Hampton Woods Dental, PC
Christopher L. Howlett, DMD

Patient Information

Name:	Preferred Name:
Street Address:	
City, State, Zip:	
Date of Birth:	Social Security #:
Home Phone:	Work Phone:
Mobile Phone:	Other Phone:
Email address:	
Whom may we thank for inviting you?	

Account Information

Person Financially Responsible:	Relationship to patient:
Street Address (if different from above):	
City, State, Zip:	
Date of Birth:	Social Security #:
Home Phone:	Work Phone:
Mobile Phone:	Other Phone:
Employer:	
Dental Insurance Company:	Group #:

Spouse Name:	Work Phone:
Mobile Phone:	Other Phone:
Date of Birth:	Social Security #:
Employer:	
Dental Insurance Company:	Group #:

Consent

Please read carefully, sign and date:

1. I hereby authorize Dr. Harry Davis or designated staff to take x-rays, impressions, photographs, and any other diagnostic aids deemed appropriate by Dr. Howlett to make a thorough diagnosis of the above named patient's dental needs.
2. Upon such diagnosis, I authorize Dr. Howlett to perform all recommended treatment mutually agreed upon by me. If necessary, I understand that a referral to another doctor or specialist may be required to complete my treatment.
3. I consent to the use of appropriate medication and therapy as deemed necessary. I fully understand that using anesthetic agents involves a certain degree of risk.
4. I understand that a **2 Business Day** notice is required should I wish to reschedule an appointment to avoid a broken appointment charge.
5. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents. I understand that payment is due at the time of service. In the event payments are not received by agreed upon dates, I understand that a **monthly finance charge of 1.5% (18% APR)** will be added to my account.

Signature_____ **Date** _____
(Patient, parent or responsible party)

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Medical History

The following information is essential for this office to provide dental care in a manner that is compatible with your general health. Your cooperation in providing accurate information is necessary to meet your dental needs safely and efficiently. **Please answer all questions. Incorrect information can be dangerous to your health.**

Primary Physician's Name:	Phone:
Address:	City, State, Zip:
Have you been under the care of a medical doctor during the past two years?	**Yes** **No**
If yes, please describe:	

Please list any medications, including asprin, you are taking and the condition you are taking it for:	
Medication:	Taking it for?
Medication:	Taking it for?
Medication:	Taking it for?
Medication:	Taking it for?

Please list any medications you are allergic to and what type allergic reaction you had:	
Medication:	Reaction
Medication:	Reaction

Have you consulted, or been treated by a psychiatrist, psychologist, or counselor?	**Yes** **No**
If yes, please describe:	

Do you have or have you had any of the following? Please circle Yes or No for each item.

Heart Disease	Y	N	Hepatitis A or B	Y	N	AIDS or HIV Positive	Y	N
Rheumatic Fever	Y	N	Stomach Problems	Y	N	Tumors or Growths	Y	N
Rheumatic Heart Disease	Y	N	Tuberculosis	Y	N	Cancer	Y	N
Heart Murmur	Y	N	Breathing, Sinus Problems	Y	N	Radiation Therapy	Y	N
Congenital Heart Disease	Y	N	Emphysema	Y	N	Chemotherapy	Y	N
Mitral Valve Prolapse	Y	N	Asthma	Y	N	Stroke	Y	N
Artificial Heart Valve	Y	N	Hay Fever or Allergies	Y	N	Jaundice or Liver Disease	Y	N
Heart Pacemaker	Y	N	Arthritis	Y	N	Diabetes	Y	N
Artificial Joints	Y	N	Seizures or Fainting Spells	Y	N	Kidney Problems	Y	N
High Blood Pressure	Y	N	Thyroid Problems	Y	N	Venereal Disease	Y	N
Excessive Bleeding	Y	N	Latex Allergy	Y	N	Allergy to metals	Y	N

If you have had any other medical problem, disease, major operation or condition not listed above, please describe:

_____

_____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medications.

Signature_____ **Date** _____

(*Patient, parent or responsible party*)

Dental History

Previous Dentist's Name: _____
Previous Dentist's Address: _____
Date of last visit: _____ what was done? _____ Last Complete X-rays: _____

Please answer the following questions by circling Yes or No for each item.

Y	N	Do you have teeth that are sensitive to temperature, sweets, or biting pressure?
Y	N	Do you have any broken or cracked teeth?
Y	N	Do you grind or clench your teeth?
Y	N	Do you have parents that experienced gum disease or tooth loss?
Y	N	Do you smoke or use other tobacco products?
Y	N	Do you frequently get cold sores, blisters, or other oral lesions?
Y	N	Do you have gums that bleed or hurt?
Y	N	Do you have any loose teeth or changes in your bite?
Y	N	Do you tend to get food caught between your teeth easily?
Y	N	Do you bite your lips or cheeks regularly?
Y	N	Have you ever had orthodontic treatment (braces)?
Y	N	Have you ever had oral surgery (including extraction of teeth)?
Y	N	Have you ever had periodontal (gum) treatments or surgery?
Y	N	Have you ever had a bite appliance or mouth guard?
Y	N	Have you ever had a serious injury to the mouth or head?
Y	N	Have you ever experienced tired jaws, especially in the morning?
Y	N	Have you ever had clicking or popping in the jaw joint?
Y	N	Have you ever had pain in the jaw joint, ear, or side of face?
Y	N	Do you have difficulty in chewing on either side of the mouth?
Y	N	Do you frequently have headaches, neckaches, or shoulder aches?

Have you ever had an upsetting dental experience? If so, please describe:
_____
_____

Do you feel nervous about having dental treatment? If yes, what is your biggest concern?
_____

If you could easily change anything about the appearance of your smile, what would it be?
_____
_____

What are your long-term goals for your oral health?
_____
_____

How often do you brush your teeth? _____ How often do you floss your teeth? _____

(Office use only) **History Review**

Doctor Signature _____ Date _____

Notice of Privacy Practices

Hampton Woods Dental, PC
Christopher L. Howlett, DMD

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.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect **May 1, 2013**, 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, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice 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.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.

Required by Law. We may use or disclose your health information when we are required to do so by law.

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

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 the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Other Uses and Disclosures of PHI
Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

Your Health Information Rights

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the

address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. 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 the additional requests.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

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. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

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 if 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.

Our Privacy Official: Elizabeth Howlett
Telephone: (864) 292-2110 Fax: (864) 268-6472
Address: 2 East Lee Road, Taylors, SC 29687-3238
eMail: office@hamptonwoodsdental.com

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowedgement*

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)

HAMPTON WOODS
DENTAL
FAMILY • IMPLANT • SEDATION

REQUEST FOR RELEASE OF DENTAL RECORDS TO:
Hampton Woods Dental, PC

Date: _____

Dentist's Name: _____

Address: _____

City, State, Zip: _____

I hereby request that my dental records be released to:

Hampton Woods Dental
Dr. Christopher L. Howlett
2 East Lee Road
Taylors, SC 29687

Digital x-rays or other digital records: records@hamptonwoodsdental.com

Patient's Name: (Printed) _____

(Signature) _____