CASTOR FAMILY DENTISTRY

PATIENT INFORMATION

_____

Last Name First Name Middle Name DOB

PATIENT INFORMATION

Social Security #: _____ Driver's License #: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Cell Phone: _____ Home Phone: _____

Work Phone: _____ Other Phone: _____

Email Address: _____

Marital Status: [ ] Minor [ ] Married [ ] Single [ ] Divorced [ ] Widowed

Patient/Guardian's Employer: _____ Occupation: _____

Spouse/Guardian's' Name: _____ Contact Number: _____

RESPONSIBLE PARTY [ ] Same as above

Name of Person Responsible for Account: _____ Relationship: _____

Social Security #: _____ Driver's License #: _____ DOB: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Cell Phone: _____ Home Phone: _____

Work Phone: _____ Other Phone: _____

Email Address: _____

INSURANCE INFORMATION

Name of Insured: _____ Relationship to Patient: _____

Policy Holder's DOB: _____ Social Security #: _____

Policy Holder's Employer: _____ Work Phone: _____

Insurance Co.: _____ Group # _____ Policy/ID#: _____

Do you have any additional dental insurance? [ ] Yes [ ] No

Authorization and Release of Information

I agree that Castor Family Dentistry may bill my insurance carrier for the service provided, as a courtesy to me, and that all payments will come directly to C. Brandon Castor, DDS at Castor Family Dentistry. I understand that I am solely responsible for the cost of my dental treatment. I hereby give authorization for the release of any information requested/ required by my insurance company with respect to any insurance claims.

Patient/ Guardian Signature: _____ Date: _____

CASTOR FAMILY DENTISTRY

MEDICAL HISTORY

Last Name _____ First Name _____ M.I. _____ DOB _____

1. Have you been under the care of a medical physician within the past 2 years? Y N
   If yes, for what? _____
   Physician's Name: _____ Phone: _____
   Address: _____
2. Do you take any drugs or medications (prescription and/or over-the-counter)? Y N
   Please list all drugs/medications including dosages on the attached page.
3. Have you ever had a substance abuse/ addiction issue? Y N
4. Do you have any allergies to any medications or substances? Y N
   If yes, please list and/or describe: _____
5. Have you been hospitalized for a surgery or serious illness within the last 5 years? Y N
   If yes, please describe: _____
6. Alcohol Consumption: _____ drinks per day OR _____ drinks per week
7. Smoking/ Tobacco _____ packs per day _____ years of use Other: _____
8. Women: Are you pregnant? Y N ___ months Nursing? Y N On Birth Control? Y N
9. Do you use more than 2 pillows to sleep at night? Y N
10. Have you lost or gained more than 10 pounds in the past year? Y N
11. Please indicate whether or not you have had, or currently have the following conditions:

Heart (Surgery, Disease, Attack)	Y N	Ulcers	Y N	Hepatitis A B C	Y N
Chest Pain	Y N	Diabetes	Y N	Venereal Disease	Y N
Congenital Heart Disease	Y N	Thyroid Problems	Y N	HIV/ AIDS	Y N
Heart Murmur	Y N	Glaucoma	Y N	Cold Sores/ Fever Blisters	Y N
High Blood Pressure	Y N	Contact Lenses	Y N	Blood Transfusion	Y N
Mitral Valve Prolapse	Y N	Emphysema	Y N	Hemophilia	Y N
Artificial Heart Valve	Y N	Chronic Cough	Y N	Sickle Cell Disease/ Trait	Y N
Heart Pacemaker	Y N	Tuberculosis	Y N	Bruise Easily	Y N
Rheumatic Fever	Y N	Asthma	Y N	Liver Disease	Y N
Arthritis	Y N	Hay Fever	Y N	Yellow Jaundice	Y N
Cortisone Medication	Y N	Latex Sensitivity	Y N	Neurological Disease	Y N
Swollen Ankles	Y N	Allergies or Hives	Y N	Epilepsy or Seizures	Y N
Stroke	Y N	Sinus Trouble	Y N	Fainting or Dizzy Spells	Y N
Diet (restricted, specialized, etc.)	Y N	Radiation Therapy	Y N	Nervous/ Anxious	Y N
Artificial Joints (hip, knee, etc.)	Y N	Chemotherapy	Y N	Psychiatric/ Psychological Care	Y N
Kidney Trouble	Y N	Tumors	Y N		

12. Any other conditions, concerns, or issues not listed that you feel are important to address? Y N
    _____
    _____

I understand that the above information 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. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient/ Guardian Signature: _____ Date: _____

CASTOR FAMILY DENTISTRY

MEDICATION LIST

_____

Last Name First Name M.I. DOB

Drug/Medication Name	Dosage	Frequency	Use/Purpose

Patient/ Guardian Signature: _____ Date: _____

By signing below, I am indicating that this medication list is correct and updated:

