Steven W. Hamrick, DMD
Sheppard A. McKenzie, DDS
Travis J. Whitley, DDS
Jesse W. Woon, DMD, MS
Diplomates of the American Board of Periodontology

RALEIGH PERIODONTICS AND IMPLANT DENTISTRY

7501 FALLS OF NEUSE RD.
SUITE 100
RALEIGH, NC 27615
(919) 846-2480
(919) 846-2482 FAX
WWW.RALEIGHPERIO.COM

PLEASE COMPLETE AND BRING TO YOUR EXAMINATION APPOINTMENT
(Call if you have questions and we will arrange to assist you in filling out these forms.)

PATIENT REGISTRATION

NAME: _____ _____ _____ _____ _____ _____ M/F
LAST FIRST MIDDLE PREFERRED BIRTHDATE AGE SEX

_____ S M W D
STREET ADDRESS CITY ZIP MARITAL STATUS

TELEPHONE NUMBER: Home _____ Work _____
MOBILE _____
E-Mail Address _____

EMPLOYER NAME _____ SOCIAL SEC.# _____ OCCUPATION _____
NAME OF SPOUSE _____ EMPLOYER _____ Phone # _____
IS THIS VISIT A RESULT OF AN INJURY? YES _____ NO _____
IF SO, WHAT WAS THE INJURY? _____
EMERGENCY CONTACT PERSON? _____ Phone # _____

DENTAL HISTORY

Referred By _____ City _____

Name of Dentist _____ City _____

How long have you been with your present dentist? _____

How often were your teeth cleaned last year? _____
When was the last time your teeth were cleaned? _____

Have you ever been given a local anesthetic for dental cleanings? _____

	PLEASE CIRCLE	
Have you or anyone in your family had any previous periodontal treatment?	YES	NO
By Whom? _____	YES	NO
Have you had any complication with previous dental treatment?	YES	NO
Do you consider yourself a nervous person when it comes to dental treatment?	YES	NO
Do you feel you have bad breath?	YES	NO
Do your gums bleed?	YES	NO
Have you noticed any loose teeth? If yes, how long? _____	YES	NO
Do you think your teeth are affecting your general health in any way?	YES	NO
Are you satisfied with the appearance of your teeth?	YES	NO
Do you have any sensitive teeth?	YES	NO

Do you have any suggestions on how we could make your treatment less stressful and more comfortable for you?

_____
_____
_____
_____

DENTAL/INSURANCE INFORMATION

[redacted]

PRIMARY DENTAL INSURANCE CARRIER:

SUBSCRIBER'S NAME: LAST FIRST MIDDLE BIRTHDATE

STREET ADDRESS CITY ZIP

TELEPHONE NUMBER: HOME _____ WORK _____

EMPLOYER NAME _____ SUBSCRIBERS ID # _____

INSURANCE CARRIER NAME _____

INSURANCE CARRIER ADDRESS _____

GROUP NUMBER _____

Primary dental insurance may be filed by our office with the exception of any medicare plan. Our office is a non medicare provider. However, secondary coverage must be filed by the patient. Our office does not accept assignment for primary or secondary dental coverage.

PLEASE INFORM THE DOCTOR IF YOUR HEALTH CHANGES IN ANY WAY

The success of periodontal therapy is dependent on many factors including the severity of the periodontal destruction, the patient's general physical status, and the patient's ability and willingness to perform proper oral hygiene and stay on a recall program after active treatment. As with treatment of any complex condition, especially where drugs and surgical procedures are being used, unusual and unanticipated problems can arise, such as bleeding, prolonged numbness, sensitivity to medications, sensitive or loose teeth and pulp damage. We will make every effort to keep you informed of the treatment necessary for you. Feel free to ask questions at any time. Your involvement and understanding are very important in the long term success of your periodontal therapy.

In implant surgery the risks and complications involved are pain, swelling, infection and discoloration. Numbness of the lip, tongue, chin, cheek, or tooth may occur. The exact duration may not be determinable and may be irreversible. Also possible are inflammation, injury to teeth, bleeding, bone fractures, sinus infection, and delayed healing. In some instances implants fail and must be removed.

If there is any further information that you feel we should be aware of, please write it here. _____

MEDICAL HISTORY

Name of Physician _____ City_____ Phone _____

Name of Pharmacy_____ City_____ Phone _____

Date of last physical examination? _____ Findings_____

What is your estimation of your general health? Good_____ Fair_____ Poor _____

Do you smoke?_____ How much? _____ How many years? _____ Have you ever smoked _____

Current Weight _____ Do you drink alcohol?_____ How much? _____ *PLEASE CIRCLE*

Has anyone in your family had diabetes? ..... YES NO

Have you had surgery or x-ray treatment for a tumor, growth, or other condition of your head, mouth or lips? ..... YES NO

Have you ever had any serious illness or major operations? ..... YES NO

Have you had abnormal bleeding associated with previous surgery, tooth extraction, or trauma? ..... YES NO

Have you ever been diagnosed with osteoporosis, or taken any bone altering/preserving medications (oral or IV)? ..... YES NO

