

PATIENT INFORMATION

Mr., Mrs., Dr., Ms., Miss Marital Status _____ E-mail Address _____ Date _____

First Name _____ Middle _____ Last _____

Nickname _____

Address _____

Home Phone _____ Work Phone _____ Cell Phone _____ Birth Date _____

Social Security Number _____ Whom may we thank for this referral? _____

Employer _____ Occupation _____

Spouse's Name _____ Spouse's DOB _____ Spouse's SSN _____

Person responsible for account (if not patient) _____

Address _____ Phone _____

MEDICAL HISTORY

Your physician's name _____ Last visit _____

Are you being treated by a physician now? _____ If yes, for what condition? _____

Please note other medical professionals that you visit at least 1 time per year (Please check all that apply):

____ Family Physician ____ Gynecologist ____ Chiropractor ____ Other specialists

Any recent serious illness? _____

Are you taking any medication? _____ If yes, what? _____

(this includes over the counter drugs, prescription drugs and birth control pills)

If yes, why? _____

Are you allergic to any medications? _____ If yes, what? _____

Are you allergic to latex? Yes ☐ No ☐

Are you in good health? _____

Kittrell Family Dentistry
8804 Patterson Ave., Ste. 100
Henrico, VA 23229

Any History of:

Heart Problems (Pacemaker/Murmur)

If yes to above, has this been confirmed with an echocardiogram by a cardiologist?

Heart Valve Problems

High Blood Pressure

Rheumatic Fever

Kidney/Liver Disease

Glaucoma

Cancer

Emotional Stress/Depression

Prolonged Bleeding/Anemia

Asthma/Respiratory Problems

Eating Disorder

Epilepsy

Arthritis

Hepatitis

Diabetes

Acid Reflux

Osteoporosis

AIDS or HIV infection

Artificial Joints

WOMEN: Are you pregnant?

Are you nursing?

Medications/Explanation

Yes ☐ No ☐ _____

Yes ☐ No ☐ _____

Yes ☐ No ☐ _____

Yes ☐ No ☐ _____

Yes ☐ No ☐ _____

Yes ☐ No ☐ _____

Yes ☐ No ☐ _____

Yes ☐ No ☐ _____

Yes ☐ No ☐ _____

Yes ☐ No ☐ _____

Yes ☐ No ☐ _____

Yes ☐ No ☐ _____

Yes ☐ No ☐ _____

Yes ☐ No ☐ _____

Yes ☐ No ☐ _____

Yes ☐ No ☐ _____

Yes ☐ No ☐ _____

Yes ☐ No ☐ _____

Yes ☐ No ☐ _____

Yes ☐ No ☐ _____

Yes ☐ No ☐ _____

Yes ☐ No ☐ _____

DENTAL HISTORY

Have you had any serious trouble associated with any previous dental treatment? Yes ☐ No ☐

If so, explain _____

Are you wearing removable dental appliances? Yes ☐ No ☐

Do you have recurring mouth ulcers? Yes ☐ No ☐

Do you have halitosis (bad breath)? Yes ☐ No ☐

Chief Dental Complaint _____

Have your dental experiences been pleasant? Yes ☐ No ☐

Have you ever worn braces? Yes ☐ No ☐

Approximate date of orthodontic treatment? From: _____ To: _____

Would you consider that treatment successful? Yes ☐ No ☐

How long did you consistently wear a retainer as part of your orthodontic treatment? No. of years _____

Are you currently experiencing any pain or discomfort of your mouth, gums or teeth? Yes ☐ No ☐

Please describe the pain or discomfort you are experiencing _____

Have you experienced any pain or discomfort of your mouth, gums or teeth in the past? Yes ☐ No ☐

Please describe any past issues involving your dental health _____

GETTING ACQUAINTED

Recent medical research indicates a strong correlation between daily habits and overall medical and dental health.

Activity and stress levels can often contribute to existing conditions or can lay at the root of other health related concerns.

