Chart #: _____
FOR OFFICE USE ONLY

Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name).
Gender: _____ Family Status: □ Single □ Married □ Child □ Email: _____
Social Security #: _____ Birth Date: ___Driver's License: _____
Phone (Home): _____ (Work): _____ Ext: _____ Cell Phone: _____
Address: _____

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐ Another patient, relative
☐ Dental Office ☐ Yellow Pages ☐ Online ☐ School ☐ Work ☐ Other _____
Name of person or office referring you to our practice: _____

Insurance Information

Primary
Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI
Insured's Birth Date: _____ ID #: _____ Group #: _____
Insured's Address: _____
Street City State Zip Code
Insured's Employer Name: _____
Address: _____
Street City State Zip Code
Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____
Insurance Plan Name and Address: _____
_____

Secondary
Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI
Insured's Birth Date: _____ ID #: _____ Group #: _____
Insured's Address: _____
Street City State Zip Code
Insured's Employer Name: _____
Address: _____
Street City State Zip Code
Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____
Insurance Plan Name and Address: _____

Responsible Party Information

Person Responsible for Account: ☐ Patient ☐ Father ☐ Mother ☐ Guardian
Name: _____
Method of Payment: ( ) Check ( ) Visa/Mastercard ( ) Discover ( ) Care Credit ( ) Cash
Where appropriate and necessary, credit bureau reports will be obtained.

Authorization: I hereby authorize payment directly to Dr. Robert L. Williamson, III, D. D.S., P.A., of the group insurance benefits otherwise payable to me. I understand that Dr. Robert L. Williamson, III, D.D.S., P.A., is not in network with any insurance company. I understand that I am responsible for all cost of dental treatment. I hereby authorize the Dental office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history are correct to the best of my knowledge.

● Signature of Responsible Party: _____ Date: _____

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

Dental History: Would you describe your present dental health as good? ☐ Yes ☐ No

If no, please explain: _____

- Do you think you have active decay or gum disease? ☐ Yes ☐ No
  Please explain: _____
- Do your gums ever bleed? ☐ Yes ☐ No
  If yes, when? _____
- How often do you brush? _____ Floss? _____
- Do you feel nervous about dental treatment? ☐ Yes ☐ No
- Have you ever had a bad experience in a dental office? ☐ Yes ☐ No
  Describe: _____
- Have you ever had braces? ☐ Yes ☐ No
- Is your water fluoridated? ☐ Yes ☐ No
- Have you had any prior dental trauma? ☐ Yes ☐ No
  If yes, please explain: _____
- Do you like your smile? ☐ Yes ☐ No
  If no, please explain: _____
- Name of your previous dentist: _____

Medical History: Medical Doctor's Name and Phone #: _____

- Are you under a physician's care now? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been hospitalized in the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you taking any medications, pills, drugs, or herbal supplements? ☐ Yes ☐ No
  If yes, please describe what, why, and dosage: _____

_____

_____

- Are you allergic to **PENICILLIN, CODEINE,** or any other medication? ☐ Yes ☐ No
  If yes, list medication and describe reaction: _____
- Pregnant or nursing? ☐ Yes ☐ No
- Do you take premedication for dental treatment? ☐ Yes ☐ No
- Do you smoke? ☐ Yes ☐ No
- Do you use alcohol? ☐ Yes ☐ No
- Are your immunizations up to date? ☐ Yes ☐ No
- **ARE YOU ALLERGIC TO LATEX?** ☐ Yes ☐ No

Have you ever had any of the following? Please check those that apply:

☐ Heart Trouble	☐ Glaucoma	☐ Artificial Heart Valve	☐ Ulcers
☐ High Blood Pressure	☐ Congenital Heart	☐ Pregnancy	☐ Chemotherapy
☐ Heart Murmur	Lesion	Due date: _____	☐ Pain in Jaw Joint
☐ Mitral Valve Prolapse	☐ Allergies	☐ Radiation Treatment	☐ Hypoglycemia
☐ Arthritis/Gout	☐ Heart Pacemaker	☐ Respiratory Problems	☐ Epilepsy/Seizures
☐ Artificial Joints/Hip	☐ Heart Surgery	☐ Rheumatic Fever	☐ Venereal Disease
☐ Asthma	☐ Anemia	☐ Rheumatism	☐ HIV Positive
☐ Blood Disease	☐ Hepatitis A (Infect)	☐ Sinus Problems	☐ Aids
☐ Cancer	☐ Hepatitis B (Serum)	☐ Thyroid Problems	☐ Cold sores/fever
☐ Diabetes	☐ Hepatitis C (Serum)	☐ Stroke	blisters
☐ Dizziness	☐ Kidney Disease	☐ ADD/ADHD	☐ Herpes
☐ Epilepsy	☐ Liver Disease	☐ Drug Addiction	☐ Eating Disorder
☐ Excessive Thirst	☐ Lung Disease	☐ Tuberculosis	☐ Psychiatric Problems
☐ Fainting/Dizziness	☐ Nervous Disorders	☐ Jaundice	☐ Frequent headache

