



# RILEY DENTAL

ASSOCIATES OF CENTRAL VIRGINIA

<span style="border: 1px solid black; padding: 2px;">1</span> <b>PATIENT INFORMATION</b>	<span style="border: 1px solid black; padding: 2px;">2</span> <b>DENTAL INSURANCE</b>
<p>Date _____</p> <p>Whom may we thank for referring you? _____</p> <p>*****</p> <p><b>Patient Name</b> _____</p> <p style="margin-left: 100px;">Last Name</p> <p style="margin-left: 100px;">_____</p> <p style="margin-left: 100px;">First Name                      Middle Initial</p> <p>Address _____</p> <p>City _____</p> <p>State _____ Zip _____</p> <p>E-mail _____</p> <p>Birth Date _____</p> <p>SS # _____</p> <p>Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female    Age _____</p> <p><input type="checkbox"/> Married                      <input type="checkbox"/> Widowed                      <input type="checkbox"/> Single</p> <p><input type="checkbox"/> Minor                              <input type="checkbox"/> Separated                      <input type="checkbox"/> Divorced</p> <p>*****</p> <p><b>Patient Employer/School</b> _____</p> <p>Occupation _____</p> <p>Employer/School Address _____</p> <p>_____</p> <p>*****</p> <p><b>Spouse/Parent Name</b> _____</p> <p>Birth Date _____ SS# _____</p>	<p><b>Primary Dental Insurance Co.</b> _____</p> <p>Subscriber's Name _____</p> <p>Subscriber's Employer _____</p> <p>Group # _____</p> <p>Birth Date _____ SS# _____</p> <p>Relationship to Patient _____</p> <p>*****</p> <p><b>Secondary Dental Insurance Co.</b> _____</p> <p>Subscriber's Name _____</p> <p>Subscriber's Employer _____</p> <p>Group # _____</p> <p>Birth Date _____ SS# _____</p> <p>Relationship to Patient _____</p> <p>*****</p> <p><b>ASSIGNMENT AND RELEASE</b></p> <p>I certify that I, and/or my dependant(s), have insurance coverage with _____ and assign directly to _____</p> <p style="margin-left: 100px;">Name of Insurance Company (ies)</p> <p>Riley Dental Associates of Central Virginia all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.</p> <p>The above-named dental group may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment of services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.</p> <p>_____</p> <p style="margin-left: 100px;">Signature of Patient, Parent, Guardian or Personal Representative</p> <p>_____</p> <p style="margin-left: 100px;">Date    Relationship to Patient</p>
<span style="border: 1px solid black; padding: 2px;">3</span> <b>PHONE NUMBERS</b>	<span style="border: 1px solid black; padding: 2px;">4</span> <b>FINANCIAL RESPONSIBILITY</b>
<p>Home (____) _____</p> <p>Work (____) _____ Ext _____</p> <p>Cell (____) _____</p> <p>Spouse's Work (____) _____</p> <p>Best time and place to reach you _____</p> <p>*****</p> <p><b>IN CASE OF EMERGENCY, CONTACT</b> (Specify someone who does not live in your household.)</p> <p>Name _____</p> <p>Relationship _____</p> <p>Home (____) _____</p>	<p>Any unpaid balance after 60 days will incur a service charge that will be added to the account. The service charge will be a periodic rate of 1.5% per month (or a minimum charge of \$2.00 for a balance under \$500.00) which is an annual percentage rate of 18% applied to the last month's balance. In case of default of payment, I promise to pay any legal interest on the balance due, together with any collection of this account or future outstanding accounts.</p> <p>_____</p> <p style="margin-left: 100px;">Patient Signature</p> <p>_____</p> <p style="margin-left: 100px;">Date</p>

**5 DENTAL HISTORY**

Reason for today's visit \_\_\_\_\_

Former Dentist \_\_\_\_\_ City/State \_\_\_\_\_

Date of last dental visit \_\_\_\_\_ Date of last dental X-rays \_\_\_\_\_

**Place a mark on "yes" or "no" to indicate if you have had any of the following:**

- |                                   |  |                                |  |                           |  |
|-----------------------------------|--|--------------------------------|--|---------------------------|--|
| Bad breath                        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Fingernail biting              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Orthodontic treatment     | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding gums                     | <input type="checkbox"/> Yes <input type="checkbox"/> No | Food collection between teeth  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pain around ear           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blisters on lips or mouth         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Grinding teeth                 | <input type="checkbox"/> Yes <input type="checkbox"/> No | Periodontal treatment     | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Burning sensation on tongue       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Gums swollen or tender         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sensitivity to cold       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chew on one side of mouth         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaw pain or tiredness          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sensitivity to heat       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cigarette, pipe, or cigar smoking | <input type="checkbox"/> Yes <input type="checkbox"/> No | Loose teeth or broken fillings | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sensitivity to sweets     | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Clicking or popping jaw           | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mouth breathing                | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sensitivity when biting   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Dry mouth                         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mouth pain with brushing       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sores or growths in mouth | <input type="checkbox"/> Yes <input type="checkbox"/> No |

