NORTH STATE PERIO

✦ PERIODONTICS & IMPLANTOLOGY ✦

Referred by: _____ PLEASE PRINT

Mr.
Ms.
Mrs.
Miss _____

LAST NAME | FIRST NAME | MIDDLE | HOME TELEPHONE

SOCIAL SECURITY NO. | DATE OF BIRTH | SEX | MARITAL STATUS | CELL TELEPHONE

STREET ADDRESS | APT NO. | CITY | STATE | ZIP

EMPLOYED BY | OCCUPATION | BUSINESS TELEPHONE

SPOUSE'S NAME | SPOUSE'S CELL TELEPHONE

SPOUSE'S EMPLOYER | SPOUSE'S OCCUPATION | SPOUSE'S BUSINESS TELEPHONE

NEAREST FRIEND OR RELATIVE NOT LIVING IN THE SAME HOUSEHOLD | RELATIONSHIP TO PATIENT | TELEPHONE

I herby authorize Tolmie, Rasenberger & van Kesteren, DDS, PA to release any information regarding my treatment, including all documents, records and radiographs, to third party payers and/or health practitioners. I understand that the policy of Drs. Tolmie, Rasenberger, van Kesteren and Getz states that I, personally, am responsible for payment of all fees; however, should special circumstances necessitate other financial arrangements, my signature below authorizes my insurance company to pay benefits directly to my doctor.

_____ _____

(Signature) (Date)

DENTAL INSURANCE INFORMATION

Primary Dental Carrier Information:

Employer/Provider of Dental Insurance: _____ Group #_____

Policyholder Name: _____ Policyholder Date of Birth: _____

Policyholder Social Security/ID Number: _____

Dental Insurance **Company** Name: _____

Claims Mailing Address: _____

CITY STATE ZIP

Telephone Number: _____

Time 4:30 PM | North State Perio | Date 11/14/2018

Medical History - updated

Patient Name: | Birth Date: | Date Created:

Regular Dentist/ Practice	○ Yes ○ No	If yes	
Physician/ Practice	○ Yes ○ No	If yes	
Emergency Contact-Name and Telephone	○ Yes ○ No	If yes	

Is there a sedation need for any dental care? ○ Yes ○ No

Please Check if you are allergic to any of the following:

Dental anesthetic	○ Yes ○ No	Penicillin	○ Yes ○ No	Codeine or other Narcotics	○ Yes ○ No
Sulfa drugs	○ Yes ○ No	Latex	○ Yes ○ No	Aspirin / NSAIDS	○ Yes ○ No
Betadine / Iodine	○ Yes ○ No	Other (Please List)	○ Yes ○ No		

I require an Antibiotic prior to Dental Treatment.	○ Yes ○ No	If yes	
I have taken a pill or had an injection for bone density issues. If yes, provide treatment dates:	○ Yes ○ No	If yes	
I am taking a Blood Thinner.	○ Yes ○ No	If yes	
PLEASE list all medications you are currently taking, as well as any vitamins and/or supplements:	○ Yes ○ No		

Do you HAVE, or have you ever HAD, any of the following:

Cancer	○ Yes ○ No	Jaundice / Liver disease	○ Yes ○ No	Asthma	○ Yes ○ No
Radiation	○ Yes ○ No	Hepatitis A	○ Yes ○ No	Pneumonia/Bronchitis/Cough	○ Yes ○ No
Chemotherapy	○ Yes ○ No	Hepatitis B	○ Yes ○ No	Emphysema	○ Yes ○ No
Heart valve replacement	○ Yes ○ No	Hepatitis C	○ Yes ○ No	Respiratory problems	○ Yes ○ No
Heart murmur / MVP	○ Yes ○ No	HIV / AIDS	○ Yes ○ No	Sinus problems / Hay fever	○ Yes ○ No
Valvular heart damage	○ Yes ○ No	Deficient immune system	○ Yes ○ No	Snoring / Sleep Apnea	○ Yes ○ No
High blood pressure	○ Yes ○ No	Tuberculosis	○ Yes ○ No	Chronic fatigue/Night sweats	○ Yes ○ No
Low blood pressure	○ Yes ○ No	Blood transfusion	○ Yes ○ No	Convulsions / Epilepsy	○ Yes ○ No
Irregular heartbeat	○ Yes ○ No	Abnormal bleeding	○ Yes ○ No	Fainting spells	○ Yes ○ No
Chest pain / Angina	○ Yes ○ No	Kidney disease	○ Yes ○ No	Psychiatric care	○ Yes ○ No
Heart attack(s)	○ Yes ○ No	Are you on Dialysis?	○ Yes ○ No	Back surgery	○ Yes ○ No
Heart surgery	○ Yes ○ No	Thyroid disease	○ Yes ○ No	Delay in healing	○ Yes ○ No
Cardiac pacemaker	○ Yes ○ No	Stomach Ulcers	○ Yes ○ No	Bruise easily	○ Yes ○ No
Stroke	○ Yes ○ No	Arthritis / Joint disease	○ Yes ○ No	Chemical dependency	○ Yes ○ No
Anemia	○ Yes ○ No	Joint replacement	○ Yes ○ No	Alcohol dependency	○ Yes ○ No
Blood disorder	○ Yes ○ No	Osteonecrosis	○ Yes ○ No	Smoke tobacco	○ Yes ○ No
Low blood sugar	○ Yes ○ No	Osteoporosis / Osteopenia	○ Yes ○ No	Smokeless tobacco	○ Yes ○ No
Diabetes I / II	○ Yes ○ No	Eye disease / Glaucoma	○ Yes ○ No	If female, are you pregnant?	○ Yes ○ No

If Diabetic, what was your last A1C ?