Please list any other serious illness if not indicated above: _____

- I understand that if any change occurs in my health, I am to report it to the dental office as soon as possible. I have read and understand each question and have answered all of them truthfully and to the best of my ability. I have discussed my health history with the doctor.

_____

Signature of patient, parent or guardian Date

_____

Signature of Doctor Date

Raleigh Comprehensive & Cosmetic Dentistry
Robert L. Williamson, III, DDS, PA & Associates

Financial Policy

Thank you for choosing our office for your dental treatment needs. We are committed to your dental health. Please understand that *payment of your bill is considered a part of your dental treatment.* The following is a supplement to our **Payment Policy**.

- ✓ Please be aware that you are responsible for all payments for treatment. If you are insured, you are responsible for any and all amounts that your insurance does not cover. All children under the age of 18 years old are the responsibility, financially, of the parent or guardian.

- ✓ ***Payment is expected in full for each appointment as services are rendered.*** For the convenience of our patients, we accept cash, personal checks (we do not accept post dated checks), MasterCard, Visa, and Discover. Additionally, we offer CareCredit for financing options.

- ✓ ***Dental Insurance Payments –*** There is **NO** direct relationship between our office and your dental insurance company. The type of plan chosen by you, and/or your employer determines your insurance benefits/coverage. As such, we have no say in the selection of your coverage, no control over the terms of your contract, the methods of reimbursement/payments for treatment, or the determination of your insurance benefits payments. Please note, any balances remaining after your insurance payments is your responsibility

We recognize that under unusual circumstances an account balance may be incurred. *Raleigh Comprehensive & Cosmetic Dentistry* requires that all outstanding balances be ***paid in full within thirty (30) days*** unless other arrangements have been made. If we have not received payment or you have not contacted us within thirty (30) days, further action may be taken with a collection agency or with Small Claims Court. We reserve the right to apply an interest rate of fifteen percent (15%) from the date of service. A $35 fee will be assessed to all returned checks. Thank you in advance for your understanding of our financial policy!

Signature _____ Date _____

Raleigh Comprehensive & Cosmetic Dentistry
Robert L. Williamson, III, DDS, PA & Associates

Insurance Submission, Estimates, and Payments

Patient Name & Address: _____
_____
_____

I understand that my insurance is filed as a courtesy. Raleigh Comprehensive & Cosmetic Dentistry will file insurance and accept assignment of benefits (the amount of insurance coverage is paid directly to our office). All costs, "patient portions" are an estimate of the amount my insurance company states it will cover based on percentages. However, deductibles, denial of benefits, waiting periods, fixed fee schedules, non-duplicating clauses, and changes in the policy of the insurance company may impact coverage amounts. Remainders may be left after insurance has paid our office which you will be billed for and be responsible for at that time.

I also understand that if my insurance company does not allow assignment of benefits the insurance payment is mailed directly to me, the subscriber, it is my responsibility to submit the payment to Raleigh Comprehensive & Cosmetic Dentistry for services rendered. I understand cashing this payment and keeping this payment is fraud and punishable by law.

DENTAL INSURANCE:
There is **NO** direct relationship between our office and your dental insurance company. The type of plan chosen by you, and/or your employer determines your insurance benefits. As such, we have no say in the selection of your coverage, no control over the terms of your contract, the methods of reimbursement or the determination of your insurance benefits payments.

_____ _____
Signature Date

Raleigh Comprehensive & Cosmetic Dentistry,

Robert L. Williamson, III, DDS, PA & Associates

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.

If you have any questions about this Notice please contact the Privacy Officer.
Nancy Campbell

Effective Date: April 14, 2003 **Revised: September 23, 2013**

We are committed to protect the privacy of your personal health information (PHI).

This Notice of Privacy Practices (Notice) describes how we may use within our practice or network and disclose (share outside of our practice or network) your PHI to carry out treatment, payment or health care operations. We may also share your information for other purposes that are permitted or required by law. This Notice also describes your rights to access and control your PHI.

We are required by law to maintain the privacy of your PHI. We will follow the terms outlined in this Notice.

