W. Randall Cline, D.D.S. 2208 Commerce Drive Monroe, NC. 28110

Patient's Name:____ Preferred Name:_______________________
(Last) (First) (MI)

Status: ☐ Married ☐ Single ☐ Minor Gender: ☐ Male ☐ Female

Date of Birth:______________ Social Security # ___________________ Parent/Guardian (If Minor)_____________

Address:____
(Street) (City) (State) (Zip)

Home #:________________ Cell #:________________ Work #:_______________ Employer:_______________

Email:____

Emergency Contact:___________________________ Preferred appointment time: ☐ Morning ☐ Afternoon

Relationship: ☐ Parent ☐ Spouse ☐ Family ☐ Friend ☐ Other Preferred appointment day: ☐M ☐ T ☐ Th

Phone #:_____________________________________

Primary Dental Information

Insurance Co.___________________________

Insurance phone #______________________

Employer: ____________________________

Group Number:________________________

Subscriber ID or SS #___________________

Subscriber Name:______________________

Subscriber Date of Birth:________________

Secondary Dental Information

Insurance Co.___________________________

Insurance phone #______________________

Employer: ____________________________

Group Number:________________________

Subscriber ID or SS #___________________

Subscriber Name:______________________

Subscriber Date of Birth:________________

I authorize payment directly to **W.Randall Cline, D.D.S.**, of insurance benefits otherwise payable to me. I understand that my dental insurance or carrier or payer of my dental benefits may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, by my dental care payer.

Patient / Guardian Signature:____________________________________ **Date:**________________

To the best of my knowledge, all of the information provided above is true and correct.

____ Date ____________________________

Patient / Guardian Signature

Whom may we thank for referring you to our practice?

☐Yellow Pages ☐Direct Mail ☐Other________________________

☐Internet ☐Walk-In ☐Another Patient_______________

W. Randall Cline, D.D.S. 2208 Commerce Drive Monroe, NC 28110

MEDICAL HISTORY

Print Name: ______________________

Your answers to the following are for our records only and are confidential.

Are you currently under a physician's care? Yes No
If yes, please explain: ______________________

Please list **all** medications you are currently taking including vitamins, natural products or herbal supplements.
Please list: ______________________

Please circle any of the following which you have at present or had in the past:

Latex/metal sensitivity	Yes	Allergies/Hives	Yes	Cancer	Yes
Artificial heart valves	Yes	Asthma	Yes	Diabetes	Yes
Heart murmurs	Yes	Arthritis/Rheumatism	Yes	Stroke	Yes
AIDS/HIV	Yes	Rheumatic fever	Yes	Chemotherapy	Yes
Pacemaker	Yes	Liver disease	Yes	Radiation treatment	Yes
Epilepsy/Seizure	Yes	Psychiatric problems	Yes	Blood disorder	Yes
Heart disease	Yes	Tuberculosis	Yes	Kidney problems	Yes
Hepatitis	Yes	Emphysema	Yes	Smoke/forms of tobacco	Yes
Implant prosthesis	Yes	Ulcers	Yes	Artificial joints/prosthesis	Yes
Bleed excessively	Yes	Venereal disease	Yes	Fainting/Dizzy Spells	Yes
Drug addiction	Yes	Anemia/Hemophilia	Yes	Take Birth Control	Yes
Codeine Allergy		Thyroid disease	Yes	Could you be pregnant	Yes
Penicillin Allergy		High blood pressure	Yes	If Yes, Due Date:	________

Have you had an allergic reaction to any medications or substances? Yes
Other: ______________________

DENTAL HISTORY

Purpose of initial visit: ______________________
Date of last cleaning: ______________________
Previous dentist name: ______________________
How often do you brush your teeth? ______________________
How often do you floss your teeth? ______________________

Are you happy with the appearance of your teeth?	Yes	No
Have any teeth been removed?	Yes	No
Have any teeth been replaced?	Yes	No
Are you interested in permanent replacement?	Yes	No
Have you had soreness around your face or ear?	Yes	No
Do you feel your breath is unpleasant at times?	Yes	No
Does food get caught in your teeth?	Yes	No

Do you have a fear of dentists?	Yes
Were x-rays taken?	Yes
Have you had orthodontic work?	Yes
Do you grind your teeth?	Yes
Does you jaw click or pop?	Yes
Have you had gum surgery?	Yes
Do your gums bleed or hurt?	Yes

If Yes, when?____________
Are your teeth sensitive to:
Hot Cold Sweets Pressure None
Do you have any questions or concerns?
____

Have you had complications with dental treatment in the past? Yes No
If yes, please explain: ______________________

To the best of my knowledge, all of the preceding answers and information provided are true and correct.
If I ever have any changes in my health, I will inform the doctors at my next appointment without fail.