How often do you brush \_\_\_\_\_

How often do you floss \_\_\_\_\_

**6 HEALTH HISTORY**

Family Physician's Name \_\_\_\_\_ Date of last visit \_\_\_\_\_

Has any doctor told you that you need to take an antibiotic before dental procedures due to a medical condition? Please circle Yes No

**Place a mark on "yes" or "no" to indicate if you have had any of the following:**

- |   |  |                       |  |                                    |  |
|---|--|-----------------------|--|------------------------------------|--|
| AIDS/HIV  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Respiratory Disease                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Fainting or dizziness | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever                    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis, Rheumatism                               | <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Scarlet Fever                      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Heart Valves                             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Headaches (Chronic)   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Shortness of Breath                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Joints                                   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Murmur          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sinus Trouble                      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Problems        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke                             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Back Problems                                       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis Type _____  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swollen Feet or Ankles             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding abnormally, with<br>extractions or surgery | <input type="checkbox"/> Yes <input type="checkbox"/> No | Herpes                | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swollen Neck Glands                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood Disease                                       | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Problems                   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaundice              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tonsillitis                        | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemical Dependency                                 | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Disease        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis                       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemotherapy  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tumor or growth on head<br>or neck | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Circulatory Problems                                | <input type="checkbox"/> Yes <input type="checkbox"/> No | Low Blood Pressure    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcer                              | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cortisone Treatments                                | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mitral Valve Prolapse | <input type="checkbox"/> Yes <input type="checkbox"/> No | Weight Loss, unexplained           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cough, persistent or bloody                         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Nervous Problems      | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                    |  |
| Diabetes  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pacemaker             | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                    |  |
| Emphysema   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric Care      | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                    |  |
|   |  | Radiation             | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                    |  |

\*\*\*\*\*

**Women:**

Are you pregnant?  Yes  No

Due Date \_\_\_\_\_

Are you nursing?  Yes  No

Taking birth control pills?  Yes  No

**MEDICATIONS**

List any medications you are currently taking and the correlating diagnosis: \_\_\_\_\_

\_\_\_\_\_

Pharmacy Name \_\_\_\_\_

Phone ( ) \_\_\_\_\_

**ALLERGIES**

Aspirin

Latex

Barbiturates (Sleeping pills)

Local Anesthetic

Codeine

Penicillin

Iodine

Sulfa

Other \_\_\_\_\_

# Riley Dental Associates of Central Virginia

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

You May Refuse to Sign This Acknowledgement

**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 all related activities to my health care.

**Notice of Privacy Practices:** You have the right to read our Notice of Privacy Practices (on back) 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. A copy of our notice accompanies this consent. 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, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

**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 Riley Dental Associates. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

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 all related activities to my health care.

\_\_\_\_\_  
PRINT PATIENT NAME

\_\_\_\_\_  
SIGNATURE OF PATIENT (OR LEGAL GUARDIAN)

\_\_\_\_\_  
DATE

I also give consent to the following people to discuss my appointments, account balance, and prescription/medical information.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

## NOTICE OF PRIVACY PRACTICES USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations.

**Treatment:** We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

**Payment:** We may use and disclose your health information to obtain payment for services we provide to you.

**Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

**Your Authorization:** If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

**To Your Family and Friends:** We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare.

**Persons Involved in Care:** We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

**Required by Law:** We may use or disclose your health information when we are required to do so by law.

**Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. WE may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

**National Security:** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

**Appointment Reminders:** WE may use or disclose your health information to provide you with appointment reminders (such as voicemail, messages, postcards, or letters).

### Patient Rights

**Access:** You have the right to look at or get copies of your health information with limited exceptions. You must make the request in writing to obtain access to your health information. We will charge you a reasonable cost-based fee for expenses such as copies, staff time, and postage.

**Disclosure Accounting:** You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last six years, but not before April 14, 2003. If you request this accounting more than once in a twelve month period, we may charge you a reasonable, cost based fee for responding to additional requests.

**Restriction:** You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

**Amendment:** You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request.

**Electronic Notice:** If you receive this Notice on our website or by electronic mail (email), you are entitled to receive this notice in written form.