

**PATIENT INFORMATION**

Patient's Full Name \_\_\_\_\_ Nickname \_\_\_\_\_  
Address \_\_\_\_\_ Birthdate \_\_\_\_\_  
City/State/Zip \_\_\_\_\_ Sex: Male Female  
Home Phone: \_\_\_\_\_ Work: \_\_\_\_\_  
Marital Status: Single Married Divorced Widowed Cell: \_\_\_\_\_ Email: \_\_\_\_\_  
Physician's Name & Medical Group: \_\_\_\_\_  
Address: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**CHILD/TEEN INFORMATION (To be filled out by parent)**

Father's Name _____	Mother's Name _____
Birthdate _____ SS# _____	Birthdate _____ SS# _____
Employer _____	Employer _____
Position _____	Position _____
Home Phone _____ Work _____	Home Phone _____ Work _____
Driver's License # _____	Driver's License # _____
Patient's School _____ Grade _____	Person present at exam Mother __ Father __ Other _____

Because \_\_\_\_\_ is a minor, it is customary to have parental consent before any necessary dental service can be given by Dr. Van Gorp. Authorization is granted in writing.

\_\_\_\_\_/\_\_\_\_\_  
*Signature (Parent or Guardian) Date*

**ADULT INFORMATION**

Birthdate _____ SS# _____	Spouse Name _____
Employer _____	Spouse Birthdate _____ SS# _____
Position _____	Employer _____
Home Phone _____ Work _____	Position _____
Driver's License # _____	Home Phone _____ Work _____
	Driver's License # _____

**DENTAL INSURANCE INFORMATION**

**PRIMARY COVERAGE:**

Insurance Company Name: \_\_\_\_\_  
Employee/Subscriber: \_\_\_\_\_  
Policy/Group#: \_\_\_\_\_

**DENTAL QUESTIONNAIRE**

PATIENT \_\_\_\_\_

DATE \_\_\_\_\_

**DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING**

<b>MOUTH</b>			<b>TEETH</b>		
Bleeding, sore gums	YES	NO	Loose teeth	YES	NO
Unpleasant taste/bad breath	YES	NO	Sensitive to hot	YES	NO
Burning tongue/lips	YES	NO	Sensitive to cold	YES	NO
Frequent blister, lips/mouth	YES	NO	Sensitive to sweets	YES	NO
Swelling/lumps in mouth	YES	NO	Sensitive to biting	YES	NO
Ortho treatment (braces)	YES	NO	Food Impaction	YES	NO
Biting cheeks/lips	YES	NO	Clenching/grinding	YES	NO
Clicking/popping jaw	YES	NO	If so, when _____		
Difficulty opening or closing jaw	YES	NO	Shifting in bite	YES	NO
			Change in bite	YES	NO

**PLEASE CIRCLE ONE ANSWER FOR EACH CATEGORY**

**PRESENT DENTAL CONDITION**

Do you now have any discomfort with your mouth?      none                                      some                                      a lot

I feel my teeth are:    very healthy                                      some disease/decay                                      in poor shape

I feel the appearance of my mouth is:    excellent                                      satisfactory                                      unsatisfactory

I would like to improve the health/appearance of my mouth:      very much                                      somewhat                                      not much

**PAST DENTAL CARE:**

Name of prior dentist \_\_\_\_\_      Date of last visit \_\_\_\_\_

In the past I have gone to the dentist:      regularly                                      occasionally                                      emergencies only

I have followed my dentist's recommendations:      regularly                                      occasionally                                      rarely

The last dental treatment I received was for:      exam/cleaning                                      filling/other restoration                                      emergency care

I have had problems or pain with past dentistry:      no                                      yes/moderate                                      yes/serious

Dentistry for myself and my family is:      high priority                                      moderate priority                                      low priority

**HOME CARE:**

I brush my teeth:    twice (or more) per day                                      once per day                                      not regularly

I floss my teeth:    routinely (once per day)                                      occasionally                                      rarely or never

