DURHAM *dental*
STEPHEN W. DURHAM, DMD

## 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:_____ Employer:_____
Relationship to Patient:_____ Dental ID #:_____
Insurance Co. Name / Address:_____

## Assignment and Release

I understand that Dr. Stephen Durham will work with most insurance companies to maximize available benefits. 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:_____

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

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# Medical History

Patient's Name: _____ Birth Date:_____

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.

Are you under a physician's care now? ❒ Yes ❒ No If yes _____

Have you ever been hospitalized or had a major operation? ❒ Yes ❒ No If yes _____

Have you ever had a serious head or neck injury? ❒ Yes ❒ No If yes _____

Are you taking any medications, pills, or drugs? ❒ Yes ❒ No If yes _____

Do you take, or have you taken, Phen-Fen or Redux? ❒ Yes ❒ No If yes _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ❒ Yes ❒ No If yes _____

Are you on a special diet? ❒ Yes ❒ No

Do you use tobacco? ❒ Yes ❒ No

Women: Are you ... ❒ Pregnant/Trying to get pregnant? ❒ Nursing? ❒ Taking oral contraceptives?

Are you allergic to any of the following?

❒ Aspirin ❒ Penicillin ❒ Codeine ❒ Acrylic ❒ Metal ❒ Latex ❒ Sulfa Drugs ❒ Local Anesthetics

❒ Other? If yes _____

Do you use controlled substances? ❒ Yes ❒ No If yes _____

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

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| AIDS/HIV Positive | ❒Yes | Excessive Bleeding | ❒Yes | Lung Disease | ❒Yes | Clenching | ❒Yes |
| Alzheimer's Disease | ❒Yes | Excessive Thirst | ❒Yes | Mitral Valve Prolapse | ❒Yes | Difficulty Chewing | ❒Yes |
| Anaphilaxis | ❒Yes | Fainting Spells/Dizziness | ❒Yes | Osteoporosis | ❒Yes | Difficulty Swallowing | ❒Yes |
| Anemia | ❒Yes | Frequent Cough | ❒Yes | Pain in Jaw Joints | ❒Yes | Dizziness | ❒Yes |
| Angina | ❒Yes | Frequent Diarrhea | ❒Yes | Parathyroid Disease | ❒Yes | Facial Pain | ❒Yes |
| Arthritis/Gout | ❒Yes | Frequent Headaches | ❒Yes | Psychyatric Care | ❒Yes | Headaches | ❒Yes |
| Artificial Heart Valve | ❒Yes | Genital Herpes | ❒Yes | Radiation Treatments | ❒Yes | Jaw Pain | ❒Yes |
| Artificial Joint | ❒Yes | Glaucoma | ❒Yes | Recent Weight Loss | ❒Yes | Limited Opening | ❒Yes |
| Asthma | ❒Yes | Hay Fever | ❒Yes | Renal Dialysis | ❒Yes | Loose Teeth | ❒Yes |
| Blood Disease | ❒Yes | Heart Attack/Failure | ❒Yes | Rheumatic Fever | ❒Yes | Neck Pain | ❒Yes |
| Blood Transfusion | ❒Yes | Heart Murmur | ❒Yes | Rheumatism | ❒Yes | Nervousness | ❒Yes |
| Breathing Problems | ❒Yes | Heart Pacemaker | ❒Yes | Scarlet Fever | ❒Yes | Noise in Jaw Joint | ❒Yes |
| Bruise Easily | ❒Yes | Heart Trouble/Disease | ❒Yes | Shingles | ❒Yes | Postural Problems | ❒Yes |
| Cancer | ❒Yes | Hemophilia | ❒Yes | Sickle Cell Disease | ❒Yes | Ringing in the Ears | ❒Yes |
| Chemotherapy | ❒Yes | Hepatitis A | ❒Yes | Sinus Trouble | ❒Yes | Sensitive Teeth | ❒Yes |
| Chest Pains | ❒Yes | Hepatitis B or C | ❒Yes | Spina Bifida | ❒Yes | | |
| Cold Sores/Fever Blisters | ❒Yes | Herpes | ❒Yes | Stomach/Intestinal Disease | ❒Yes | | |
| Congenital Heart Disorder | ❒Yes | High Blood Pressure | ❒Yes | Stroke | ❒Yes | | |
| Convulsions | ❒Yes | High Cholesterol | ❒Yes | Swelling of Limbs | ❒Yes | | |
| Cortisone Medicine | ❒Yes | Hives or Rash | ❒Yes | Thyroid Disease | ❒Yes | | |
| Diabetes | ❒Yes | Hypoglycemia | ❒Yes | Tonsilitis | ❒Yes | | |
| Drug Addiction | ❒Yes | Irregular Heartbeat | ❒Yes | Tuberculosis | ❒Yes | | |
| Easily Winded | ❒Yes | Kidney Problems | ❒Yes | Tumors or Growths | ❒Yes | | |
| Emphysema | ❒Yes | Leukemia | ❒Yes | Ulcers | ❒Yes | | |
| Epilepsy or Seizures | ❒Yes | Liver Disease | ❒Yes | Venereal Disease | ❒Yes | | |
| | | Low Blood Pressure | | Yellow Jaundice | | | |

Have you ever had any serious illness not listed above? ❒ Yes ❒ No If yes _____

Comments: _____

To the 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 any changes in medical status.

Signature of Patient, Parent, or Guardian _____ Date: _____

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## 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 to determine what is important to you ... please rate on the following scale from 10 to 1, with 10 being the most important. (please check the box to the left of your response)

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

Anything else you would like to mention?

_____

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**Dr. Stephen W. Durham, DMD, MAGD**
**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**

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**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

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Our office values your time and our goal is to provide all of our patients with quality dental treatment in a timely manner. **We make every effort to confirm scheduled reservations through phone calls, text messages and emails**. Failure to show for a scheduled reservation, late arrivals and last minute cancellations can be costly and unfair to other patients. Our missed appointment policy enables us to better utilize available appointment time for all of our patients who are in need of dental treatment.

In order to be respectful of the dental needs of other patients, please be courteous and call our office if you are unable to show up for an appointment. This will allow us to reallocate your appointment time to another patient in need of treatment. We ask that you provide us with at least 48 hours notice if you need to cancel your appointment. To cancel an appointment, please call our office at 843.379.5400 during regular business hours (8:00am – 5:00pm).

For hygiene appointments, I acknowledge after 2 appointments (in 12 months) for which I do not provide 48 hours notice, I *may* be required to leave a $150 non-refundable deposit in order to schedule my next appointment OR I *may* not be able to pre-appoint.

I acknowledge that my scheduled appointment is a reservation and I am required to provide 48 hours notice to make any changes to my appointment (excluding emergencies).

***I agree to receive text messages, e-mails or automated phone calls regarding my appointment.*** _____ ***Initial***

My cell phone number is:_____

My E-mail address is:_____

_____

Signature Date