Do you routinely take natural/herb medications or supplements? ..... YES NO

Are you allergic or have you had any adverse reaction to any medications? ..... YES NO

_____

Have you ever been warned against taking any drug or medicine for your own personal health? If so, what drug and why? ..... YES NO

Are you routinely pre-medicated with an antibiotic for a dental procedure? ..... YES NO

Have you ever had Sleep Apnea or used a C-PAP machine? ..... YES NO

Please list all prescription drugs and over the counter medication(s) and why you are taking them:

_____

_____

_____

_____

_____

_____

Do you or have you had any of the following conditions:

Heart (Surgery, Disease, Attack) ..... Yes No	Ulcers ..... Yes No	Drug/ Alcohol abuse ..... Yes No
Chest Pain ..... Yes No	Diabetes / Last A1C ..... Yes No	H.I.V. Positive/ A.I.D.S ..... Yes No
Congenital Heart Disease ..... Yes No	Thyroid Problems ..... Yes No	Cold Sores/Fever Blisters ..... Yes No
Heart Murmur ..... Yes No	Glaucoma ..... Yes No	Blood Transfusion ..... Yes No
High Blood Pressure ..... Yes No	Contact lenses ..... Yes No	Hemophilia ..... Yes No
High Cholesterol ..... Yes No	Emphysema/ COPD ..... Yes No	Sickle Cell Disease ..... Yes No
Mitral Valve Prolapse ..... Yes No	Chronic Cough ..... Yes No	Bruise Easily ..... Yes No
Artificial Heart Valve ..... Yes No	Tuberculosis ..... Yes No	Liver Disease ..... Yes No
Heart Pacemaker ..... Yes No	Asthma ..... Yes No	Yellow Jaundice ..... Yes No
Rheumatic Fever ..... Yes No	Hay Fever ..... Yes No	Neurological Disorders ..... Yes No
Arthritis/Rheumatism ..... Yes No	Latex Sensitivity ..... Yes No	Epilepsy or Seizures ..... Yes No
Cortisone Medicine ..... Yes No	Allergies or Hives ..... Yes No	Fainting or Dizzy Spells ..... Yes No
Swollen Ankles ..... Yes No	Sinus Trouble ..... Yes No	Nervous/Anxious ..... Yes No
Stroke ..... Yes No	Radiation Therapy ..... Yes No	Psychiatric/Psychological Care ..... Yes No
Diet (Special/Restricted) ..... Yes No	Chemotherapy ..... Yes No	Parkinson's Disease ..... Yes No
Artificial Joints (hip knee, etc.) ..... Yes No	Tumors ..... Yes No	Alzheimer's Disease ..... Yes No
Kidney Trouble ..... Yes No	Hepatitis A (infectious) B (serum) ..... Yes No	Skin/ dermatologic condition ..... Yes No
Osteoporosis/ Osteopenia ..... Yes No	Venereal Disease ..... Yes No	Any condition not listed _____

FOR WOMEN ONLY:

Are you taking female hormones *(oral contraceptives, etc.)?* ..... YES NO _____

Are you pregnant at the present time? ..... YES NO _____

if so, month of pregnancy_____ _____

Are you planning on becoming pregnant in the near future? ..... YES NO _____

Have you reached menopause? ..... YES NO _____

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
(Patient Name)

_____ _____ _____
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
- ❑ Communication barriers prohibited obtaining the acknowledgement
- ❑ An emergency situation prevented us from obtaining acknowledgement
- ❑ Other (Please Specify) _____

_____

_____ _____
Witness/Office Agent Date

CONSENT FOR TREATMENT

1. I hereby authorize Raleigh Periodontics or designated staff to take x-rays, study models, photographs and any other diagnostic aids as deemed necessary by the Doctor(s) _____'s dental needs.