**FEELINGS ABOUT DENTAL CARE:**

The thought of dental care makes me:      not nervous                                      somewhat nervous                                      very nervous

My greatest fear about dental treatment is:      discomfort/pain                                      expense                                      time it takes

The kind of dental care I want now is:      for highest level of dental health                                      adequate maintenance                                      emergency only

1. What are some questions about dental care that have not been answered for you? \_\_\_\_\_
2. What did you dislike about your past dental care/dental office? \_\_\_\_\_
3. What things have you appreciated about your past dental care/dental office? \_\_\_\_\_
4. If you could change anything about your teeth, what would you change? \_\_\_\_\_

### MEDICAL HISTORY

PATIENT NAME \_\_\_\_\_ Birth Date \_\_\_\_\_

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

- Are you under a physician's care now?  Yes  No If yes, please explain: \_\_\_\_\_
- Have you ever been hospitalized or had a major operation?  Yes  No If yes, please explain: \_\_\_\_\_
- Have you ever had a serious head or neck injury?  Yes  No If yes, please explain: \_\_\_\_\_
- Are you taking any medications, pills, or drugs?  Yes  No If yes, please explain: \_\_\_\_\_
- Do you take, or have you taken, Phen-Fen or Redux?  Yes  No \_\_\_\_\_
- Are you on a special diet?  Yes  No \_\_\_\_\_
- Do you use tobacco?  Yes  No \_\_\_\_\_
- Do you use controlled substances?  Yes  No \_\_\_\_\_

Women: Are you  
Pregnant/Trying to get pregnant?  Yes  No Taking oral contraceptives?  Yes  No Nursing?  Yes  No

Are you allergic to any of the following?  
 Aspirin  Penicillin  Codeine  Acrylic  Metal  Latex  Local Anesthetics  
 Other If yes, please explain: \_\_\_\_\_