______________________ ______________________
Signature of Patient **Date**

W. RANDALL CLINE, D.D.S. **(704)283-2998 phone**
2208 COMMERCE DRIVE
Monroe, NC 28110

CONSENT FOR GENERAL DENTAL PROCEDURES

You have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment.

It is very important that you provide your dentist with accurate information before, during and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre-and post treatment instructions, referrals to other dentists or specialists, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.

Certain heart conditions may create a risk of serious or fatal complications. If you (or a minor patient) have a heart condition or heart murmur, advise your dentist immediately so he/she can consult with your physician if necessary.

The patient is an important part of the treatment team. In addition to complying with instructions given to you by this office, it is important to report any problems or complications you experience so they can be addressed by your dentist.

Do not consent to treatment until you discuss potential benefits, risks, and complications with your dentist and all of your questions are answered. By consenting to treatment you signal your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

In the event that W. Randall Cline D.D.S., or a staff member is exposed to my blood or other bodily fluids, I agree to have my blood drawn and tested for Hepatitis B virus (HBV), Hepatitis C virus (HCV), and the human immunodeficiency virus (HIV). I understand that this testing would be done in a confidential manner, and would be made available only to the person who was exposed, and the person would be advised of his/her rights regarding protected health information.

In an effort to control the increasing cost of dental care, any claims or disputes against this office shall be resolved by "binding arbitration". By signing this agreement, the patient agrees with the office of Dr. Randall Cline, that any dispute relating to dental or medical care services rendered for any condition, including any services rendered prior to the date this agreement was signed, and any dispute arising out of the diagnosis, treatment, or care of the patient, including the scope of this arbitration clause and the arbitrability of any claim or dispute, against whenever made, (including to the full extent permitted by applicable law third parties who are not signatories to this agreement including associates) shall be resolved by binding arbitration, by the National Arbitration Forum, under the Code of Procedure then in effect. The patient understands that the result of this arbitration agreement is that claims, including malpractice claims he/she may have against the doctor, cannot be brought as a lawsuit in court before a judge, and agrees that all such claims will be resolved as described in this section.

______________________________________ ______________________

Patient Signature **Date**

CONSENT TO LOCAL ANESTHESIA

I hereby authorize Dr. Randall Cline, to administer local anesthesia to me. I have been informed of the usual side effects and have been informed of the advantages and disadvantages of anesthesia. I understand the risk of reactions, such as redness, swelling, pain, itching, vomiting, anaphylactic shock and/ or permanent nerve damage or other unforeseeable complications which may result from the administration of anesthetics. I realize that in spite of the possible complications, the use of anesthesia is necessary and desired by me.

______________________________________ ______________________

Patient Signature **Date**

W. Randall Cline, D.D.S.

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.

This Notice describes how we may use and disclose your protected health information to provide treatment, obtain payment and conduct health care operations and for other purposes permitted or required by law. It also describes your rights concerning your protected health information. "Protected health information" is information about you, including demographic information that may identify you and relates to your past, present or future physical or mental health or condition and related health care services.

We are required by law to follow the practices described in this Notice. We may change the terms of this Notice at any time. The new Notice will be effective for all protected health information we maintain at that time including health information we created or received before we made the changes.

You may obtain a copy of our Notice of Privacy Practices at any time by calling our office or requesting one at your next appointment.

Uses and Disclosures of Health Information

Treatment: We will use and disclose your health information to provide, coordinate and manage health care and related services for you. For example we will disclose information to a specialist to whom you have been referred to ensure the provider has enough information to diagnose and/or treat you. We may also disclose information to a laboratory that, at our request, becomes involved in your treatment.

Payment: We may use and disclose your information to obtain payment for services we provided to you. For example we will send the necessary information to your health or dental insurance company to obtain payment for the treatment provided.

Healthcare Operations: We will use and disclose your health information to conduct the business activities of this office. These activities include, but are not limited to, quality assessment and improvement activities, review of the performance and qualifications of employees, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

We may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when we are ready to begin your treatment. We may call to remind you of an appointment and if you are not available we may leave a message on your voice mail or with another member of your household.

