New Patient Information
Welcome to Our Office

Hampton Roads Center for Cosmetic Dentistry
Dr. Carol F. Morgan, DDS, PC

PATIENT INFORMATION:

Last Name: ______________________________ First Name: ________________________ Middle Initial: ____

I Prefer to be Called: __________________________________ Date of Birth: _____ / _____ / ___________

Home Address: ____

City: ___________________________________ State: ______________________ Zip Code: ________________

Home Phone: ( ) _________________ Work: ( ) ________________ Cell: ( ) __________________

Email Address: ___________________________________ May we confirm appointment by email? YES NO

Male Female Marital Status: _____________________ Soc. Security No.: ___________________________

Occupation: ________________________________ Employer: ____

May we call you at work if necessary? YES NO Direct Dial No.: ( )

EMERGENCY CONTACT:

Name: __________________________________ Relation: ______________________________________

Day Phone: ( ) ______________ Night Phone: ( ) ________________

REFERRAL INFORMATION:

Who May We Thank For Referring You to Us? ____

If Not Referred, Did You Find Us Online? Yes No If Yes, Please Share What You Searched And Why You Selected Us:____

If neither of the above how did you find us? ____

DO YOU HAVE DENTAL INSURANCE? Yes No

Name of Subscriber ______________________________ DOB _______________________

Soc. Security No.___________________________ Employer____

Insurance Company______________________________ Group Number ______________________________

MEDICAL HISTORY

Are You Currently Under the Care of a Physician? Yes No

If Yes, Please Explain: ____

Please List All Health Professionals Concerning Any Treatment Related To Jaw Pain or Headaches.

	Practitioner	Specialty	Treatment and Approximate Dates
1:			
2:			
3:			

List Any Medications You Are Currently Taking: ____

ARE YOU ALLERGIC TO ANY MEDICATIONS: Antibiotics Aspirin Codeine Iodine

Latex Metals, Others: ____

Have You Had Any of the Following: Mitral Valve Prolapse Artificial Joint

Heart Murmur Rheumatic Fever Hepatitis Asthma

Have You Ever Been Told That You Need to Pre-Medicate Prior to Having Dental Treatment? Yes No

If Yes, By Whom? ____

Is Your Skin Sensitive to Any Type of Metal? Yes No

Is Your Skin Sensitive to Any Type of Latex? Yes No

If Female, Are You Pregnant? Yes No

If Female, Are You Taking Any Type of Birth Control Medication? Yes No

DENTAL HISTORY:

What Is The Reason You Are Here Today? ____

Are You Currently In Pain? Yes No

If Yes, Please Describe: ____

____

Name of Your Dentist: ____

Telephone Number of Previous Dentist: (   ) _______________

Last Cleaning/Checkup: ____ / ____ / ________ X-Rays: ____ / ____ / ________

Are You Happy With Your Smile? Yes No

Do You Suffer From Reoccurring Cold Sores? Yes No

Are You Interested In A Brighter Smile? Yes No

Are You Concerned About Mouth Odor? Yes No

The Above Answers Are True And Correct To The Best Of My Knowledge:

Signature: ______________________________________ Date: ___________________

Print Name: ______________________________________

Conditions for Dental (Healthcare) Treatment

<u>Authorization for Medical Treatment</u>: I authorized and consent to dental (healthcare) services including, but not limited to, diagnostic, cosmetic and dental procedures and treatment at Carol F. Morgan, DDS, V.B., PLLC. I understand that no guarantees or promises have been made to me as to the result to be obtained from such services.

<u>Financial Agreement</u>: In consideration for dental (healthcare) services provided to me and/or a person whom I claim financial responsibility (family member) by Carol F. Morgan, DDS, V.B., PLLC. for this and all subsequent services, I agree to pay Carol F. Morgan, DDS, V.B., PLLC. in accordance with their regular rates and terms of payment. I assume full responsibility for payment of all charges associated with the dental (healthcare) services provided to me and/or any person whom I claim financial responsibility (family member), including any portion of any charges not paid by insurance carriers, workers' compensation or any other party. Such unpaid charges may include, but not limited to, coinsurance amounts. I agree to pay a cancelation fee if I do not notify Carol F. Morgan, DDS, V.B., PLLC. of cancelation 48 hours (2 business days) prior to my appointment. Should my account become delinquent, I agree to pay all collection costs and expenses, including attorney's fees, and court costs, additionally, I waive homestead and all other exemptions to such debt.

<u>Assignment of Benefits</u>: In consideration for dental (healthcare) services provided to me by Carol F. Morgan, DDS, V.B., PLLC. for this and any subsequent services, I hereby assign to Carol F. Morgan, DDS, V.B., PLLC. any and all rights, benefits and claims I may have under any policy of insurance (dental, hospitalization, major medical, automobile, liability, workers' compensation, and any other) and the proceeds from any claim that I may have for injuries. Such assignments hereby authorize direct payment to Carol F. Morgan, DDS, V.B., PLLC. under and/or from any such policy of insurance or proceeds.

I certify that I have reviewed this document in full, understand its terms, and have had the opportunity to ask questions regarding its content. I understand that this document is valid and remains in effect unless revoked by Carol F. Morgan, DDS, V.B., PLLC.

Patient Name: ___________________________

Signature: ______________________________ Date: __________________

OUR APPOINTMENT POLICY

Your appointment is reserved just for you. It is your time with the doctor or hygienist. We do not “double book” appointments. If you must change an appointment, please give 48 hours notice. Otherwise, we reserve the right to charge you the full value of the missed time. Please help us to serve you better by keeping scheduled appointments.

________________________________ ______________

Signature of Patient *Date*

OUR FINANCIAL POLICY

Thank you for choosing us for your care. We are committed to the success of your treatment. Please understand that payment of your bill is considered part of your treatment.

Regarding Insurance ---You are responsible for payment of your account. We will file a claim form as a courtesy to you. We will do all that we can to get the most benefits reimbursed to you. Please be aware that we do not allow insurance companies to dictate our fees or what we consider the best treatment for our patients. We believe our fees reflect the excellent standards we have set for your care.

________________________________ ______________

Signature of Patient *Date*

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowedgement *

I, ____, have been offered/received a copy of this office's Notice of Privacy Practices.

____
Please Print Name

____
Signature

____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

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Carol F. Morgan DDS, PC

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 your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003, 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 our 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 of 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 infonnation 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 infonnation of Anned Forces personnel under certain circumstances. We may disclose to authorized federal officials health infonnation 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 infonnation of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health infonnation 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 fonnat other than photocopies. We will use the fonnat you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health infonnation. You may obtain a fonn to request access by using the contact infonnation 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 $0._ for each page, $_ per hour for staff time to locate and copy your health infonnation, and postage if you want the copies mailed to you. If you request an alternative fonnat, we will charge a cost-based fee for providing your health infonnation in that fonnat. If you prefer, we will prepare a summary or an explanation of your health infonnation 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 infonnation for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. 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 or disclosure of your health infonnation. 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 infonnation 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 infonnation. (Your request must be in writing, and it must explain why the infonnation 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 (e-mail), you are entitled to receive this Notice in written fonn.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us at (757)412-1400 or in office at 984 First Colonial Rd, Suite 101, Virginia Beach, VA 23454.

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 infonnation 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 infonnation 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.