

J. HUNTER HICKLIN, DMD
Bringing natural smiles to Greenville

DENTAL HISTORY

Name: [REDACTED]

How did you hear about us? [REDACTED]

Reason for Appointment? [REDACTED]

Have you had regular preventive dental care in the past? [REDACTED]

When was your last cleaning appointment? [REDACTED]

Previous Dentist? [REDACTED]

Have you had xrays in the past year? [REDACTED]

Are you satisfied with appearance of your teeth? [REDACTED]

If you could change anything about your smile, what would it be? [REDACTED]

Have you ever had orthodontic (braces) treatment? [REDACTED]

Have you had any or all of your wisdom teeth removed? [REDACTED]

Do you wear a removable partial or denture? [REDACTED] Year made? [REDACTED]

If so, are you satisfied? [REDACTED]

Have you ever had any injuries to your mouth? [REDACTED]

Have you ever been told you have gum disease? [REDACTED]

Do your gums bleed when you brush or floss? [REDACTED]

Do you have any sore or sensitive teeth? [REDACTED]

Do you have any pain or clicking in the jaw joint? [REDACTED]

Do you clench or grind your teeth? [REDACTED]

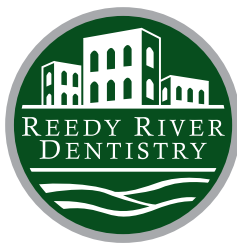
Have you ever had a negative dental experience? [REDACTED]

Do you drink soft drinks, sports drinks, or any sweetened beverage regularly? [REDACTED]

What and how many per day? [REDACTED]

Do you have any other concerns we should know about? [REDACTED]

[REDACTED]



J. HUNTER HICKLIN, DMD
Bringing natural smiles to Greenville

HIPAA

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.

This Notice of privacy practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or healthcare operations (TPO) and for other purpose that are permitted or required by law. It also describes your right to access and control your protected health information. "Protected health information" is information about you including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

Use and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside our office that are involved in your care and treatment for the purpose of providing health care services to you to, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment

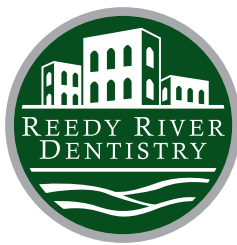
We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care for you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment

Your protected health information will be used as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations

We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients in our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you, we may use or disclose your protected health information, to contact you of your appointment. We may use or disclose your protected health information in the following situations without your authorization. These situations include: Required by law, Public Health issues as required by law, Communicable Diseases: Health oversight: Abuse or Neglect: Food and Drug Administration requirements: legal proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation; Research: Criminal Activity: Military Activity and National Security: Workers Compensation: Inmates Required Uses and Disclosures: Under the law we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with requirements of section 164.500



J. HUNTER HICKLIN, DMD
Bringing natural smiles to Greenville

Other permitted and required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with the respect to your protected health information

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following: Psychotherapy notes; information compiled in reasonable anticipation of, or use in a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us to use or disclose any part of your protected health information for the purpose of treatment, payment or healthcare operation. You may also request that any part of your protected health information not to be disclosed to family members or friends who may be involved in your care or for notification purposes as described in the Notice of Privacy Practices. Your request must state the specific restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us. Upon request, even if you agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. We have the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before April 23, 2003.

We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Signature below is acknowledgement that you have received this notice of our Privacy Practices:

Print Name

Signature

Date

PATIENT REGISTRATION

ID: _____

Chart ID: _____

First Name: _____

Last Name: _____

Middle Initial: _____

Patient Is: Policy Holder Responsible Party

Preferred Name: _____

Responsible Party (if someone other than the patient)

First Name: _____

Last Name: _____

Middle Initial: _____

Address: _____

Address 2: _____

City, State, Zip: _____

Pager: _____

Home Phone: _____

Work Phone: _____

Ext: _____

Cellular: _____

Birth Date: _____

Soc Sec: _____

Drivers Lic: _____

Responsible Party is also a Policy Holder for Patient

Primary Insurance Policy Holder

Secondary Insurance Policy Holder

Patient Information

Address: _____

Address 2: _____

City: _____

State / Zip: _____

Pager: _____

Home Phone: _____

Work Phone: _____

Ext: _____

Cellular: _____

Sex: Male Female

Marital Status: Married Single

Divorced Separated Widowed

Birth Date: _____

Age: _____

Soc Sec: _____

Drivers Lic: _____

E-mail: _____ I would like to receive correspondences via e-mail.