Patient/ Guardian Signature: _____ Date: _____

Patient/ Guardian Signature: _____ Date: _____

Patient/ Guardian Signature: _____ Date: _____

Patient/ Guardian Signature: _____ Date: _____

CASTOR FAMILY DENTISTRY

FINANCIAL POLICY

We believe that your dental care and treatment is an investment in yourself and your future.
In an effort to control fees, payment in full is due at the time of service. For patients without dental insurance, we offer several payment options and discounts described below. If you have dental insurance, our staff will do our best to estimate your benefits and collect your estimated patient portion when treatment is provided. We accept cash, checks ($25 returned check fee), credit cards (VISA, MasterCard, Discover and American Express), and CareCredit.

Patients with Dental Insurance:
Please be sure to bring your most updated insurance card to each appointment, and inform us if there have been any changes to your coverage. We are in-network with BCBS, Cigna, Delta Dental, and MetLife; however, we will still help you to file with other insurance providers. Our staff will happily assist you to file the necessary paperwork so that you can receive the full benefits of your coverage. Remember that dental insurance is an agreement between the carrier and patient. As such, we can make no guarantee of the estimated coverage or payment; however, we will do everything possible to see that you receive the full benefits of your policy. We understand the tremendous value of insurance benefits and will assist you to get the maximum benefit available. We will be happy to file for a pre-determination of benefits for your treatment plan; these estimates of coverage are not an actual guarantee of insurance payment, however. Pre-determinations may be required by insurance carriers for more extensive work (i.e.; crowns, periodontal cleanings, etc).

Payment Options:
Payment is due in full at the time of service. Due to the fact that we cannot guarantee your exact insurance coverage, there may be a balance remaining on your account after the insurance payment is received. We ask that this balance be paid within 30 days. Credits or over-payments to your account can either be reimbursed directly to you, or applied to your next visit.

CareCredit is a health care credit option, offering “same as cash,” interest-free credit lines (6-24 months) for qualifying patients. Information and applications are available at the front desk or online.

Patients without dental insurance may receive a 5% discount on any services paid in full with cash or personal check, or a 2% discount on services paid in full with a credit card, if paid in advance or on the day of service.

Separate financial plans may be offered to patients in good standing with balances over $500 after discussion with Amy and Dr. Castor.

A $25 charge will be applied for any returned checks or missed/ canceled appointments without 24hours advanced notice.

CASTOR FAMILY DENTISTRY

AUTHORIZATION FOR RELEASE OF INFORMATION

Name of Patient: _____ Date of Birth: _____

CASTOR FAMILY DENTISTRY is authorized to release protected health information about the above-named patient to the entities named below.

Check each person/entity approved to receive information	**Check type of information that can be given to person/entity on the left of the same section.**
[ ] Voice Mail	[ ] Results of lab tests/ x-rays [ ] Other: _____
[ ] Other person(s) (provide name & phone number)	[ ] Financial [ ] Medical
[ ] Email communication – Provide email address* *For email communication to occur, please accept the disclosure below:	[ ] Financial [ ] Medical [ ] Appointment reminders [ ] Breach notification
[ ] Text communication – Provide number* *For text communication to occur, accept the disclosure below:	[ ] Appointment reminder [ ] Other:
[ ] For **email and/or text communication** I understand that if notification is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected.	
[ ] Photo of patient received by patient or legal guardian [ ] Photo taken by staff (ex: pre/post procedure) [ ] Other	[ ] May be posted in office [ ] May be posted on website [ ] Other

Patient Rights

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization will remain in effect until revoked by the patient.

_____ _____

Signature of Patient or Personal Representative Date

NOTICE OF PRIVACY PRACTICES

CASTOR FAMILY DENTISTRY

1430 East Cone Blvd.
Greensboro, NC 27405
(336) 621-4927
www.castorfamilydentistry.com

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.

If you have any questions about this notice, please contact Dr. Brandon Castor, DDS
Effective Date: March 17, 2017 Revised: March 17, 2017

We are committed to protect the privacy of your personal health information (PHI).

This Notice of Privacy Practices (Notice) describes how we may use within our practice or network and disclose (share outside of our practice or network) your PHI to carry out treatment, payment or health care operations. We may also share your information for other purposes that are permitted or required by law. This Notice also describes your rights to access and control your PHI.

We are required by law to maintain the privacy of your PHI. We will follow the terms outlined in this Notice.

We may change our Notice, at any time. Any changes will apply to all PHI. Upon your request, we will provide you with any revised Notice by:

- Posting the new Notice in our office.
- If requested, making copies of the new Notice available in our office or by mail.

Uses and Disclosures of Protected Health Information

We may use or disclose (share) your PHI to provide health care treatment for you.