- Do you have, or have you had, any of the following?
- |  |  |  |   |
|--|--|--|---|
| AIDS/HIV Positive <input type="radio"/> Yes <input type="radio"/> No         | Cortisone Medicine <input type="radio"/> Yes <input type="radio"/> No        | Hemophilia <input type="radio"/> Yes <input type="radio"/> No            | Renal Dialysis <input type="radio"/> Yes <input type="radio"/> No             |
| Alzheimer's Disease <input type="radio"/> Yes <input type="radio"/> No       | Diabetes <input type="radio"/> Yes <input type="radio"/> No                  | Hepatitis A <input type="radio"/> Yes <input type="radio"/> No           | Rheumatic Fever <input type="radio"/> Yes <input type="radio"/> No            |
| Anaphylaxis <input type="radio"/> Yes <input type="radio"/> No               | Drug Addiction <input type="radio"/> Yes <input type="radio"/> No            | Hepatitis B or C <input type="radio"/> Yes <input type="radio"/> No      | Rheumatism <input type="radio"/> Yes <input type="radio"/> No                 |
| Anemia <input type="radio"/> Yes <input type="radio"/> No                    | Easily Winded <input type="radio"/> Yes <input type="radio"/> No             | Herpes <input type="radio"/> Yes <input type="radio"/> No                | Scarlet Fever <input type="radio"/> Yes <input type="radio"/> No              |
| Angina <input type="radio"/> Yes <input type="radio"/> No                    | Emphysema <input type="radio"/> Yes <input type="radio"/> No                 | High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No   | Shingles <input type="radio"/> Yes <input type="radio"/> No                   |
| Arthritis/Gout <input type="radio"/> Yes <input type="radio"/> No            | Epilepsy or Seizures <input type="radio"/> Yes <input type="radio"/> No      | Hives or Rash <input type="radio"/> Yes <input type="radio"/> No         | Sickle Cell Disease <input type="radio"/> Yes <input type="radio"/> No        |
| Artificial Heart Valve <input type="radio"/> Yes <input type="radio"/> No    | Excessive Bleeding <input type="radio"/> Yes <input type="radio"/> No        | Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No          | Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No              |
| Artificial Joint <input type="radio"/> Yes <input type="radio"/> No          | Excessive Thirst <input type="radio"/> Yes <input type="radio"/> No          | Irregular Heartbeat <input type="radio"/> Yes <input type="radio"/> No   | Spina Bifida <input type="radio"/> Yes <input type="radio"/> No               |
| Asthma <input type="radio"/> Yes <input type="radio"/> No                    | Fainting Spells/Dizziness <input type="radio"/> Yes <input type="radio"/> No | Kidney Problems <input type="radio"/> Yes <input type="radio"/> No       | Stomach/Intestinal Disease <input type="radio"/> Yes <input type="radio"/> No |
| Blood Disease <input type="radio"/> Yes <input type="radio"/> No             | Frequent Cough <input type="radio"/> Yes <input type="radio"/> No            | Leukemia <input type="radio"/> Yes <input type="radio"/> No              | Stroke <input type="radio"/> Yes <input type="radio"/> No                     |
| Blood Transfusion <input type="radio"/> Yes <input type="radio"/> No         | Frequent Diarrhea <input type="radio"/> Yes <input type="radio"/> No         | Liver Disease <input type="radio"/> Yes <input type="radio"/> No         | Swelling of Limbs <input type="radio"/> Yes <input type="radio"/> No          |
| Breathing Problem <input type="radio"/> Yes <input type="radio"/> No         | Frequent Headaches <input type="radio"/> Yes <input type="radio"/> No        | Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No    | Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No            |
| Bruise Easily <input type="radio"/> Yes <input type="radio"/> No             | Genital Herpes <input type="radio"/> Yes <input type="radio"/> No            | Lung Disease <input type="radio"/> Yes <input type="radio"/> No          | Tonsillitis <input type="radio"/> Yes <input type="radio"/> No                |
| Cancer <input type="radio"/> Yes <input type="radio"/> No                    | Glaucoma <input type="radio"/> Yes <input type="radio"/> No                  | Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No | Tuberculosis <input type="radio"/> Yes <input type="radio"/> No               |
| Chemotherapy <input type="radio"/> Yes <input type="radio"/> No              | Hay Fever <input type="radio"/> Yes <input type="radio"/> No                 | Pain in Jaw Joints <input type="radio"/> Yes <input type="radio"/> No    | Tumors or Growths <input type="radio"/> Yes <input type="radio"/> No          |
| Chest Pains <input type="radio"/> Yes <input type="radio"/> No               | Heart Attack/Failure <input type="radio"/> Yes <input type="radio"/> No      | Parathyroid Disease <input type="radio"/> Yes <input type="radio"/> No   | Ulcers <input type="radio"/> Yes <input type="radio"/> No                     |
| Cold Sores/Fever Blisters <input type="radio"/> Yes <input type="radio"/> No | Heart Murmur <input type="radio"/> Yes <input type="radio"/> No              | Psychiatric Care <input type="radio"/> Yes <input type="radio"/> No      | Venereal Disease <input type="radio"/> Yes <input type="radio"/> No           |
| Congenital Heart Disorder <input type="radio"/> Yes <input type="radio"/> No | Heart Pace Maker <input type="radio"/> Yes <input type="radio"/> No          | Radiation Treatments <input type="radio"/> Yes <input type="radio"/> No  | Yellow Jaundice <input type="radio"/> Yes <input type="radio"/> No            |
| Convulsions <input type="radio"/> Yes <input type="radio"/> No               | Heart Trouble/Disease <input type="radio"/> Yes <input type="radio"/> No     | Recent Weight Loss <input type="radio"/> Yes <input type="radio"/> No    |   |

Have you ever had any serious illness not listed above?  Yes  No If yes, please explain: \_\_\_\_\_

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN \_\_\_\_\_ DATE \_\_\_\_\_

