



**Patient Information**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Sex: \_\_\_M\_\_\_F Birth date: \_\_\_\_\_ Age: \_\_\_\_\_

Married: \_\_\_ \_\_\_ Widowed: \_\_\_ \_\_\_ Single: \_\_\_ \_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

How did you hear about our office? \_\_\_\_\_

**Contact Information:**

Home: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_

Work: (\_\_\_\_) \_\_\_\_\_ E-mail Address: \_\_\_\_\_

**In Case of Emergency:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_

**Insurance Information:**

Subscriber's Name: \_\_\_\_\_ Subscriber's SS #: \_\_\_\_\_

Subscriber's Birth Date: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Insurance Co. Name / Address: \_\_\_\_\_

**Assignment and Release:**

I understand that Dr. Stephen Durham does not participate with any insurance companies and that reimbursements will come directly to me from the insurance company. As a courtesy, I am aware the office will file primary claim forms that are necessary. I will be responsible for the fee of treatment at the appointment time.

Signature : \_\_\_\_\_ Date: \_\_\_\_\_

Signature (If not patient): \_\_\_\_\_



### Medical History

Patient's Name \_\_\_\_\_ Phone # \_\_\_\_\_ Date of Last Visit \_\_\_\_\_

Have you ever been hospitalized or had a major operation? \_\_\_Y\_\_\_N If yes, please explain: \_\_\_\_\_

Have you ever had a serious head or neck injury? \_\_\_Y\_\_\_N If yes, please explain: \_\_\_\_\_

Are you taking any medications, pills, or drugs? \_\_\_Y\_\_\_N If yes, please explain: \_\_\_\_\_

Are you on a restricted diet by a physician? \_\_\_Y\_\_\_N If yes, please explain: \_\_\_\_\_

Do you use tobacco? \_\_\_Y\_\_\_N

Do you use any controlled substance? \_\_\_Y\_\_\_N

Women: Are you...

Pregnant \_\_\_ Nursing \_\_\_ Taking oral contraceptives \_\_\_

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?

- |   |  |  |  |   |
|---|--|--|--|---|
| <input type="checkbox"/> AIDS/HIV Positive      | <input type="checkbox"/> Chest Pains               | <input type="checkbox"/> Frequent Headaches    | <input type="checkbox"/> Irregular Heartbeat   | <input type="checkbox"/> Scarlet Fever              |
| <input type="checkbox"/> Alzheimer's Disease    | <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Genital Herpes        | <input type="checkbox"/> Kidney Problems       | <input type="checkbox"/> Shingles                   |
| <input type="checkbox"/> Anaphylaxis            | <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Glaucoma              | <input type="checkbox"/> Leukemia              | <input type="checkbox"/> Sickle Cell Disease        |
| <input type="checkbox"/> Anemia                 | <input type="checkbox"/> Convulsions               | <input type="checkbox"/> Hay Fever             | <input type="checkbox"/> Liver Disease         | <input type="checkbox"/> Sinus Trouble              |
| <input type="checkbox"/> Angina                 | <input type="checkbox"/> Cortisone Medicine        | <input type="checkbox"/> Heart Attack/Failure  | <input type="checkbox"/> Low Blood Pressure    | <input type="checkbox"/> Spina Bifida               |
| <input type="checkbox"/> Arthritis/Gout         | <input type="checkbox"/> Diabetes                  | <input type="checkbox"/> Heart Murmur          | <input type="checkbox"/> Lung Disease          | <input type="checkbox"/> Stomach/Intestinal Disease |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Drug Addiction            | <input type="checkbox"/> Heart Pace Maker      | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Stroke                     |
| <input type="checkbox"/> Artificial Joint       | <input type="checkbox"/> Easily Winded             | <input type="checkbox"/> Heart Trouble/Disease | <input type="checkbox"/> Pain in Jaw Joints    | <input type="checkbox"/> Swelling of Limbs          |
| <input type="checkbox"/> Asthma                 | <input type="checkbox"/> Emphysema                 | <input type="checkbox"/> Hemophilia            | <input type="checkbox"/> Parathyroid Disease   | <input type="checkbox"/> Thyroid Disease            |
| <input type="checkbox"/> Blood Disease          | <input type="checkbox"/> Epilepsy or Seizures      | <input type="checkbox"/> Hepatitis A           | <input type="checkbox"/> Psychiatric Care      | <input type="checkbox"/> Tonsillitis                |
| <input type="checkbox"/> Blood Transfusion      | <input type="checkbox"/> Excessive Bleeding        | <input type="checkbox"/> Hepatitis B or C      | <input type="checkbox"/> Radiation Treatments  | <input type="checkbox"/> Tuberculosis               |
| <input type="checkbox"/> Breathing Problem      | <input type="checkbox"/> Excessive Thirst          | <input type="checkbox"/> Herpes                | <input type="checkbox"/> Recent Weight Loss    | <input type="checkbox"/> Tumors or Growths          |
| <input type="checkbox"/> Bruise Easily          | <input type="checkbox"/> Fainting Spells/Dizziness | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Renal Dialysis        | <input type="checkbox"/> Ulcers                     |
| <input type="checkbox"/> Cancer                 | <input type="checkbox"/> Frequent Cough            | <input type="checkbox"/> Hives or Rash         | <input type="checkbox"/> Rheumatic Fever       | <input type="checkbox"/> Venereal Disease           |
| <input type="checkbox"/> Chemotherapy           | <input type="checkbox"/> Frequent Diarrhea         | <input type="checkbox"/> Hypoglycemia          | <input type="checkbox"/> Rheumatism            | <input type="checkbox"/> Yellow Jaundice            |