I consider my teeth/smile to be (please check all that apply):

____ Perfect ____ Slightly crooked ____ Very crooked ____ Discolored ____ Painful ____ Chipped

____ Other _____

Have you set goals for your dental and periodontal health with a previous dentist? Yes ☐ No ☐

Did you successfully complete the plan as outlined by you and your previous dentist? Yes ☐ No ☐

Have you set goals with a previous dentist for the aesthetic or cosmetic improvement of your smile? Yes ☐ No ☐

Did you successfully complete the treatment plan for these aesthetic or cosmetic improvements with your previous dentist? Yes ☐ No ☐

I currently use these over the counter medications or treatments (Please check all that apply):

____ Whitening Strips ____ Whitening Toothpaste ____ Whitening Trays ____ Orajel ____ Sensitivity Toothpaste

____ Medication for canker or mouth sores How often do you experience mouth sores? _____

____ Night Guards/Grinding Guard ____ Pain relievers ____ Pain relievers especially designed for night usage

____ Icy Hot, Bengay other topical pain relievers for muscle pain relief including sleeves and other treated wraps or bandages

____ Antacids such as Roloids, Tums, Pepcid etc. ____ Calcium supplements _____ Other _____

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquires set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient or Parent _____

Kittrell Family Dentistry
8804 Patterson Ave., Suite 100
Henrico, VA 23229

Patient Name _____ Date _____

Preferred Method of Contact and List of Those Persons Who May Receive My Private Health Information:

For purposes of reminding me of my dental appointments and/or reminders to schedule appointments by automated system, contacting me regarding my insurance, if applicable, contacting me regarding my account, contacting me concerning lab tests, or for any other reasons regarding my Private Health Information that pertains to treatment, payment and healthcare operations, I give my consent and preferences for contact by the office of Kittrell Family Dentistry by the following method(s): (Please indicate all that apply)

Home Telephone # _____ OK to leave message? Yes No

Work Telephone # _____ OK to leave message? Yes No

Cell Phone# _____ OK to leave message? Yes No

Email: _____ (Please enter email address)

Text Message: _____ (Please enter cell phone #)

In Case of Emergency, Please Contact: Name _____
Relationship to Patient _____ Phone # _____

Persons who may receive information pertaining to my Personal Health Information are as follows:

1. _____

2. _____

3. _____

I give my permission for Dr. Kittrell, Dr. Ball, Dr. Byrne and/or their team members to correspond with those persons I have listed above, when necessary, regarding my Private Health Information and/or my child's(childrens') Private Health Information. I understand that this may include information regarding treatment, payment, and healthcare operations on my or my child's(childrens') behalf.

Signature of Patient, Parent, or Guardian

Date

Kittrell Family Dentistry
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Payment Policy

I understand that I am fully responsible for payment of any and all services rendered to me by Kittrell Family Dentistry. I give permission for you to file my insurance to my dental insurance company (if applicable) and authorize the release of any medical information necessary to process my claims. I understand that if I have dental insurance, you will file it as a courtesy to me and that assignment of benefits may be made to your office. I further understand that you will bill me or notify me of any balances on my account that are the result of insurance deductibles, co-payments, partially covered or non-covered services, or if I have no dental insurance at all. My account will be considered to be delinquent if there is a balance remaining after 60 days from the initial billing. If my account becomes delinquent, it may be referred to an attorney or collection agency for collections. I understand that I will be responsible for payment of all costs of collection, including attorney's fees, equal to 33% of all sums due and payable and interest on the outstanding principal balance of 18% per annum. There will be a \$25.00 charge for returned checks and I agree to pay these costs should they occur.

Signature of Patient or Guarantor_____

Date_____

Witness_____

Or

Signature of Parent or Guardian (if patient is a minor)_____

Date_____

Witness_____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this Acknowledgement

I, _____, have 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)

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 June 12th, 2015, 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 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 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 \$0._____ for each page, \$_____ per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a 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, 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 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 (e-mail), you are entitled to receive this Notice in written form.

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.

Contact Officer: Stacie Floyd

Telephone: (804) 359-6471

Fax: (804) 354-9583

E-mail: JohnKittrelldds@gmail.com

Address: 2600 Grove Ave, Richmond, Virginia 23220

8804 Patterson Ave, #100 Henrico, VA 23229

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