DR. PAUL E. GAUTHIER
GENERAL AND ESTHETIC DENTISTRY

SOPINESDENTAL@GMAIL.COM
910-692-6500

655 SW BROAD STREET, SOUTHERN PINES
NORTH CAROLINA, 28387

PATIENT INFORMATION

Date: ☐ NEW PATIENT ☐ UPDATE

Patient:

LAST FIRST MI PREFERRED TITLE

☐ MALE ☐ FEMALE ☐ CHILD* ☐ STUDENT** ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

*IF CHILD, PROVIDE PARENT/GUARDIAN NAME(S) BELOW:

PARENT/GUARDIAN NAME(S)

**IF STUDENT, PLEASE COMPLETE: ☐ FULL-TIME ☐ PART-TIME

SCHOOL/LOCATION

Patient Date of Birth: Patient SSN:

Address:

ADDRESS LINE 1

ADDRESS LINE 2

CITY ST ZIP CODE

E-Mail:

HOME:
CELL:
OTHER:
PAGER:
FAX:

Referral? ☐ Yes ☐ No Referred by:

MEDICAL HISTORY UPDATES

GENERAL HEALTH: ☐ EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR

☐Y ☐N Under a physician's care now?

☐Y ☐N Any hospitalization in the past 5 years?

☐Y ☐N Any serious illnesses/surgeries?

☐Y ☐N Use tobacco in any form? If Yes, Type:

☐Y ☐N Is pre-medication required before dental visits due to heart condition or artificial joint?

FEMALE PATIENTS: ☐Y ☐N Currently nursing? ☐Y ☐N Currently pregnant? Due Date:

Do you know of any reason why routine dental procedures might pose a risk to you, our staff, or other patients? ☐ Y ☐ N
If yes, please describe:

Is there anything important about your medical condition we have not asked? ☐ Y ☐ N If yes, please describe:

DENTAL INSURANCE

Insurance Co_____ Subscriber _____

Member ID _____ Subscriber SSN_____ Subscriber DOB_____

Group #_____ Insurance Phone #_____

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ALL PATIENTS: DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY): ☐ NONE

☐ ACID REFLUX	☐ BULIMIA	☐ HEARING PROBLEMS	☐ PSYCHIATRIC TREATMENT
☐ ADHD	☐ CANCER/MALIGNANCY	☐ HEART ATTACK	☐ RADIATION/CHEMO
☐ AIDS/HIV	☐ CEREBRAL PALSY	☐ HEART DISEASE	☐ RESPIRATORY DISEASE
☐ ANEMIA	☐ CHEMICAL DEPENDENCY	☐ HEART MURMUR	☐ RHEUMATIC FEVER
☐ ANOREXIA	☐ CHICKEN POX	☐ HEPATITIS	☐ SINUS PROBLEMS
☐ ANXIETY	☐ CONVULSIONS	☐ HIGH BLOOD PRESSURE	☐ STROKE
☐ ARTIFICIAL HEART VALVE	☐ DEPRESSION	☐ KIDNEY DISEASE	☐ THYROID CONDITION
☐ ARTIFICIAL JOINTS	☐ DIABETES	☐ LIVER PROBLEMS	☐ TUBERCULOSIS
☐ ARTHRITIS	☐ DIZZINESS/FAINTING	☐ MITRAL VALVE PROLAPSE	☐ ULCERS
☐ ASTHMA	☐ EPILEPSY/SEIZURES	☐ MONONUCLEOSIS	☐ VENEREAL DISEASE
☐ AUTISM/ASPERGER'S	☐ FREQUENT EAR INFECTIONS	☐ PACEMAKER	
☐ BLEEDING DISORDER	☐ FREQUENT HEADACHES	☐ OTHER – PLEASE LIST:	

ALLERGIES/ALLERGIC REACTIONS

ALL PATIENTS: ARE YOU ALLERGIC TO OR HAVE YOU EVER HAD ANY REACTION TO THE FOLLOWING? (CHECK ALL THAT APPLY):

☐ ASPIRIN	☐ CODEINE	☐ LACTOSE INTOLERANCE	☐ SLEEPING PILLS	☐ NONE
☐ ANESTHETIC – LOCAL	☐ DAIRY	☐ METAL SENSITIVITY	☐ SULFA DRUGS	
☐ BARBITURATES	☐ LATEX	☐ NITROUS OXIDE SEDATION	☐ PENICILLIN/OTHER ANTIBIOTICS	
☐ OTHER – PLEASE LIST				