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

### Dental History

Have you ever been concerned with having fresh breath? \_\_\_Y\_\_\_N \_\_\_\_\_

Have your gums ever bled when you brushed or flossed? \_\_\_Y\_\_\_N \_\_\_\_\_

Do you feel that you clench or grind your teeth? \_\_\_Y\_\_\_N \_\_\_\_\_

Are you having any sensitivity to cold or hot? \_\_\_Y\_\_\_N \_\_\_\_\_

Have you ever been treated for gum disease? \_\_\_Y\_\_\_N \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_



### Dental Inquiry

As you will see during your first appointment in our office, we are like no other dental practice. This might be the most important dental visit you will ever have. We feel that helping you determine your present and future dental needs is the most important service we offer. Although these are issues you have probably never thought of in detail, please answer the following to your best ability...Thank you!

- What is your primary concern for this visit and what did you want to accomplish?  
\_\_\_\_\_
- Have you ever had any serious problems or positive experiences associated with previous dental visits?  
\_\_\_\_\_
- What are your expectations of this office?  
\_\_\_\_\_

### Treatment Recommendations or Treatment Options

We prefer to give you options based on how you would like to treat your dental health. We are here to make recommendations on how to achieve those goals.

The following questions help us determine what is important to you...please rate on the following scale from 1 to 10, with 10 being the most important. (please select one)

1. How healthy would you like your dental health to be?  
1    2    3    4    5    6    7    8    9    10
2. How preventive (or proactive) would you like to be regarding dental health?  
1    2    3    4    5    6    7    8    9    10
3. How important are dental cosmetics to you?  
1    2    3    4    5    6    7    8    9    10

Anything else you would like to mention?  
\_\_\_\_\_



Stephen W. Durham, DMD

## CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

### SECTION A: PATIENT GIVING CONSENT

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Telephone: \_\_\_\_\_ Social Security # \_\_\_\_\_

### SECTION B: TO THE PATIENT - PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

**Purpose of Consent:** By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

**Notice of Privacy Practices:** You have been given and are in agreement with our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. We encourage you to read it carefully and completely before signing this Consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting our office at 843-379-5400 or by mailing us at 2015 Boundary Street, Suite 104, Beaufort, SC 29902.

**Right to Revoke:** You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the address above. Please understand that revocation of this Consent will not affect any action we took before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

### SIGNATURE

I, \_\_\_\_\_, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that by signing this Consent form I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations. My signature indicates you have received a copy of the HIPAA law and Dental Materials forms releases Dr. Durham to utilize any dental photographs for lecturing and educational purposes.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

**YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.**

**2015 Boundary Street, Suite 104 • Beaufort, SC 29902 • (843) 379-5400**

**www.DurhamDental.net**



## NOTICE OF PRIVACY PRACTICES

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAYBE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes:

- *Treatment* means providing, coordinating, or managing health care and related services by one or more health care providers. Examples would be teeth cleaning services, extraction letters, and periodontal or endodontic referrals.
- *Payment* means such activities as obtaining reimbursement for services, confirming coverage, and obtaining specific benefit information such as benefit maximums and deductibles met, etc., billing or collection activities, and utilization review.
- *Health care operations* include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individual identifiable information. We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain—and we have the obligation to provide—a paper copy of this notice from us at your first delivery of services date.
- The right to provide—and we are obligated to receive—a written acknowledgement that you have received a copy of our Notice of Privacy Protection Practices.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health.

This notice is effective as of April 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that our privacy protections have been violated. You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, about violations of their provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

Durham Dental  
2015 Boundary Street, Suite 104  
Beaufort, SC 29902  
843-379-5400  
www.durhamdental.net

For more information about HIPAA or to file a complaint:

The U. S. Department of Health & Human Services  
Office of Civil Rights  
200 Independence Avenue, SW  
Washington, DC 20201  
202-619-0257  
Toll Free: 1-877-696-6775