We may change our Notice, at any time. Any changes will apply to all PHI. Upon your request, we will provide you with any revised Notice by:

- Posting the new Notice in our office.
- If requested, making copies of the new Notice available in our office or by mail.
- Posting the revised Notice on our website: **www.RaleighDenstist.com**

Uses and Disclosures of Protected Health Information

We may use or disclose (share) your PHI to provide health care treatment for you.

Your PHI may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you.

EXAMPLE: Your PHI may be provided to a physician to whom you have been referred for evaluation to ensure that the physician has the necessary information to diagnose or treat you. We may also share your PHI from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

We may also share your PHI with people outside of our practice that may provide medical care for you such as home health agencies.

We may use and disclose your PHI to obtain payment for services. We may provide your PHI to others in order to bill or collect payment for services. There may be services for which we share information with your health plan to determine if the service will be paid for.

PHI may be shared with the following:

- Billing companies
- Insurance companies, health plans
- Government agencies in order to assist with qualification of benefits
- Collection agencies

EXAMPLE: You are seen at our practice for a procedure. We will need to provide a listing of services such as x-rays to your insurance company so that we can get paid for the procedure. We may at times contact your health care plan to receive approval PRIOR to performing certain procedures to ensure the services will be paid for. This will require sharing of your PHI.

We may use or disclose, as-needed, your PHI in order to support the business activities of this practice which are called health care operations.

EXAMPLES:

- Training students, other health care providers, or ancillary staff such as billing personnel to help them learn or improve their skills.
- Quality improvement processes which look at delivery of health care and for improvement in processes which will provide safer, more effective care for you.
- Use of information to assist in resolving problems or complaints within the practice.

We may use and disclosure your PHI in other situations without your permission:

- If required by law: The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. For example, we may be required to report gunshot wounds or suspected abuse or neglect.
- Public health activities: The disclosure will be made for the purpose of controlling disease, injury or disability and only to public health authorities permitted by law to collect or receive information. We may also notify individuals who may have been exposed to a disease or may be at risk of contracting or spreading a disease or condition.
- Health oversight agencies: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.
- Legal proceedings: To assist in any legal proceeding or in response to a court order, in certain conditions in response to a subpoena, or other lawful process.
- Police or other law enforcement purposes: The release of PHI will meet all applicable legal requirements for release.
- Coroners, funeral directors: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law
- Medical research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.
- Special government purposes: Information may be shared for national security purposes, or if you are a member of the military, to the military under limited circumstances.
- Correctional institutions: Information may be shared if you are an inmate or under custody of law which is necessary for your health or the health and safety of other individuals.
- Workers' Compensation: Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.

Other uses and disclosures of your health information.

Business Associates: Some services are provided through the use of contracted entities called "business associates". We will always release only the minimum amount of PHI necessary so that the business associate can perform the identified services. We require the business associate(s) to appropriately safeguard your information. Examples of business associates include billing companies or transcription services.

Health Information Exchange: We may make your health information available electronically to other healthcare providers outside of our facility who are involved in your care.

Fundraising activities: We may contact you in an effort to raise money. You may opt out of receiving such communications.

Treatment alternatives: We may provide you notice of treatment options or other health related services that may improve your overall health.

Appointment reminders: We may contact you as a reminder about upcoming appointments or treatment.

We may use or disclose your PHI in the following situations UNLESS you object.

- We may share your information with friends or family members, or other persons directly identified by you at the level they are involved in your care or payment of services. If you are not present or able to agree/object, the healthcare provider using professional judgment will determine if it is in your best interest to share the information. For example, we may discuss post procedure instructions with the person who drove you to the facility unless you tell us specifically not to share the information.
- We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death.
- We may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts.

The following uses and disclosures of PHI require your written authorization:

- Marketing
- Disclosures of for any purposes which require the sale of your information

All other uses and disclosures not recorded in this Notice will require a written authorization from you or your personal representative.

Written authorization simply explains how you want your information used and disclosed. Your written authorization may be revoked at any time, in writing. Except to the extent that your doctor or this practice has used or released information based on the direction provided in the authorization, no further use or disclosure will occur.

Your Privacy Rights

You have certain rights related to your protected health information. All requests to exercise your rights must be made in writing. [Describe how the patient may obtain the written request document and to whom the request should be directed, i.e. practice manager, privacy officer.]

You have the right to see and obtain a copy of your protected health information.

This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. If requested we will provide you a copy of your records in an electronic format. There are some exceptions to records which may be copied and the request may be denied. We may charge you a reasonable cost based fee for a copy of the records.