2. Upon such diagnosis, I authorize Raleigh Periodontics to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

4. Lastly, I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1/2% late charge (18% APR) may be added to my account.

Patient _____ Date _____

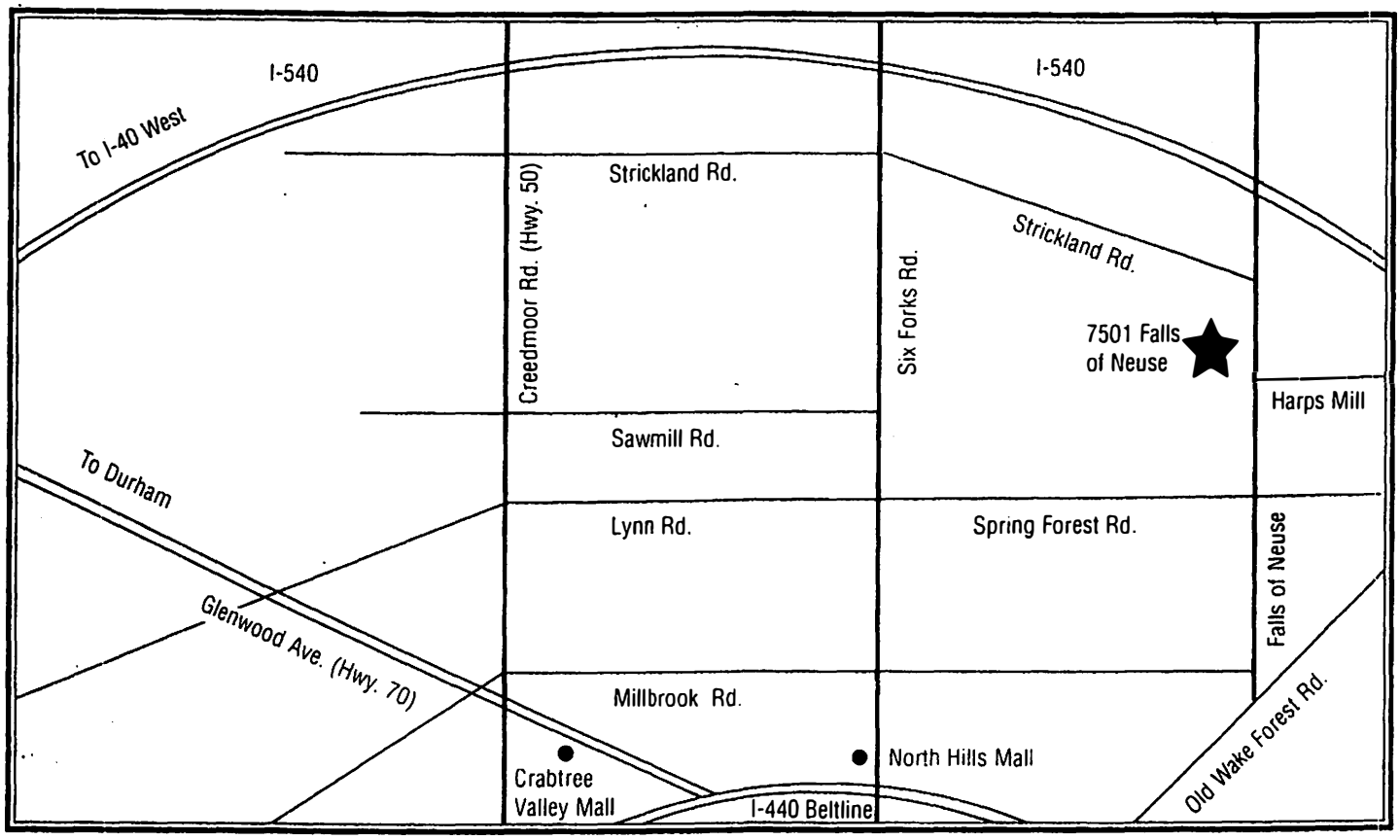
Parent or Responsible Party _____ Relationship to Patient _____

WE WANT TO THANK YOU FOR TAKING THE TIME TO FILL OUT THIS QUESTIONNAIRE FOR US!

Dr. Steve W. Hamrick
Dr. Sheppard A. McKenzie
Dr. Travis J. Whitley
Dr. Jesse W. Woon

Raleigh Periodontics and Implant Dentistry
7501 Falls of Neuse Rd.
Suite 100
Raleigh, NC 27615
(919) 846-2480 Phone
(919) 846-2482 Fax
www.raleighperio.com

Diplomates of the American Board of Periodontology



Our office is located at 7501 Falls of Neuse Rd. next to Ravenscroft School.

- If driving north on Falls of Neuse Rd. it is approximately 4 miles north of Interstate 440. (take Old Wake Forest Rd. exit)

- If driving south on Falls of Neuse Rd. it is approximately 2 miles south of Interstate 540.

RALEIGH PERIODONTICS
AND IMPLANT DENTISTRY

Notice of Privacy Practices

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:
Stephanie Garnuette, RDH, Privacy Officer or Amy McLamb, Practice Manager
919-846-2480

Effective Date: April 14, 2003 Revised Date: July 9, 2024

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

- Posting the revised Notice on our website: www.raleighperio.com

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 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.

EXAMPLE: Your PHI may be provided to a physician 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 qualifications of benefits.
- Collection agencies

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 protected health information 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 protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.
- Special government 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 and safety of other individuals.
- Worker's Compensation: Your protected health information 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 Associate: 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 transcription 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 to disclose protected health information 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 protected health information 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 of 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 treatment 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 release 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 protected health information. All requests to exercise your rights must be made in writing. (Describe how the patient may obtain the written request document and to whom the request should be directed, i.e. practice manager, privacy officer.)

You have the right to see and obtain a copy of your protected health information.

This means you may inspect and obtain a copy of protected health information about you that is contacted in a designated record set for as long as we maintain the protected health information. 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 protected health information.

You may request for this practice not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. We are not required to agree with these requests. If we agree to a restriction request 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 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 April 14, 2003. You may request them for the previous six years or a shorter timeframe. If you request 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 protected health information.

Complaints

If you think we have violated your rights, or you have a complaint about our privacy practices you can contact:
Amy McLamb, Practice Manager 919-846-2480
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 July 9, 2024.