## Dr. Richard W. Van Gorp

### Consent for Services

Patient full name: \_\_\_\_\_

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished and charged directly to the patient and that he or she is personally responsible for payment of all dental services. Dental insurance information will be retained on file, and this office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1\_% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months for the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing within the time for payment thereof. I further agree that a waiver of any breach of my time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant permission to you or your assignee to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

\_\_\_\_\_  
Signature of guarantor of payment/responsible party

\_\_\_\_\_  
Date

## **NOTICE OF PRIVACY PRACTICES**

Richard W. Van Gulp, DDS  
3111 Springbank Lane, Suite F  
Phone: 708.542.2884  
Fax: 704.542.8056  
Email: info@vangurpdentistry.com  
Contact: Dr. Richard W. Van Gulp

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### **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.**

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We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

#### **TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS**

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; examining your teeth; prescribing medications and faxing them to be filled; referring you to another doctor or clinic for other health care or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or dental care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we will ask you for special written permission.

#### **USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION**

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- when a state or federal law mandates that certain health information be reported for a specific purpose;
- for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
- disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
- disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to

- report a crime that happened somewhere else;
- disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- uses or disclosures for health related research;
- uses and disclosures to prevent a serious threat to health or safety;
- uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
- disclosures of de-identified information;
- disclosures relating to worker's compensation programs;
- disclosures of a "limited data set" for research, public health, or health care operations;
- incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information;

As designated, we will also share relevant information about your care with your family or friends who are helping you with your dental care.

### **APPOINTMENT REMINDERS**

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

### **OTHER USES AND DISCLOSURES**

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours. If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this Notice.

### **YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION**

The law gives you many rights regarding your health information. You can:

- ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address, fax or E Mail shown at the beginning of this Notice.
- ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E mail to your personal E Mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30 day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written

request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

- ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

#### **OUR NOTICE OF PRIVACY PRACTICES**

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our Web site.

#### **COMPLAINTS**

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or E mail shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

#### **FOR MORE INFORMATION**

If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this Notice.

Effective Date: January 1, 2006

Richard W. Van Gulp, DDS, PA

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## Acknowledgement of Receipt Of Notice of Privacy Practices

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Patient Name : \_\_\_\_\_

I have received a copy of the Notice of Privacy Practices for the above named practice.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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### Authorization for Release of Information to Family and/or Friends

This office is authorized to release protected health information about the above named patient to the entities named below:

\_\_\_\_\_ Leave information on the voice mail. \_\_\_\_\_ Give information to spouse.  
\_\_\_\_\_ Give information to the following persons: \_\_\_\_\_

Information to be released:

\_\_\_\_\_ Financial Information \_\_\_\_\_ Information result from test or x-rays.  
\_\_\_\_\_ Medical Information  
\_\_\_\_\_ Other information as described: \_\_\_\_\_  
Statements will list family activity unless otherwise directed.

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to Dr. Richard W. Van Gulp, 3111 Springbank Lane, Suite F, Charlotte, NC 28226. I understand that 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. I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing this authorization. This authorization shall be in force and effect until revoked by the patient or representative signing the authorization.

\_\_\_\_\_  
Signature of Patient or Personal Representative

Date \_\_\_\_\_

Richard W. Van Gulp, DDS, PA  
3111 Springbank Lane  
Suite F  
Charlotte, NC 28226  
704.542.2884

Thank you for scheduling your dental appointment at our office. We would like to thank the individual who referred you to us and/or know how you heard about our office.

Please help us by completing the following, marking all that apply:

- Referred by Individual (Name): \_\_\_\_\_
- Referred by Another Doctor (Name): \_\_\_\_\_
- Dr. Van Gulp's Website
- Internet/Google, etc
- Mailer
- CHARLOTTE WEEKLY
- CHARLOTTE HEALTH AND FITNESS
- CHARLOTTE MAGAZINE
- Angie's List
- General Yellow Pages
- Community Phone Book
- Other (describe): \_\_\_\_\_