You have the right to request a restriction of your protected health information.

You may request for this practice not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. We are not required to agree with these requests. If we agree to a restriction request we will honor the restriction request unless the information is needed to provide emergency treatment.

There is one exception: we must accept a restriction request to restrict disclosure of information to a health plan if you pay out of pocket in full for a service or product unless it is otherwise required by law.

You have the right to request for us to communicate in different ways or in different locations.

We will agree to reasonable requests. We may also request alternative address or other method of contact such as mailing information to a post office box. We will not ask for an explanation from you about the request.

You may have the right to request an amendment of your health information.

You may request an amendment of your health information if you feel that the information is not correct along with an explanation of the reason for the request. In certain cases, we may deny your request for an amendment at which time you will have an opportunity to disagree.

You have the right to a list of people or organizations who have received your health information from us.
This right applies to disclosures for purposes other than treatment, payment or healthcare operations. You have the right to obtain a listing of these disclosures that occurred after April 14, 2003. You may request them for the previous six years or a shorter timeframe. If you request more than one list within a 12 month period you may be charged a reasonable fee.

Additional Privacy Rights

- You have the right to obtain a paper copy of this notice from us, upon request. We will provide you a copy of this Notice the first day we treat you at our facility. In an emergency situation we will give you this Notice as soon as possible.
- You have a right to receive notification of any breach of your protected health information.

Complaints

If you think we have violated your rights or you have a complaint about our privacy practices you can contact:

Nancy Campbell – Privacy Officer
Raleigh Comprehensive & Cosmetic Dentistry
119 N Boylan Ave.
Raleigh, NC 27603

You may also complain to the United States Secretary of Health and Human Services if you believe your privacy rights have been violated by us.

If you file a complaint we will not retaliate against you for filing a complaint.

This notice was published and becomes effective on April 13, 2003

Raleigh Comprehensive & Cosmetic Dentistry
Robert L. Williamson, III, DDS, PA & Associates

Acknowledgement of Receipt Of Notice of Privacy Practices

Patient Name & Address: _____

_____

_____

I have received a copy of the Notice of Privacy Practices for the above named practice.

_____ _____

Signature Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- ❑ An emergency existed & a signature was not possible at the time.
- ❑ The individual refused to sign.
- ❑ A copy was mailed with a request for a signature by return mail.
- ❑ Unable to communicate with the patient for the following reason: _____
- ❑ Other:_____

_____

Prepared By _____

Signature _____

Date _____

Authorization to Release Health Information

Patient Information:

Name of Patient _____ Date of Birth _____

Address_____

City, State, Zip _____Phone _____

At my request the following information may be released:

- ☐ Entire record
- ☐ Financial records
- ☐ Office visit notes
- ☐ Marketing*
- ☐ On site record review by the patient
- ☐ Psychotherapy notes – if this box is checked only psychotherapy notes may be released.
- ☐ Diagnostic studies (list):
- ☐ Billing/Insurance
- ☐ Other as listed

*Financial compensation is received for this communication.

Entity or person who will receive the information:

Name _____

Address_____

City, State, Zip _____Phone _____

This authorization shall be in effect until the information has been forwarded as requested or until the course of treatment is complete.

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

I understand that released information may include a communicable disease diagnosis such as HIV.

_____Date _____

Signature of Patient or Personal Representative

_____

Description of Personal Representative's Authority (attach necessary documentation)

Revised August 2013

Authorization for Release of Information – Compound Release

Name of Patient _____ Date of Birth _____

Raleigh Comprehensive & Cosmetic Dentistry is authorized to release protected health information about the above-named patient in the following manner and to identify persons.

Entity to Receive Information. Check each person/entity that you approve to receive information.	**Description of information to be released.** Check each that can be given to person/entity on the left in the same section.
☐ Voice Mail ☐ Post Card Appointment Reminder	☐ Results of lab tests/x-rays ☐ Other_____
☐ Another person (s) (provide name and phone number)	☐ Financial ☐ Medical
☐ Email communication-Provide email address* _____ *For email communication to occur, please accept the disclosure below:	☐ Financial ☐ Medical ☐ Appointment reminders ☐ Breach notification
☐ Text Communication – Provider number * (919) 624-7207 _____ *For text communication to occur, please accept the disclosure below:	
☐ For **email and/or text communication** I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected.	

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization will remain in effect until revoked by the patient.

_____Date _____

Signature of Patient or Personal Representative

*Description of Personal Representative's Authority (attach necessary documentation)

_____

Revised-8-2022