Your PHI may be used and disclosed by our 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.

EXAMPLE: Your PHI may be provided to a physician to whom you have been referred for evaluation to ensure that the physician has the necessary information to diagnose or treat you. We may also share your PHI from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

We may also share your PHI with people outside of our practice that may provide medical care for you such as home health agencies.

We may use and disclose your PHI to obtain payment for services. We may provide your PHI to others in order to bill or collect payment for services. There may be services for which we share information with your health plan to determine if the service will be paid for.

PHI may be shared with the following:

- Billing companies
- Insurance companies, health plans
- Government agencies in order to assist with qualification of benefits
- Collection agencies

EXAMPLE: You are seen at our practice for a procedure. We will need to provide a listing of services such as x-rays to your insurance company so that we can get paid for the procedure. We may at times contact your health care plan to receive approval PRIOR to performing certain procedures to ensure the services will be paid for. This will require sharing of your PHI.

We may use or disclose, as-needed, your PHI in order to support the business activities of this practice which are called health care operations.

EXAMPLES:

- Training students, other health care providers, or ancillary staff such as billing personnel to help them learn or improve their skills.
- Quality improvement processes which look at delivery of health care and for improvement in processes which will provide safer, more effective care for you.
- Use of information to assist in resolving problems or complaints within the practice.

We may use and disclose your PHI in other situations without your permission:

- If required by law: The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. For example, we may be required to report gunshot wounds or suspected abuse or neglect.
- Public health activities: The disclosure will be made for the purpose of controlling disease, injury or disability and only to public health authorities permitted by law to collect or receive information. We may also notify individuals who may have been exposed to a disease or may be at risk of contracting or spreading a disease or condition.
- Health oversight agencies: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.
- Legal proceedings: To assist in any legal proceeding or in response to a court order, in certain conditions in response to a subpoena, or other lawful process.
- Police or other law enforcement purposes: The release of PHI will meet all applicable legal requirements for release.
- Coroners, funeral directors: We may disclose PHI to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law.
- Medical research: We may disclose your PHI to researchers when their research has been approved by an institutional review board that has reviewed the research protocol and established protocols to ensure the privacy of your PHI.
- Special governmental purposes: Information may be shared for national security purposes, or if you are a member of the military, to the military under limited circumstances.
- Correctional institutions: Information may be shared if you are an inmate or under custody of law which is necessary for your health or the health and safety of other individuals.
- Workers' Compensation: Your PHI may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.

Other uses and disclosures of your health information.

- Business Associates: Some services are provided through the use of contracted entities called "business associates." We will always release only the minimum amount of PHI necessary so that the business associate can perform the identified services. We require the business associate(s) to appropriately safeguard your information. Examples of business associates include billing companies or transcriptions services.

- Health Information Exchange: We may make your health information available electronically to other healthcare providers outside of our facility who are involved in your care.
- Fundraising activities: We may contact you in an effort to raise money. You may opt out of receiving such communications.
- Treatment alternatives: We may provide you notice of treatment options or other health related services that may improve your overall health.
- Appointment reminders: We may contact you as a reminder about upcoming appointments or treatment.

We may use or disclose your PHI in the following situations UNLESS you object.

- We may share your information with friends or family members, or other persons directly identified by you at the level they are involved in your care or payment of services. If you are not present or able to agree/ object, the healthcare provider using professional judgment will determine if it is in your best interest to share the information. For example, we may discuss post procedure instructions with the person who drove you to the facility unless you tell us specifically not to share the information.
- We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition, or death.
- We may use or disclose your PHI to an authorized public or private entity to assist in disaster relief efforts.

The following uses and disclosures of PHI require your written authorization:

- Marketing
- Disclosures for any purposes which require the sale of your information
- Release of psychotherapy notes: Psychotherapy notes are notes by a mental health professional for the purpose of documenting a conversation during a private session. This session could be with an individual or with a group. These notes are kept separate from the rest of the medical record and do not include: medications and how they affect you, start and stop time of counseling sessions, types of treatments provided, results of tests, diagnosis, treatment plan, symptoms, prognosis.

All other uses and disclosures not recorded in this Notice will require a written authorization from you or your personal representative.

Written authorization simply explains how you want your information used and disclosed. Your written authorization may be revoked at any time, in writing. Except to the extent that your doctor or this practice has used or released information based on the direction provided in the authorization, no further use or disclosure will occur.

Your Privacy Rights

You have certain rights related to your PHI. All requests to exercise your rights must be made in writing.

You have the right to see and obtain a copy of your PHI.

This means you may inspect and obtain a copy of PHI about you that is contained in a designated record set for as long as we maintain the PHI. If requested, we will provide you a copy of your records in an electronic format. There are some exceptions to records which may be copied and the request may be denied. We may charge you a reasonable cost based fee for a copy of the records.