Have you had any medical conditions, illnesses or surgeries not listed above?	○ Yes ○ No	If yes	

By signing below, I affirm that I have carefully reviewed the information contained in the document and that said information is true.

Signature of Patient, Parent or Guardian:

X

Date:_____

North State Perio DBA Tolmie, Rasenberger & van Kesteren, DDS, PA
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.
[2315 West Arbors Drive, Suite 100 Charlotte, NC 28262 (704) 549-4991]

Effective Date: April 14, 2003 **Revised: August 1, 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.northstateperio.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.

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

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. [Direct request to Privacy Officer 2315 West Arbors Drive, Suite 100 Charlotte, NC 28262.]

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:

[Privacy Officer 2315 West Arbors Drive, Suite 100 Charlotte, NC 28262]

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.

Tolmie, Rasenberger & van Kesteren, DDS, PA
DBA North State Perio

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of this office's Notice of Privacy Practices.

_____
(Please Print Patient Name)

_____
(Signature of Patient or Guardian)

_____
(Date)

(See Reverse)

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notices 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)

_____

COMPOUND RELEASE AUTHORIZATION

RELEASE INFORMATION

Entity to Receive Information:

- ☐ Spouse (provide name)_____
- ☐ Parent (provide name)_____
- ☐ Other (provide name)_____
- ☐ No Restrictions
- ☐ E-Mail _____

Description of information to be released:

- ☐ No Restrictions
- ☐ Appointment
- ☐ Treatment Plan Information
- ☐ Financial
- ☐ Results of lab tests/x-rays

_____
(Signature of Patient or Guardian)

_____
(Date)

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

NORTH STATE PERIO

PERIODONTICS & IMPLANTOLOGY

Driving Instructions to Our Office

From Interstate 85 Traveling North

Exit 46 B

You will take a Right onto Mallard Creek Church Road

You will drive through three set of traffic lights

You will take the first available right off of Mallard Creek Church Road (just past BB&T Bank and Tide Dry Cleaners) onto Arbors Corporate Drive

2315 West Arbors Drive Suite 100

From Interstate 85 Traveling South

Exit 46

You will take a Right onto Mallard Creek Church Road at the intersection at the end of the ramp

You will drive through two sets of traffic lights

You will take the first available right off of Mallard Creek Church Road (just past BB&T Bank and Tide Dry Cleaners) onto Arbors Corporate Drive

2315 West Arbors Drive Suite 100

From Interstate 77 Traveling South

Exit 19 B-A Take A exit I-485 Inner to Matthews

Exit 30 I-85 South (stay in left hand exit lane)

Exit 46

You will take a Right onto Mallard Creek Church Road at the intersection at the end of the ramp

You will drive through two sets of traffic lights

You will take the first available right off of Mallard Creek Church Road (just past BB&T Bank and Tide Dry Cleaners) onto Arbors Corporate Drive

2315 West Arbors Drive Suite 100

PAUL N. TOLMIE, D.D.S. · KENNETH P. RASENBERGER, D.M.D. · CHRISTOPHER J. VAN KESTEREN, D.D.S. · GEORGE I. GETZ, D.D.S.
2315 W. ARBORS DR, SUITE 100, CHARLOTTE, NC 28262 Phone: (704) 549-4991 Fax: (704) 549-0135 www.northstateperio.com

NORTH STATE PERIO

♦ PERIODONTICS & IMPLANTOLOGY ♦

Referred by: _____ PLEASE PRINT

NAME OF PATIENT: _____
LAST NAME FIRST NAME MIDDLE NICKNAME

ADDRESS _____
STREET APT # CITY STATE ZIP

PHONE: _____ AGE _____ DATE OF BIRTH _____ SEX _____

FATHER'S NAME: _____
LAST FIRST MIDDLE EMPLOYED BY OCCUPATION BUSINESS TELEPHONE

HOME ADDRESS: _____
STREET APT # CITY STATE ZIP TELEPHONE #

FATHER'S S.S. # _____ FATHER'S BIRTH DATE _____ FATHER'S CELL TELEPHONE _____

MOTHER'S NAME _____
LAST FIRST MIDDLE EMPLOYED BY OCCUPATION BUSINESS TELEPHONE

HOME ADDRESS _____
STREET APT # CITY STATE ZIP TELEPHONE #

MOTHER'S S.S. # _____ MOTHER'S BIRTH DATE _____ MOTHER'S CELL TELEPHONE _____

NAME OF FRIEND OR RELATIVE WHO
CAN REACH YOU IN CASE OF EMERGENCY _____

ADDRESS: _____ TELEPHONE: _____
STREET APT # CITY STATE ZIP

OUR OFFICE POLICY IS THE PARENT WHO REQUESTS TREATMENT FOR THE CHILD IS RESPONSIBLE FOR ALL FEES FOR SERVICES RENDERED

_____ _____
(Signature of Parent/Guardian Requesting Care) (Date)

DENTAL INSURANCE INFORMATION

Primary Dental Carrier Information:

Employer/ Provider of Dental Insurance: _____ Group # _____

Policyholder Name: _____ Policyholder Date of Birth: _____

Policyholder Social Security/ID Number: _____

Dental Insurance **Company** Name: _____

Claims Mailing Address: _____
CITY STATE ZIP

Telephone Number: _____