MEDICATION INFORMATION

ALL PATIENTS: ARE YOU CURRENTLY TAKING ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY): ☐ NONE

☐ ANTIBIOTICS/SULFA DRUGS	☐ ANTIHISTAMINES/ALLERGY	☐ DAILY ASPIRIN	☐ BLOOD PRESSURE MEDICATIONS
☐ BLOOD THINNERS	☐ CANCER/CHEMO MEDICATIONS	☐ CORTISONE/STEROIDS	☐ HEART MEDICATION/DIGITALIS
☐ INSULIN	☐ NITROGLYCERIN	☐ ORAL CONTRACEPTIVES	☐ OSTEOPOROSIS MEDICATIONS
☐ RECREATIONAL DRUGS	☐ THYROID MEDICATIONS	☐ TRANQUILIZERS	☐ OTHER DIABETIC MEDICATIONS
☐ OTC DRUGS/ MEDICATIONS (PLEASE LIST BELOW)	☐ OTHER (PLEASE LIST BELOW)		

DRUG NAME	DOSAGE	REASON PRESCRIBED

PATIENT CONSENT

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status of if my medication changes, I shall inform the dentist and staff at the next appointment without fail.

Signature: DATE:

RELATIONSHIP TO PATIENT: ☐ADULT PATIENT ☐PARENT ☐GUARDIAN ☐OTHER

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ACKNOWLEDGEMENT OF PRIVACY PRACTICES

Updated 2013

My signature confirms that I have been informed of my rights to privacy regarding my protected personal and health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand the terms in which my personal health and identification information may be used.

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Name: **Date:**

RELATIONSHIP TO PATIENT: ☐ SELF ☐ PARENT ☐ GUARDIAN ☐ OTHER(PLEASE EXPLAIN)

Please list any dependent children under the age of 18 also covered by this acknowledgement:

I give permission for the following communications to be used by Dr. Paul E. Gauthier, DDS .

☐ Cell phone: ☐ Text Message reminders permitted
☐ Home phone ☐ Work ☐ E-Mail:

I give permission for Dr. Paul E Gauthier, DDS to disclose their identity when calling; to anyone who may answer my phone. ☐Y ☐N ☐ Other (Please explain)

I grant permission for Dr. Paul E. Gauthier, DDS to leave a message on:

☐ Home phone ☐ Work Phone
☐ Cell Phone ☐ With any person who may answer when calling the home or cell phone
☐ None of the above (Please explain)

I would like the following person(s) to have access to my personal information including but not limited to appointments, treatment, and billing of myself and any dependent children listed above:

For Office Use Only:

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:

☐ The patient refused to sign
☐ Communication barriers
☐ Emergency situation
☐ Other – please list:

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NOTICE OF PRIVACY PRACTICES

The dental practice of Dr. Paul E. Gauthier understands that your medical and dental information is personal and we are committed to protecting it. We create a record of the care and services you receive at our office. We need this record to provide you with quality dental care and to comply with certain legal requirements. This notice will tell you about the way we may use and share your Protected Health Information (PHI). We have a Legal Duty to: Keep your personal health information private
1. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information
2. Follow the terms of the current notice
3. Notify you in a timely manner of an accidental disclosure of your private health information We Have the Right to: 1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law. 2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes. Notice of Change to Privacy Practices: When we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

USE AND DISCLOSURE OF YOUR PRIVATE HEALTH INFORMATION

The following describes different ways that we use and disclose your private health information. Not every use or disclosure is listed. However, we have listed all the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical or dental information for any purpose not listed below without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.
1. For Treatment: We may use your PHI to provide you with dental treatment or services. We may disclose medical information about you to healthcare providers who may be involved in your treatment both directly and indirectly.
2. For Payment: We may use and disclose your PHI for payment purposes. A bill may be sent to you, a third-party payer or to a collection agency. The information on or accompanying the bill may include your treatment information.
3. We will not sell or use your personal health information for marketing or fundraising purposes without first obtaining your signed authorization.
4. We are required to inform you if there are any financial conflicts of interest with us and the products or services utilized by us.
5. If you pay for your dental treatment and request that we not disclose the procedure to your insurance company we must comply with your request as long as you pay in full for the procedure in a timely manner.
6. You have the right to request a copy of your health records and to request the type of format you want (paper or electronic). If you request, in writing, that a copy of your records be sent to a specific third party, we are required to send them as directed and in a timely manner.
7. You have the right to be notified upon a breach of any of your unsecured Protected Health Information. PATIENT ACKNOWLEDGEMENT I have had an opportunity to read and consider the contents of this Notice of Privacy Practices. I understand that, by signing this form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations. I understand that I may request in writing that you restrict how my private health information is used or disclosed

PATIENT/GUARDIAN NAME:(PRINT)_____
RELATIONSHIP TO PATIENT:_____
SIGNATURE: _____ DATE: _____