Carolina CB Braces

New Patient Information – General Information

Today's Date:___________________________________

Name: ____
First Middle Last

Street Address:____

City, State, Zip:____

General Dentist:____
Doctor Name Street Address & City

Who referred you to our office?:____

Date of birth:______________________ SS#:_____________________ Email:____

Names / Ages of siblings:____

Family members being seen by office?:____

Home #:______________________________ Work #:______________________________ Cell #:__________________________________

Employer (or School if student):____

Signature of Patient (Parent if minor):____

Note: a credit report may be run to determine possible financing options

Medical History

List any medications presently being taken:____

Are you currently under the care of a physician? ☐ yes ☐ no If yes, please explain:______________________________________

____

List any known allergies:____

Have you ever had a blood transfusion? ☐ yes ☐ no If so, most recent?:____

WOMEN: Are you pregnant? ☐ yes ☐ no If so, in what month?:____

Have you ever had any of the following? (Please circle if yes)

High blood pressure	Anemia	Kidney Trouble	Epilepsy
Low blood pressure	Stroke	Blood disease	Glaucoma
Clotting problems	Ulcers	Sinus Trouble	Malignancy
Rheumatic fever	Asthma	Liver Trouble	Tuberculosis
Heart disease	Arthritis	Lung Disease	Thyroid Disease
Radiation therapy	Hepatitis	Bowel Disease	TMJ
Venereal disease	Diabetes	Psychiatric Treatment	Other:
Mitral Valve Prolapse	HIV	Rheumatism	_____________

Reason for today's appointment:____

Do you have any fears or apprehensions based on past dental experiences? ☐ yes ☐ no If yes, explain:_________________________

____

Have you ever seen an Orthodontist before? ☐ yes ☐ no

Please complete the following if patient is a minor

♦**Guardian 1** - Name: ________________________________ ☐ Mother ☐Father ☐Other:_______________

Street Address:____

____

Home #:______________________ Work #:______________________ Cell #:______________________

Employer:____

SS #: ______________________ Date of birth:______________________________

Email address:____

♦**Guardian 2** - Name: ________________________________ ☐ Mother ☐Father ☐Other:_______________

Street Address:____

____

Home #:______________________ Work #:______________________ Cell #:______________________

Employer:____

SS #: ______________________ Date of birth:______________________________

Email address:____

Please complete the following information if you have dental insurance

(Note: All general information must be completed)

Insurance Company Name and Address:____

____

Employee/ Subscriber Name and Address: ____

____

Employee/ Subscriber SS#: ______________________Employee/Subscriber Birthdate:______________________

Group Number: ______________________________

Employer/ Company Name and Address: ____

____

Patient Relationship to Employee (circle): Self Spouse Child Other:______________________

Is patient covered by another plan of benefits? ☐ yes ☐ no If yes, name and address of carrier: ______________________

____

Group Number: ______________________________

Name and address of employer: ____

Employee/Subscriber Name: ______________________ Employee/Subscriber SS#: ______________________

Employee/Subscriber Birthdate: ______________________

Patient Relationship to Employee (circle): Self Spouse Child Other:______________________

Please sign so that we can release information to your insurance company: ______________________________

Please sign if you wish your benefits to be paid directly to our office: ______________________________

Compound Authorization Form

Name of patient: ____ Date of birth: _________/____________/___________
Day Month Year

The purpose of this authorization is to inform the patient or others with pertinent patient information. The patient has requested that **Carolina Braces** is to release the following information about the above named patient to the entities named below:

______ **Voice Mail/Answering Machine** Phone number: ____

_____ Appointments _____ Instructions (Pre/Post Procedure/ Operation)

_____ Financial _____ Lab/Test Results _____ Medical

______ **Email** Email address: ____

_____ Appointments _____ Instructions (Pre/Post Procedure/Operation)

_____ Lab/Test Results _____NPP _____Breach Information Details

_____ Financial _____ Medical

______ **Text Message** Phone number: ____

_____ Appointments _____ Instructions (Pre/Post Procedure/ Operation)

_____ Financial _____ Lab/Test Results _____ Medical

______ **Spouse** Name: ____

_____ Appointments _____ Instructions (Pre/Post Procedure/ Operation)

_____ Financial _____ Lab/Test Results _____ Medical

______ **Other** Name: ____

_____ Appointments _____ Instructions (Pre/Post Procedure/ Operation)

_____ Financial _____ Lab/Test Results _____ Medical

Right of the Patient:

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy protected health information to be disclosed as described in this document by sending written notification to **Carolina Braces**.

I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward. I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

____ ___________________________________

Signature of Patient or Legal Representative **Date**

____

Description of Legal Representative Authority (provide supporting documentation)

Carolina Braces

100 Sawmill Rd #200
Raleigh, NC 27615
(919) 676-7846
smpatientcare@carolinabraces.com

7780 Brier Creek Pkwy #100
Raleigh, NC 27617
(919) 957-9400
patientcarebc@carolinabraces.com

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to patient: We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the notice. You may refuse to sign this acknowledgement of receipt, but we must keep a record of your refusal. If you refuse to sign this acknowledgement of receipt, we are required to treat you and we may still use and/or disclose your health information as HIPAA permits.

I acknowledge that I have received a copy of this office's Notice of Privacy practices.

____

Print Name

____

Signature

____

Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgement or receipt of our Notice of Privacy from this patient, but it could not be obtained because:

- The patient refused to sign
- Due to an emergency situation it was not possible to obtain acknowledgement
- We were unable to communicate with the patient
- Other (provide specific details)
  - ____
    ____

____________________________________ ____________________

Employee Signature Date

HIPAA Acknowledgement of receipt of the Notice of Privacy Practices

This form does not constitute legal advice and covers only federal, not state law.

AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Information to be Used or Disclosed

The information covered by this authorization includes:

PATIENT'S PHOTO AND PATIENT'S NAME

Persons Authorized to Use or Disclose Information

Information listed above will be used or disclosed by

OFFICE OF DR. ROBERT KENT DDS MS PA

Persons to Whom Information May Be Disclosed

Information described above may be disclosed to:

OFFICE OF DR. ROBERT KENT DDS MS PA WEBSITE

SOCIAL MEDIA OF DR. ROBERT KENT DDS MS

Expiration Date of Authorization

This authorization is effective unless revoked or terminated by the patient or the patient's representative.

Right to Terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to **DR. ROBERT KENT DDS MS PA**. You should contact the Privacy Compliance Officer to terminate this authorization.

Potential for Re-Disclosure

Information that is disclosed under this authorization may be disclosed again by this person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

Name of Patient　　　　　　　　　　　　　　　　　　　　　　Date

Signature of Patient Representative and Relationship　　　　　　　Date