BRITT DENTAL CENTER
Confidential Patient Information

PATIENT

Name _____ □ Male □ Female
Last First Middle Preferred

Address _____
City State Zip

Home Phone _____ Cell Phone _____ Email _____

Do we have your permission to contact you via email or text message with appointment reminders and other office information? Email: □ Yes □ No Text: □ Yes □ No

Date of Birth _____/_____/_____ SSN _____-_____-_____

Emergency Contact _____
Name Phone Number Relationship

Place of Employment _____Occupation _____

Has any member of your family previously been treated in our office? □ Yes □ No

If so, what is his/her name and relationship to you? _____

Do you have dental insurance? □ Yes □ No If yes, please provide us a copy of your most recent insurance card.

Are you interested in more information on our Britt Dental Care discount savings plan for you or your family as an alternative to dental insurance? □ Yes □ No

PERSON RESPONSIBLE FOR ACCOUNT □ Same as above

Name _____ Date of Birth _____/_____/_____ SSN _____-_____-_____

Place of Employment _____Occupation _____

Business Address _____ Business Phone _____
City State

MEDICAL HISTORY

Physician's Name _____ Phone Number _____

Date of last complete physical: _____ Are you under a doctor's care now? □ Yes □ No

Please describe any current medical conditions: _____

_____

Please list any medications (with dosages) or vitamins you are currently taking: _____

_____

Are you pregnant? □ Yes □ No If you are pregnant, when is your due date? _____

Are you currently nursing? □ Yes □ No (continued on reverse)

Are you allergic to any of the following? □ Penicillin □ Latex □ Other: _____

Do you have a history of endocarditis? □ Yes □ No

Have you received a prosthetic joint in the last 6 months? □ Yes □ No

Are you subject to prolonged bleeding? □ Yes □ No

Do you smoke or use tobacco in any form? □ Yes □ No Frequency: _____ Type: _____

Please CHECK if you have or have had any of the following:

□ High Blood Pressure
□ Low Blood Pressure
□ Rheumatic Fever
□ Congenital Heart Lesion
□ Artificial Heart Valve
□ Heart Murmur
□ Shielded Pacemaker
□ Unshielded Pacemaker
□ Mitral Valve Prolapse
□ Fainting or Dizziness
□ Swelling of Feet/Ankles/Hands
□ Stroke
□ Diabetes
□ Tuberculosis
□ Kidney Trouble
□ Lung Disease
□ Sleep Apnea
□ Liver Disease
□ Hepatitis A (infectious)
□ Hepatitis B (serum)
□ Hepatitis C
□ HIV Positive
□ Fever Blisters/Herpes
□ Cancer
□ Chemotherapy/ Radiation
□ Thyroid/Parathyroid Disease
□ Arthritis/Gout
□ Epilepsy or Seizures
□ Acid Reflux
□ Hypoglycemia
□ Drug/Alcohol Abuse
□ Psychiatric Care

Please describe any serious illness you have had not listed above: _____

DENTAL HEALTH

Why have you chosen our dental practice? _____

What is your reason for today's visit? _____

Previous Dentist _____Date of last visit: _____Need records transferred? □ Yes □ No

How important is it for you to keep your teeth for the rest of your life? □ Very □ Somewhat □ Not important

Have you ever had complications following dental treatment? _____

Have you ever received orthodontic treatment? □ Yes □ No Periodontal treatment? □ Yes □ No

Are you concerned about any of the following? □ Discolored teeth □ Discolored fillings

□ Spaces between teeth □ Broken or chipped teeth □ Missing teeth □ Crowding or crooked teeth

□ Loose teeth □ Joint/Jaw pain □ Other _____

Have you been told that you grind your teeth? □ Yes □ No Have you been told that you snore? □ Yes □ No

Do you have any other concerns not mentioned above? _____

_____

To the best of my knowledge, all of the preceding information is true and correct.
If I ever have a change in my health, I will inform the office at my next dental appointment without fail.

_____ _____

Patient or Guardian's Signature Date

BRITT DENTAL CENTER

FAMILY, COSMETIC, AND IMPLANT DENTISTRY

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Please read the following statements carefully.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us a written notice of your revocation submitted to the Contact Person mentioned in our Notice. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I have had full opportunity to read and consider the contents of this Consent for and Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Name of Patient _____

Signature of Patient _____ Date _____

I give permission for _____, my _____
(NAME) (RELATIONSHIP TO PATIENT)

to communicate with Britt Dental Center on my behalf.

Signature of Patient _____ Date _____

BRITT DENTAL CENTER
FAMILY, COSMETIC, AND IMPLANT DENTISTRY

ACCOUNT RESPONSIBILITY

Payment is due at time of service rendered.

Insurance:
We file all insurance for you as a courtesy. If your insurance company fails to cover all benefits, you are responsible for the remaining balance. We do our best to provide an accurate estimate regarding the fees for service, however, that is just an estimate and not a final quote.

