WELCOME

DESIREE T. PALMER, D.M.D., P.A.

ABOUT YOU

Today's Date: _____/_____/_____

Patient's Name

_____
Last First MI

What you prefer to be Called: _____ Male / Female

Birthdate: _____ Age ____ _ SS# _____

Mailing Address:

_____

_____
City State Zip

Home Phone#: (____)_____

Work Phone #: (____)_ _____

Cell Phone #: ____)_____

Email address: _____

Referred by: _____

Employer: _____How long_____

Occupation: _____

Status: __minor __Single __Married __Divorced __Separated ___Widowed

Spouse's Name _____

Do you have children? ____Yes ____No How many? _____

INSURANCE INFORMATION

Company Name:_____

Address: _____

_____

Phone#: _____

Insured ID: # _____

Group# _____

Insured Name: _____

Relation: _____Date of Birth: _____

Insured's Employer: _____

IN EVENT OF EMERGENCY

Whom should we contact?

_____

Relationship:

_____

Best contact #

_____

Medical Doctor:

_____

Medical Phone# : _____

PERSON ULTIMATELY RESPONSIBLE FOR ACCOUNT

Name: _____ Relation: _____

Home _____ Work Phone# _____

____ I hereby authorize assignment of my insurance rights and benefits and directly to the provider for services rendered. I fully understand I am solely responsible for any insurance company (if offered at this office).

- We invite you to discuss with us any questions regarding our services. The best dental health services are based on friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangement has been made with the business office. If account is not paid within 90 days of the date and no financial arrangements have been made, you will be responsible for legal fees, collections agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature _____Date _____

O Adult Patient o Parent or Guardian o Spouse

DENTAL INFORMATION

Reason for Today's visit: [] Exam & Cleaning [] Emergency [] Consultation

Are you in any pain? [] No [] Yes. If yes, for how long? _____

Please indicate if you have any of the following problems:

[] Discomfort, clicking or popping in jaw [] Stained Teeth [] Teeth grinding [] Ringing in ears [] Locking jaw

[] Bad breath [] Red, swollen or bleeding gums [] Broken/chipped tooth [] Blisters/sores in or around the mouth

[] Sensitive tooth, teeth or gums [] lost/Broken Filling (s] [] Other:_____

How would you rate you smile? (Worst) 1 2 3 4 5 6 7 8 9 10 (Best)

How many times a day do you brush your teeth? _____ Times a week you Floss? _____

What type of tooth brush bristles do you use? [] Soft [] Medium [] Hard [] I do not know

Last Dental exam: ___/___/___ Last Dental Cleaning: __/___/___ Last Dental X-rays:___/___/___

Previous Dentist: _____ (____)_____

MEDICAL HISTORY

Do you see a medical/primary care provider? [] Yes [] No If yes _____

Have you ever been hospitalized or had a major operation? [] Yes [] No if yes, what operation and when

_____

Are you taking any medications (pills, supplements, vitamins or drugs) _____

_____

Do you require pre-medication before dental treatment? [] Yes [] No [] I don't know

Do you use tobacco/Marijuana? [] Yes [] No. How much a day? _____ For how long?_____

Women are you: [] Pregnant/Trying to get pregnant. How far along? _____

[] Nursing [] Taking oral contraceptive. Name _____

Are you allergic to any of the following?

[] Aspirin [] Penicillin [] Codeine [] Acrylic [] Metal [] Latex [] Sulfa Drugs [] Local Anesthetics

[] Tetracycline/Minocycline [] Other: _____

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

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

Have you ever had any serious illness not listed [] Yes [] No

To 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: _____

Desiree T. Palmer, DMD, PA

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning you health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect (4/14/08), and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of your Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

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

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: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. 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, but only if you agree that we may do so.

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 or health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

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 in the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

Nation 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 may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so, (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $1.00 for each page, $45 per hour for staff time to locate and copy your health information, and postage if you want copies mailed to you. If you request an alternative format, we will charge cost based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

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 6 years, but not before April 14, 2008. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use of 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).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (you must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

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 under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (email), our are entitled to receive this Notice in written form upon request.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Telephone: (919) 471-9106 Fax: (919) 477-0954

Address: 105 Newsom Street, Suite 204 Durham NC 27704

Notice of Privacy Practices Acknowledgement

Desiree T. Palmer DMD, PA
105 Newsom Street, Suite 204
Durham, NC 27704

I understand that under the Health Insurance Portability & accountability Act of 1996 (HIPAA). I have certain rights to privacy regarding my protected Health Information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your Notice of Privacy Practices and Policies containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices and Policies.

I understand that I may request in writing that you restrict my information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my request restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name _____

Relationship to Patient: _____

Signature: _____

Date _____

Office Use Only

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgment, but was unable to do as documented below:

Date	Initials	Reason

Financial Policy

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment.

All patients must complete the patient information and medical history forms before seeing the doctor.

FULL PAYMENT OF PATIENTS PORTION IS DUE AT TIME OF SERVICE.

WE ACCEPT CASH, PERSONAL CHECKS, VISA, MASTER CARD AND DISCOVER.

WE OFFER AN EXTENDED PAYMENT PLAN WITH PRIOR CREDIT APPROVAL.

ALL MAJOR TREATMENT AND ANY TREATMENT INVOLVING A LABORATORY PROCEDURE WILL REQUIRE AN APPROPRIATE INTIAL PAYMENT TO BEGIN TREATMENT AND THE REMAINING BALANCE UPON COMPLETION.

Returned Checks

There is a $30.00 charge for all returned checks.

Statements

There will be no charge for your initial statement, however for each additional statement there will be a $3.00 charge per statement.

Regarding Insurance

We may accept assignment of insurance benefits at your first visit. However, we do require your estimated portion of the bill to be paid at time of service. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Please be aware that some, and perhaps all of the services provided may be non-covered services under your insurance plan. We will make every effort to collect payment from your insurance company, but after 90days and we have not received payment from you insurance company we will take no further action with your insurance company. Please also realize that our dental diagnosis and treatment is not based on your insurance benefits.

Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients, and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Minor Patients

The adult accompanying a minor (parent or guardian) is responsible for payment.

Missed Appointments

Unless cancelled, at least 24 hours in advance, our policy is to charge for missed appointments at the rate of $35. Please help us serve you better by keeping scheduled appointments.

Thank you and please let us know if you have questions or concerns. I have read the Financial Policy, I understand and agree to this Financial Policy.

_____ Date_____

Signature of Responsible Party