You have the right to request a restriction of your PHI.

You may request for this practice not to use or disclose any part of your PHI for the purposes of treatment, payment or healthcare operations. We are not required to agree with these requests. If we agree to a restriction, we will honor the restriction request unless the information is needed to provide emergency treatment.

There is one exception: We must accept a restriction request to restrict disclosure of information to a health plan if you pay out of pocket in full for a service or product unless it is otherwise required by law.

You have the right to request for us to communicate in different ways or in different locations.

We will agree to reasonable requests. We may also request alternative address or other method of contact such as mailing information to a post office box. We will not ask for an explanation from you about the request.

You may have the right to request an amendment of your health information.

You may request an amendment of your health information if you feel that the information is not correct along with an explanation of the reason for the request. In certain cases, we may deny your request for an amendment at which time you will have an opportunity to disagree.

You have the right to a list of people or organizations who have received your health information from us.

This right applies to disclosures for purposes other than treatment, payment or healthcare operations. You have the right to obtain a listing of these disclosures that occurred after March 17, 2017. You may request them for the previous six years or a shorter timeframe. If you requested more than one list within a 12-month period, you may be charged a reasonable fee.

Additional Privacy Rights

- You have the right to obtain a paper copy of this notice from us, upon request. We will provide you a copy of this Notice the first day we treat you at our facility. In an emergency situation, we will give you this Notice as soon as possible.
- You have a right to receive notification of any breach of your PHI.

Complaints

If you think we have violated your rights or you have a complaint about our privacy practices you can contact Dr. Brandon Castor, DDS.

You may also complain to the United States Secretary of Health and Human Services if you believe your privacy rights have been violated by us.

If you file a complaint, we will not retaliate against you for filing a complaint.

This Notice was published and becomes effective on March 17, 2017.

CASTOR FAMILY DENTISTRY

Acknowledgement of Receipt of
NOTICE OF PRIVACY PRACTICES

1430 East Cone Blvd.
Greensboro, NC 27405
(336) 621-4927
www.castorfamilydentistry.com

Patient Name & Address: _____

_____

_____

I have received a copy of the Notice of Privacy Practices for Castor Family Dentistry

_____ _____
Signature Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

[ ] An emergency existed & a signature was not possible at the time.

[ ] The individual refused to sign.

[ ] A copy was mailed with a request for a signature by return mail.

[ ] Unable to communicate with the patient for the following reason:

_____

[ ] Other: _____

_____

Prepared By: _____

Signature: _____

Date: _____

CASTOR FAMILY DENTISTRY

DENTAL HISTORY

_____

Full Name

Purpose of your visit today: _____
_____
_____

Are you receiving routine dental care? Y N

Date of last dental visit: _____

Name of previous dentist: _____

Have any of the following prevented you from seeking dental care?

___ Fear or anxiety
___ Lack of time
___ Lack of funds/ cost
___ No insurance
___ Other: _____

Have you ever had problems/ complications with past dental care? Y N

If yes, describe: _____
_____

Did you drink fluoridated water as a child (age 1-12)? Y N

What is your current primary water source?

_____ City _____ Well _____ Bottle

HYGIENE PRACTICES

Tooth Brush: _____ Electric _____ Manual
_____ Soft _____ Medium _____ Hard

Brush: _____ # times per day
Floss: _____ # times per day
Rinse: _____ # times per day

Other home care: _____
_____
_____

Do you use bleaching products? Y N

Describe: _____
_____

DENTURES/ PARTIALS

How long have you worn them? _____

Any current problems? _____
_____

Indicate any past dental treatment:

_____ Orthodontics (braces)
_____ Oral surgery (extractions, biopsy)
_____ Periodontics (gum treatment or surgery)

Are your teeth sensitive to:

_____ Sweets
_____ Hot
_____ Cold
_____ Pressure (chewing/ biting)
_____ Other

Do you have any swelling(s) in your mouth? Y N
Are your teeth shifting? Y N
Are your teeth loose? Y N

SALIVARY FUNCTION

Does your saliva feel thick? Y N
Does your mouth often feel dry? Y N
Do you have difficulty chewing food? Y N
Do you have difficulty swallowing? Y N
Do you have difficulty speaking? Y N
Do you have excess saliva? Y N

TMJ/ JAW PROBLEMS

Clicking/Popping jaws? Y N
Pain? Y N
Locked open or closed? Y N

OTHER CONCERNS: _____
_____
_____
_____
_____
_____

SMILE EVALUATION

1. Are you satisfied with the appearance of your teeth? Y N
   _____
2. Are your teeth straight? Y N
   _____
3. Do you like the color of your teeth? Y N
   _____
4. Are there old fillings or other dental work that you don't like the look of? Y N
   _____