We will share your protected health information with business associates that perform specific functions for our practice such as billing. When a business arrangement of this type requires the use of your information, we will have a written contract with the third party to protect the privacy of your protected health information.

Others Involved in Your Health Care: 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 or other person to the extent necessary to help with your health care or with payment for your health care, but only if you agree. If we determine it is in your best interest based on our professional judgement or experience with common practices, we may allow another person to pick up filled prescriptions, medical supplies, x-rays or other forms of health information.

We may use or disclose protected health information to notify or assist in notifying a family member, a personal representative or any other person responsible for your care of your location, your general condition or death. If you are present prior to the use or disclosure of your protected health information, we will provide you with the opportunity to object to such uses or disclosures. Finally, we may use or disclose your protected health information

to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family members or others involved in your health care.

Emergencies: In the event of your incapacity or in emergency circumstances, we may use or disclose your protected health information to treat you.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization: Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that an action has already been taken in reliance on the authorization.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object
We may use or disclose your protected health information in the following situations without your consent or authorization. These situations include:

Required By Law: We may use or disclose your protected health information to the extent that law requires the use or disclosure. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law.

We must make disclosures to you and, when required, to the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of the Privacy Rule, Section 164.500 et. seq.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. Additionally, we may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

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.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the practice, and (6) medical emergency (not on the Practice's premises) and it is likely that a crime has occurred.

Military Activity and National Security: When the appropriate conditions apply, we may disclose, to military authorities, protected health information of individuals who are Armed Forces personnel. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities including for the provision of protective services to the President or others legally authorized.

Workers' Compensation: we may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally established programs.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

Your Rights

Your rights with respect to your protected health information and how you may exercise those rights are outlined below.

You have a right to obtain a copy and/or inspect your health information: Health information includes treatment records, billing records and any other records used by us to make decision about your treatment. You may obtain a form from our office to request access. A reasonable cost-based fee will be charged for expenses such as staff time, copies and postage. Contact us as indicated at the end of this Notice to obtain information about our fees or if you have any questions about your access.

You have a right to request a restriction on the use and disclosure of your protected health information: You may ask us not to use or disclose some part of your protected health information for the purposes of treatment, payment or operations. You may also request that we not disclose some part of your information to family and others who may be involved in your care or for notification purposes as otherwise described in this Notice. We are not required to agree to the restrictions but if we do, we are obligated to abide by the agreement except in cases of emergency. You may request a restriction by sending your request in writing to our Privacy Contact.

You have a right to request to receive confidential communications by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Contact.

You may have the right to request an amendment to your protected health information. You may request that we amend protected health information about you. Your request must be in writing with an explanation as to why the information should be amended. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. 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. This right applies to disclosures made by our Business Associates or us. It excludes disclosures for treatment, payment or healthcare operations as described in this Notice of Privacy Practices, to you, to family members or friends involved in your care, for notification purposes or as a result of an authorization signed by you. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003 for up to the previous 6 years. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations. If you request an accounting more than once in a 12 month period, we will charge you a reasonable cost-based fee for responding to the additional request.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

Questions and Complaints

If you have any questions, concerns or want more information about our privacy practices please contact us using the information below.

If you are concerned that we may have violated your privacy rights or you disagree with a decision we have made regarding your access to your health information or any other request you have made in the exercise of your rights, you may send your complaint to us using the information below. You may also submit a written complaint to the Secretary of Health and Human Services. Contact us for the address of the Department of Health and Human Services.

We support your right to the privacy of your health information and we will not retaliate against you in any way for filing a complaint.

Contact our office:

W. Randall Cline, D.D.S.
2208 Commerce Drive
Monroe, NC 28110

704-283-2998 Phone
704-283-6883 Fax

This notice was published and becomes effective on **09/13/2011.**

W. Randall Cline, D.D.S. 2208 Commerce Drive Monroe, NC 28110

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

You May Refuse to Sign This Acknowledgement

Patient Name: ____ Date:_____________

Patient Address: ____
Street City Zip

I have read and received a copy of the Notice of Privacy Practices for Dr. W. Randall Cline.

Patient Signature: ____ Date:______________

For Office Use Only

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

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

Prepared By: ____

Signature: ____

Date: ____