Section 2

Section 3

Employment Status: Full Time Part Time Retired

Student Status: Full Time Part Time

Medicaid ID: _____ Pref. Dentist: _____

Employer ID: _____ Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hyg: _____

Referred By _____
Previous Dentist _____
Emergency Contact _____
Emergency Contact # _____

Primary Insurance Information

Name of Insured: _____

Relationship to Insured: Self Spouse Child Other

Insured Soc. Sec: _____

Insured Birth Date: _____

Employer: _____

Ins. Company: _____

Address: _____

Address: _____

Address 2: _____

Address 2: _____

City, State, Zip: _____

City, State, Zip: _____

Rem. Benefits: _____

Rem. Deduct: _____

Secondary Insurance Information

Name of Insured: _____

Relationship to Insured: Self Spouse Child Other

Insured Soc. Sec: _____

Insured Birth Date: _____

Employer: _____

Ins. Company: _____

Address: _____

Address: _____

Address 2: _____

Address 2: _____

City, State, Zip: _____

City, State, Zip: _____

Rem. Benefits: _____

Rem. Deduct: _____

Patient Name:

Birth Date:

Date Created:

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

Are you under a physician's care now? Yes No If yes

Have you ever been hospitalized or had a major operation? Yes No If yes

Have you ever had a serious head or neck injury? Yes No If yes

Are you taking any medications, pills, or drugs? Yes No If yes

Do you take, or have you taken, Phen-Fen or Redux? Yes No If yes

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No If yes

Are you on a special diet? Yes No

Do you use tobacco? Yes No

Women: Are you...

Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic
 Metal Latex Sulfa Drugs Local Anesthetics