ASSIGNMENT OF BENEFITS

I certify that I, and/or my dependent(s), have insurance coverage with _____ [Name of insurance company(ies)] and assign directly to Dr. Ben H. Britt, Jr. and Dr. Nicholas C. Beane all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named doctors may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Broken Appointments:
Fees for missed appointments or appointments canceled or rescheduled within ***48 hours*** will be assigned as follows:

Exam and Cleaning appointments: $50.00
Restoration procedures/Whitening appointments: 50% of scheduled fee

IF YOU ARE MORE THAN 10 MINUTES LATE TO YOUR APPOINTMENT, YOU MAY BE ASKED TO RESCHEDULE

Signature acknowledges receipt and understanding of financial agreement. I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

Signature of Patient, Parent, Guardian, or Personal Representative DATE

Please print name of Patient, Parent, Guardian, or Personal Representative Relationship to Patient

Britt Dental Center 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.

I. Dental Practice Covered by this Notice. This Notice describes the privacy practices of Britt Dental Center ("Dental Practice"). "We" and "our" means the Dental Practice. "You" and "your" means our patient.

II. How to Contact Us/Our Privacy Official. If you have any questions or would like further information about this Notice, you can contact Britt Dental Center by emailing smile@brittdental.com or by calling 919-957-4500.

III. Our Promise to You and Our Legal Obligations. The privacy of your health information is important to us. We understand that your health information is personal and we are committed to protecting it. This Notice describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights 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 or condition and related health care services.

We are required by law to:

- Maintain the privacy of your protected health information;
- Give you this Notice of our legal duties and privacy practices with respect to that information; and
- Abide by the terms of our Notice that is currently in effect.

IV. Last Revision Date. This Notice was last revised on January 1, 2019.

V. How We May Use or Disclose Your Health Information. The following examples describe different ways we may use or disclose your health information. These examples are not meant to be exhaustive. We are permitted by law to use and disclose your health information for the following purposes:

A. Common Uses and Disclosures

1. Treatment. We may use your health information to provide you with dental treatment or services, such as cleaning or examining your teeth or performing dental procedures. We may disclose health information about you to dental specialists, physicians, or other health care professionals involved in your care.

2. Payment. We may use and disclose your health information to obtain payment from health plans and insurers for the care that we provide to you.

3. Health Care Operations. We may use and disclose health information about you in connection with health care operations necessary to run our practice, including review of our treatment and services, training, evaluating the performance of our staff and health care professionals, quality assurance, financial or billing audits, legal matters, and business planning and development.

4. Appointment Reminders. We may use or disclose your health information when contacting you to remind you of a dental appointment. We may contact you by using a postcard, letter, phone call, voice message, text or email.

5. Treatment Alternatives and Health-Related Benefits and Services. We may use and disclose your health information to tell you about treatment options or alternatives or health-related benefits and services that may be of interest to you.

6. Disclosure to Family Members and Friends. We may disclose your health information to a family member or friend who is involved with your care or payment for your care if you do not object or, if you are not present, we believe it is in your best interest to do so.

7. Disclosure to Business Associates. We may disclose your protected health information to our third-party service providers (called, "business associates") that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use a business associate to assist us in maintaining our practice management software. All of our business associates are obligated, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

B. Less Common Uses and Disclosures

1. Disclosures Required by Law. We may use or disclose patient health information to the extent we are required by law to do so. For example, we are required to disclose patient health information to the U.S. Department of Health and Human Services so that it can investigate complaints or determine our compliance with HIPAA.

2. Public Health Activities. We may disclose patient health information for public health activities and purposes, which include: preventing or controlling disease, injury or disability; reporting births or deaths; reporting child abuse or neglect; reporting adverse reactions to medications or foods; reporting product defects; enabling product recalls; and notifying a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

3. Victims of Abuse, Neglect or Domestic Violence. We may disclose health information to the appropriate government authority about a patient whom we believe is a victim of abuse, neglect or domestic violence.

4. Health Oversight Activities. We may disclose patient health information to a health oversight agency for activities necessary for the government to provide appropriate oversight of the health care system, certain government benefit programs, and compliance with certain civil rights laws.

5. Lawsuits and Legal Actions. We may disclose patient health information in response to (i) a court or administrative order or (ii) a subpoena, discovery request, or other lawful process that is not ordered by a court if efforts have been made to notify the patient or to obtain an order protecting the information requested.

6. Law Enforcement Purposes. We may disclose your health information to a law enforcement official for a law enforcement purposes, such as to identify or locate a suspect, material witness or missing person or to alert law enforcement of a crime.

7. Coroners, Medical Examiners and Funeral Directors. We may disclose your health information to a coroner, medical examiner or funeral director to allow them to carry out their duties.

8. Organ, Eye and Tissue Donation. We may use or disclose your health information to organ procurement organizations or others that obtain, bank or transplant cadaveric organs, eyes or tissue for donation and transplant.

9. Research Purposes. We may use or disclose your information for research purposes pursuant to patient authorization waiver approval by an Institutional Review Board or Privacy Board.

10. Serious Threat to Health or Safety. We may use or disclose your health information if we believe it is necessary to do so to prevent or lessen a serious threat to anyone's health or safety.

