or C	❍ Yes ❍ No	Rheumatism	❍ Yes ❍ No
Anemia	❍ Yes ❍ No	Easily Winded	❍ Yes ❍ No	Herpes	❍ Yes ❍ No	Scarlet Fever	❍ Yes ❍ No
Angina	❍ Yes ❍ No	Emphysema	❍ Yes ❍ No	High Blood Pressure	❍ Yes ❍ No	Shingles	❍ Yes ❍ No
Arthritis/Gout	❍ Yes ❍ No	Epilepsy or Seizures	❍ Yes ❍ No	Hives or Rash	❍ Yes ❍ No	Sickle Cell Disease	❍ Yes ❍ No
Artificial Heart Valve	❍ Yes ❍ No	Excessive Bleeding	❍ Yes ❍ No	Hypoglycemia	❍ Yes ❍ No	Sinus Trouble	❍ Yes ❍ No
Artificial Joint	❍ Yes ❍ No	Excessive Thirst	❍ Yes ❍ No	Irregular Heartbeat	❍ Yes ❍ No	Spina Bifida	❍ Yes ❍ No
Asthma	❍ Yes ❍ No	Fainting Spells/Dizziness	❍ Yes ❍ No	Kidney Problems	❍ Yes ❍ No	Stomach/Intestinal Disease	❍ Yes ❍ No
Blood Disease	❍ Yes ❍ No	Frequent Cough	❍ Yes ❍ No	Leukemia	❍ Yes ❍ No	Stroke	❍ Yes ❍ No
Blood Transfusion	❍ Yes ❍ No	Frequent Diarrhea	❍ Yes ❍ No	Liver Disease	❍ Yes ❍ No	Swelling of Limbs	❍ Yes ❍ No
Breathing Problem	❍ Yes ❍ No	Frequent Headaches	❍ Yes ❍ No	Low Blood Pressure	❍ Yes ❍ No	Thyroid Disease	❍ Yes ❍ No
Bruise Easily	❍ Yes ❍ No	Genital Herpes	❍ Yes ❍ No	Lung Disease	❍ Yes ❍ No	Tonsillitis	❍ Yes ❍ No
Cancer	❍ Yes ❍ No	Glaucoma	❍ Yes ❍ No	Mitral Valve Prolapse	❍ Yes ❍ No	Tuberculosis	❍ Yes ❍ No
Chemotherapy	❍ Yes ❍ No	Hay Fever	❍ Yes ❍ No	Pain in Jaw Joints	❍ Yes ❍ No	Tumors or Growths	❍ Yes ❍ No
Chest Pains	❍ Yes ❍ No	Heart Attack/Failure	❍ Yes ❍ No	Parathyroid Disease	❍ Yes ❍ No	Ulcers	❍ Yes ❍ No
Cold Sores/Fever Blisters	❍ Yes ❍ No	Heart Murmur	❍ Yes ❍ No	Psychiatric Care	❍ Yes ❍ No	Venereal Disease	❍ Yes ❍ No
Congenital Heart Disorder	❍ Yes ❍ No	Heart Pace Maker	❍ Yes ❍ No	Radiation Treatments	❍ Yes ❍ No	Yellow Jaundice	❍ Yes ❍ No
Convulsions	❍ Yes ❍ No	Heart Trouble/Disease	❍ Yes ❍ No	Recent Weight Loss	❍ Yes ❍ No		

Have you ever had any serious illness not listed above? ❍ Yes ❍ No If yes, please explain: _____

Name and phone number of your preferred pharmacy _____

TAYLOR POPE, DMD

CONSENT FOR TREATMENT

I understand that the information contained in the dental and medical histories is necessary to provide me with dental care in a safe and efficient manner, I have answered all questions to the best of my knowledge. If further information is needed, you have my permission to ask my respective health care provider or agency who may release such information to you. I will notify Taylor B. Pope, DMD of any changes in my health or medication. The undersigned hereby authorizes Taylor B. Pope, DMD to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs. Upon such diagnosis, I authorize Taylor B. Pope, DMD to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I understand that using anesthetic agents embodies a certain risk. All diagnostic aids and documentation are the property of the practice. Original records may not be taken by the patient. All records are strictly confidential. Signing this form authorizes us to transfer records to another healthcare provider.

I have reviewed a copy of this office's Notice of Privacy Practices and I have been notified that I may have a copy.

Patient Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

DENTAL HISTORY

Please answer the following questions accurately to permit us to treat you appropriately based on your particular needs. Your answers are confidential and will be used for our records only.

What is the reason for your visit today? _____

_____

Date of your last dental visit _____Previous Dentist's name _____

What was done at your last dental visit?_____

When were last xrays taken?_____

How often do you have dental examinations? _____

How often do you brush?_____ Brush is: [ ] Soft [ ] Medium [ ] Hard

How often do you floss? _____

What other oral hygiene aids do you use? _____

Are you having any discomfort at this time? [ ] Yes [ ] No

If yes, please describe _____

_____

Have you ever had any unpleasant experiences associated with previous dentistry? [ ] Yes [ ] No

If yes, please describe _____

_____

Are you nervous about having dental treatment? [ ] Yes [ ] No

If yes, please describe _____

_____

Do you have any of the following?

Teeth sensitive to [ ] hot, [ ] cold, [ ] biting, [ ] sweets?	[ ] Yes	[ ] No
Frequent mouth odors or bad tastes?	[ ] Yes	[ ] No
Frequent cold sores, blisters, etc. in your mouth?	[ ] Yes	[ ] No
Swelling or lumps in your mouth?	[ ] Yes	[ ] No
Gums that [ ] bleed, [ ] are sore, [ ] are swollen?	[ ] Yes	[ ] No
Loose teeth?	[ ] Yes	[ ] No
A change in your bite or the way your teeth come together?	[ ] Yes	[ ] No
Food packing between your teeth?	[ ] Yes	[ ] No
Clicking or popping in your jaws?	[ ] Yes	[ ] No
Difficulty in opening or closing your mouth?	[ ] Yes	[ ] No
Frequent headaches, neck aches or shoulder aches?	[ ] Yes	[ ] No

Have you ever had any of the following?

Periodontal (gum) treatment? _____	[ ] Yes	[ ] No
If yes, type of treatment		
Orthodontic treatment (braces)? If so, when?	[ ] Yes	[ ] No
A bite plate or mouthguard made?	[ ] Yes	[ ] No

Is there anything else about having dental treatment you would like us to know? [ ] Yes [ ] No

If yes, please describe _____

_____

_____

TAYLOR POPE, DMD

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAM 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 Slate 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 heath 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 disclosure permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your heath 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 judgement 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 er 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, counter intelligences, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmates 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, post cards, 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 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, 2024. 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 disclosures 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 and emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alterative 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 Website or by electronic mail (e-mail), you are entitled to receive this Notice in written form

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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 alternate locations, you may complain to us by using the contact information listed at the end of this Notice. You also may submit a written complaint in 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 he U.S. Department of Health and Human Services.

Contact Officer: **Jessica Creel**

Telephone: **252-746-2801** Fax: **252-304-2388**

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

TAYLOR POPE, DMD

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)

_____

_____

_____