Other? If yes

Do you use controlled substances? Yes No If yes

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

AIDS/HIV Positive <input type="radio"/> Yes <input type="radio"/> No	Cortisone Medicine <input type="radio"/> Yes <input type="radio"/> No	Hemophilia <input type="radio"/> Yes <input type="radio"/> No	Radiation Treatments <input type="radio"/> Yes <input type="radio"/> No
Alzheimer's Disease <input type="radio"/> Yes <input type="radio"/> No	Diabetes <input type="radio"/> Yes <input type="radio"/> No	Hepatitis A <input type="radio"/> Yes <input type="radio"/> No	Recent Weight Loss <input type="radio"/> Yes <input type="radio"/> No
Anaphylaxis <input type="radio"/> Yes <input type="radio"/> No	Drug Addiction <input type="radio"/> Yes <input type="radio"/> No	Hepatitis B or C <input type="radio"/> Yes <input type="radio"/> No	Renal Dialysis <input type="radio"/> Yes <input type="radio"/> No
Anemia <input type="radio"/> Yes <input type="radio"/> No	Easily Winded <input type="radio"/> Yes <input type="radio"/> No	Herpes <input type="radio"/> Yes <input type="radio"/> No	Rheumatic Fever <input type="radio"/> Yes <input type="radio"/> No
Angina <input type="radio"/> Yes <input type="radio"/> No	Emphysema <input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Rheumatism <input type="radio"/> Yes <input type="radio"/> No
Arthritis/Gout <input type="radio"/> Yes <input type="radio"/> No	Epilepsy or Seizures <input type="radio"/> Yes <input type="radio"/> No	High Cholesterol <input type="radio"/> Yes <input type="radio"/> No	Scarlet Fever <input type="radio"/> Yes <input type="radio"/> No
Artificial Heart Valve <input type="radio"/> Yes <input type="radio"/> No	Excessive Bleeding <input type="radio"/> Yes <input type="radio"/> No	Hives or Rash <input type="radio"/> Yes <input type="radio"/> No	Shingles <input type="radio"/> Yes <input type="radio"/> No
Artificial Joint <input type="radio"/> Yes <input type="radio"/> No	Excessive Thirst <input type="radio"/> Yes <input type="radio"/> No	Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No	Sickle Cell Disease <input type="radio"/> Yes <input type="radio"/> No
Asthma <input type="radio"/> Yes <input type="radio"/> No	Fainting Spells/Dizziness <input type="radio"/> Yes <input type="radio"/> No	Irregular Heartbeat <input type="radio"/> Yes <input type="radio"/> No	Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No
Blood Disease <input type="radio"/> Yes <input type="radio"/> No	Frequent Cough <input type="radio"/> Yes <input type="radio"/> No	Kidney Problems <input type="radio"/> Yes <input type="radio"/> No	Spina Bifida <input type="radio"/> Yes <input type="radio"/> No
Blood Transfusion <input type="radio"/> Yes <input type="radio"/> No	Frequent Diarrhea <input type="radio"/> Yes <input type="radio"/> No	Leukemia <input type="radio"/> Yes <input type="radio"/> No	Stomach/Intestinal Disease <input type="radio"/> Yes <input type="radio"/> No
Breathing Problems <input type="radio"/> Yes <input type="radio"/> No	Frequent Headaches <input type="radio"/> Yes <input type="radio"/> No	Liver Disease <input type="radio"/> Yes <input type="radio"/> No	Stroke <input type="radio"/> Yes <input type="radio"/> No
Bruise Easily <input type="radio"/> Yes <input type="radio"/> No	Genital Herpes <input type="radio"/> Yes <input type="radio"/> No	Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Swelling of Limbs <input type="radio"/> Yes <input type="radio"/> No
Cancer <input type="radio"/> Yes <input type="radio"/> No	Glaucoma <input type="radio"/> Yes <input type="radio"/> No	Lung Disease <input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No
Chemotherapy <input type="radio"/> Yes <input type="radio"/> No	Hay Fever <input type="radio"/> Yes <input type="radio"/> No	Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No	Tonsillitis <input type="radio"/> Yes <input type="radio"/> No
Chest Pains <input type="radio"/> Yes <input type="radio"/> No	Heart Attack/Failure <input type="radio"/> Yes <input type="radio"/> No	Osteoporosis <input type="radio"/> Yes <input type="radio"/> No	Tuberculosis <input type="radio"/> Yes <input type="radio"/> No
Cold Sores/Fever Blisters <input type="radio"/> Yes <input type="radio"/> No	Heart Murmur <input type="radio"/> Yes <input type="radio"/> No	Pain in Jaw Joints <input type="radio"/> Yes <input type="radio"/> No	Tumors or Growths <input type="radio"/> Yes <input type="radio"/> No
Congenital Heart Disorder <input type="radio"/> Yes <input type="radio"/> No	Heart Pacemaker <input type="radio"/> Yes <input type="radio"/> No	Parathyroid Disease <input type="radio"/> Yes <input type="radio"/> No	Ulcers <input type="radio"/> Yes <input type="radio"/> No
Convulsions <input type="radio"/> Yes <input type="radio"/> No	Heart Trouble/Disease <input type="radio"/> Yes <input type="radio"/> No	Psychiatric Care <input type="radio"/> Yes <input type="radio"/> No	Venereal Disease <input type="radio"/> Yes <input type="radio"/> No
			Yellow Jaundice <input type="radio"/> Yes <input type="radio"/> No

Have you ever had any serious illness not listed Yes No If yes

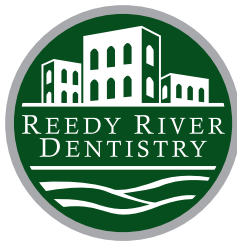
Comments:

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:

X

Date: _____



J. HUNTER HICKLIN, DMD
Bringing natural smiles to Greenville

PATIENT PAYMENT POLICY

Thank you for choosing Reedy River Dentistry for your dental needs. We appreciate the opportunity to care for you and your family's dental needs. The following information is provided to avoid any confusions regarding payment for dental services. Please sign below that you have read and agree to the policy.

Payment Policy

- At date of service you are required to pay your estimated amount due. After insurance has paid you are responsible for any remaining balance.
- Payment for service is due in full provided there is no insurance.
- We accept Cash, Check, Visa, Mastercard. Any returned check is subject to a \$20.00 return check fee.
- If a patient is younger than 18 years of age, we do require a parent or guardian to be responsible for the account, and to be in accordance with the request shown above.
- If your account is overdue for longer than 90 days, it may be referred to a collection agency.

Insurance

As a courtesy, we file insurance. It is your responsibility to notify us of any changes to your insurance coverage. This is your insurance policy and we require that you know your benefits regarding maximums, waiting periods, benefits year, and deductibles. Please know that any information required from your insurance company regarding the treatment done will be provided by us as it is requested.

Print Patient Name

Responsible Party Signature