11. Specialized Government Functions. We may disclose your health information to the military (domestic or foreign) about its members or veterans, for national security and protective services for the President or other heads of state, to the government for security clearance reviews, and to a jail or prison about its inmates.

12. Workers' Compensation. We may disclose your health information to comply with workers' compensation laws or similar programs that provide benefits for work-related injuries or illness.

VI. Your Written Authorization for Any Other Use or Disclosure of Your Health Information. Uses and disclosures of your protected health information that involve the release of psychotherapy notes (if any), marketing, sale of your protected health information, or other uses or disclosures not described in this notice will be made only with your written authorization, unless otherwise permitted or required by law. You may revoke this authorization at any time, in writing, except to the extent that this office has taken an action in reliance on the use of disclosure indicated in the authorization. If a use or disclosure of protected health information described above in this notice is prohibited or materially limited by other laws that apply to use, we intend to meet the requirements of the more stringent law.

VII. Your Rights with Respect to Your Health Information. You have the following rights with respect to certain health information that we have about you (information in a Designated Record Set as defined by HIPAA). To exercise any of these rights, you must submit a written request to our Privacy Official listed on the first page of this Notice.

A. Right to Access and Review. You may request to access and review a copy of your health information. We may deny your request under certain circumstances. You will receive written notice of a denial and can appeal it. We will provide a copy of your health information in a format you request if it is readily producible. If not readily producible, we will provide it in a hard copy format or other format that is mutually agreeable. If your health information is included in an Electronic Health Record, you have the right to obtain a copy of it in an electronic format and to direct us to send it to the person or entity you designate in an electronic format. We may charge a reasonable fee to cover our cost to provide you with copies of your health information.

B. Right to Amend. If you believe that your health information is incorrect or incomplete, you may request that we amend it. We may deny your request under certain circumstances. You will receive written notice of a denial and can file a statement of disagreement that will be included with your health information that you believe is incorrect or incomplete.

C. Right to Restrict Use and Disclosure. You may request that we restrict uses of your health information to carry out treatment, payment, or health care operations or to your family member or friend involved in your care or the payment for your care. We may not (and are not required to) agree to your requested restrictions, with one exception: If you pay out of your pocket in full for a service you receive from us and you request that we not submit the claim for this service to your health insurer or health plan for reimbursement, we must honor that request.

D. Right to Confidential Communications, Alternative Means and Locations. You may request to receive communications of health information by alternative means or at an alternative location. We will accommodate a request if it is reasonable and you indicate that communication by regular means could endanger you. When you submit a written request to the Privacy Official listed on the first page of this Notice, you need to provide an alternative method of contact or alternative address and indicate how payment for services will be handled.

E. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information for the six (6) years prior to the date that the accounting is requested except for disclosures to carry out treatment, payment, health care operations (and certain other exceptions as provided by HIPAA). The first accounting we provide in any 12-month period will be without charge to you. We may charge a reasonable fee to cover the cost for each subsequent request for an accounting within the same 12-month period. We will notify you in advance of this fee and you may choose to modify or withdraw your request at that time.

F. Right to a Paper Copy of this Notice. You have the right to a paper copy of this Notice. You may ask us to give you a paper copy of the Notice at any time (even if you have agreed to receive the Notice electronically). To obtain a paper copy, ask the Privacy Official.

G. Right to Receive Notification of a Security Breach. We are required by law to notify you if the privacy or security of your health information has been breached. The notification will occur by first class mail within sixty (60) days of the event. A breach occurs when there has been an unauthorized use or disclosure under HIPAA that compromises the privacy or security of your health information.

The breach notification will contain the following information: (1) a brief description of what happened, including the date of the breach and the date of the discovery of the breach; (2) the steps you should take to protect yourself from potential harm resulting from the breach; and (3) a brief description of what we are doing to investigate the breach, mitigate losses, and to protect against further breaches.

VIII. Special Protections for HIV, Alcohol and Substance Abuse, Mental Health and Genetic Information. Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including HIV-related information, alcohol and substance abuse information, mental health information, and genetic information. For example, a health plan is not permitted to use or disclose genetic information for underwriting purposes. Some parts of this HIPAA Notice of Privacy Practices may not apply to these types of information. If your treatment involves this information, you may contact our office for more information about these protections.

IX. Our Right to Change Our Privacy Practices and This Notice. We reserve the right to change the terms of this Notice at any time. Any change will apply to the health information we have about you or create or receive in the future. We will promptly revise the Notice when there is a material change to the uses or disclosures, individual's rights, our legal duties, or other privacy practices discussed in this Notice. We will post the revised Notice on our website (www.brittdental.com) and in our office and will provide a copy of it to you on request. The effective date of this Notice is January 1, 2019.

X. How to Make Privacy Complaints. If you have any complaints about your privacy rights or how your health information has been used or disclosed, you may file a complaint with us by contacting our Privacy Official listed on the first page of this Notice.

You may also file a written complaint with the Secretary of the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you in any way if you choose to file a complaint.