Springhill Dental, PLLC
Ryan C. Shearer, DDS

Date: _____

PATIENT REGISTRATION

Welcome to Springhill Dental!

Would you please be kind enough to answer the following questions? Thank you so much for being our guest!

NAME (FIRST/MIDDLE/LAST): _____ PREFERRED NAME: _____

ADDRESS: _____ CITY/STATE/ZIP: _____

HOME PHONE: (_____) _____ - _____ CELL PHONE: (_____) _____ - _____ BUS PHONE (_____) _____ - _____

GENDER: M or F MARITAL STATUS: S M D W DOB: ____ /____ /_____ SOCIAL SECURITY: _____ - ____ - _____

DRIVERS LICENSE # AND STATE ISSUE: _____ EMAIL: _____

NAME OF EMPLOYER: _____ OCCUPATION: _____

BUSINESS ADDRESS: _____ CITY/STATE/ZIP: _____

EMERGENCY CONTACT NAME: _____ RELATIONSHIP: _____

CELL PHONE: (_____) _____ - _____ HOME/WORK PHONE: (_____) _____ - _____

PERSON RESPONSIBLE FOR ACCOUNT

Who is responsible for account: SELF SPOUSE PARENT/GUARDIAN OTHER

Please fill in the following information if the person responsible is different from self.

NAME (FIRST/MIDDLE/LAST): _____ RELATIONSHIP: _____

ADDRESS: _____ CITY/STATE/ZIP: _____

HOME PHONE: (_____) _____ - _____ CELL PHONE: (_____) _____ - _____ BUS PHONE (_____) _____ - _____

NAME OF EMPLOYER: _____ OCCUPATION: _____

INSURANCE INFORMATION

PRIMARY POLICY HOLDER'S NAME: _____ DOB: ____ /____ /____SOCIAL SECURITY: _____ - ____ - _____

NAME OF EMPLOYER: _____ BUS PHONE (_____) _____ - _____

INSURANCE COMPANY NAME: _____ GROUP: _____ MEMBER ID: _____

Is patient covered by a second insurance?

PRIMARY POLICY HOLDER'S NAME: _____ DOB: ____ /____ /____SOCIAL SECURITY: _____ - ____ - _____

NAME OF EMPLOYER: _____ BUS PHONE (_____) _____ - _____

INSURANCE COMPANY NAME: _____ GROUP: _____ MEMBER ID: _____

How did you hear about Springhill Dental? _____

Patient:

_____

Sign Name Date

If patient was assisted with this form, enter name below of person assisting:

_____

Print Name Sign Name Date

3401 Springhill Drive, Suite 285 • North Little Rock, AR 72117 • (501) 955-0155

www.springhilldentalnlr.com

MEDICAL HISTORY

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 that you will be receiving. Thank you for answering the following questions.

General health (please check): EXCELLENT ❑ GOOD ❑ FAIR ❑ POOR ❑ Name of physician _____
Physician's Address _____ Telephone Number _____ Date of Last Physical _____
Are you now under care of a physician? Yes ❑ No ❑
Are you taking any medication now? Yes ❑ No ❑ If yes, names of medications and problems for which they are taken:
Medication 1) _____ Taken for _____ 3) _____ Taken For _____
2) _____ Taken for _____ 4) _____ Taken For _____

Have you ever taken Fen-Phen or Redux? Yes ❑ No ❑
Do you smoke? Yes ❑ No ❑ If yes, how much? _____
Do you use tobacco? Yes ❑ No ❑
Are you pregnant or think you may be pregnant? Yes ❑ No ❑ If yes, expected delivery date: _____
Are you nursing? Yes ❑ No ❑
Are you taking birth control pills? Yes ❑ No ❑
Have you ever required a blood transfusion? Yes ❑ No ❑
Do you or have you used controlled substances? Yes ❑ No ❑
Are you wearing contact lenses? Yes ❑ No ❑
Do you bruise easily? Yes ❑ No ❑

Are you allergic to or have you had reactions to:

Aspirin ..... Yes ❑ No ❑
Penicillin or other antibiotics ..... Yes ❑ No ❑
Codeine or other pain medications ..... Yes ❑ No ❑
Iodine ..... Yes ❑ No ❑
Any metal (e.g. gold, nickel, etc.) ..... Yes ❑ No ❑
Latex/Rubber ..... Yes ❑ No ❑
Sulfa drugs ..... Yes ❑ No ❑
Local anesthetics like Novocaine ..... Yes ❑ No ❑

Other (please list) _____

Have you ever had (please check-mark appropriate boxes):

AIDS/HIV ..... Yes ❑ No ❑
Arthritis ..... Yes ❑ No ❑
Asthma or hay fever ..... Yes ❑ No ❑
Chemotherapy ..... Yes ❑ No ❑
Congenital heart lesions ..... Yes ❑ No ❑
Chemical dependency ..... Yes ❑ No ❑
Prolonged bleeding ..... Yes ❑ No ❑
Persistent diarrhea ..... Yes ❑ No ❑
Heart murmur ..... Yes ❑ No ❑
Heart disease ..... Yes ❑ No ❑
Hepatitis ..... Yes ❑ No ❑
Abnormal blood pressure ..... High ❑ Low ❑ No ❑
Mitral valve prolapse ..... Yes ❑ No ❑
Thyroid problem ..... Yes ❑ No ❑
X-ray treatments for cancer ..... Yes ❑ No ❑
Rheumatic fever ..... Yes ❑ No ❑
Stroke ..... Yes ❑ No ❑
Tuberculosis or lung disease ..... Yes ❑ No ❑
Night sweats ..... Yes ❑ No ❑
Glaucoma ..... Yes ❑ No ❑
Sexually transmitted disease ..... Yes ❑ No ❑
Eating disorders ..... Yes ❑ No ❑
Anemia ..... Yes ❑ No ❑
Joint replacement or implant ..... Yes ❑ No ❑
Cancer ..... Yes ❑ No ❑
Cold sores/Fever blisters ..... Yes ❑ No ❑
Diabetes ..... Yes ❑ No ❑
Epilepsy/Seizures ..... Yes ❑ No ❑
Excessive urination and/or thirst ..... Yes ❑ No ❑
Allergies ..... Yes ❑ No ❑
Pacemaker ..... Yes ❑ No ❑
Heart surgery ..... Yes ❑ No ❑
Jaundice ..... Yes ❑ No ❑
Kidney trouble ..... Yes ❑ No ❑
Osteoporosis ..... Yes ❑ No ❑
Mental health care ..... Yes ❑ No ❑
Drastic weight loss ..... Yes ❑ No ❑
Sinus trouble ..... Yes ❑ No ❑
Swollen ankles ..... Yes ❑ No ❑
Ulcers ..... Yes ❑ No ❑
Lymph node enlargement (swollen glands) ..... Yes ❑ No ❑
Fainting spells ..... Yes ❑ No ❑
Back problems ..... Yes ❑ No ❑

If you have entered "yes" to any of the above, please explain: _____

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*Your signature indicates you have received a copy of the HIPAA law and Dental Materials forms and release Springhill Dental to utilize any dental photographs for lecturing and educational purposes.

Signature: _____ Date: _____

Springhill Dental, PLLC
Ryan C. Shearer, DDS

APPOINTMENT AGREEMENT

Trying to accommodate every patient's individual needs and work schedules can be difficult, but we always try to do our best. We work very hard to stay on schedule so that our valuable patients will not spend time in our reception area waiting for an appointment.

A scheduled appointment is a commitment of time between you and our practice. We have reserved that time just for you. When appointments are missed or canceled, that time is permanently lost.

We ask when you schedule an appointment that you make every effort to keep that commitment. We understand that personal emergencies sometimes occur, and we always take that into consideration when receiving a last-minute cancellation. If you find that you cannot keep your scheduled appointment, we ask you to provide a minimum of twenty-four hours notice to us so we may schedule another patient in need of treatment. For your convenience, we have an appointment secretary available Monday through Thursday, 8:30 to 5:00, as well as an answering machine to take messages after business hours.

It is our policy that with less than twenty-four hours notice on a change of commitment, a charge of $50 will be applied to your account.

If you have any questions regarding this policy please do not hesitate to contact us. We sincerely appreciate your understanding and cooperation with this matter.

_____

Patient Signature

_____

Date

3401 Springhill Drive, Suite 285 • North Little Rock, AR 72117 • (501) 955-0155
www.springhilldentalnlr.com

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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 the right to read 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 (501) 955-0155 or by mailing us at 3401 Springhill Drive, Suite 285, North Little Rock, AR 72117.

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.

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.

Springhill Dental, PLLC
Ryan C. Shearer, DDS

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.

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.

By signing this form, I agree to allow the use and disclosure of my medical record information for the purposes described above. A copy of this authorization (consent) form will be given to me.

Signature:_____Date:_____

Please contact us for more information: Springhill Dental, PLLC
3401 Springhill Drive, Suite 285
North Little Rock, AR 72117
(501) 955-0155
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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 or Toll Free: 1-877-696-6775