

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

MOUTH			TEETH		
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? _____

Richard W. Van Gulp, 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.
3111 Springbank Lane, Suite F, Charlotte, NC 28226
704.542.2884 info@vangurpdentistry.com

Effective Date: January 1, 2006

Revised: July 16, 2016

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.vangurpdentistry.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
- Disclosures of for any purposes which require the sale of your information

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. To obtain the form for a Written Request document, contact the Privacy Officer.

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:

Dr. Richard W. Van Gorp
3111 Springbank Lane
Suite F
Charlotte, NC 28226

Phone: 704.542.2884

Fax: 704.542.8056

Email: info@vangurpdentistry.com

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 January 1, 2006, Revised July 16, 2016.

Bus: Notice of Privacy Practices July 2016

Richard W. Van Gorp, DDS, PA

Notice of Privacy Practices

Effective Date: January 1, 2006

Revised Date: July 16, 2016

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 _____

Richard W. Van Gulp, DDS, PA

Acknowledgement of Receipt Of Notice of Privacy Practices

Patient Name & Address: _____

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

Signature

Date

For Office Use Only

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

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

Other: _____

Prepared By _____

Signature _____

Date _____

Dr. Richard W. Van Gulp

Consent for Services

Patient full name: _____

As a condition of your treatment by this office, financial arrangements must be made in advance. Patients are responsible for the cost incurred for their care. Financial arrangements must be determined before treatment.

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

Patients who carry dental/medical insurance understand that all dental/medical services furnished are charged directly to the patient and that he or she is personally responsible for payment. Dental/medical 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 if possible. However, this dental office cannot render services on the **assumption** that our charges will be paid by an insurance company.

A service charge of 1½% 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 dental/medical care can only be extended for a period of twelve (12) months from the date of treatment plan.

In consideration for the professional services rendered to me, I therefore agree to pay the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered. 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

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): _____

Richard W. Van Gulp, DDS, PA
Authorization for Release of Information – Compound Release

Name of Patient _____ Date of Birth _____

The office of Dr. Richard W. Van Gulp is authorized to release protected health information about the above named patient in the following manner and to identified persons.

Entity to Receive Information. Check each person/entity that you approve to receive information.	Description of information to be released. Check each that can be given to person/entity on the left in the same section.
--	--

Voice Mail

Results of lab tests/x-rays

Other _____

Other person (s) (provide name and phone number)

Financial

Medical/Dental

Email communication - Provide email address*

Financial

Medical/Dental

Appointment reminders

Breach notification

*For email communication to occur, please accept the disclosure below:

Text communication – Provide number *

Appointment reminder

Other: _____

*For text communication to occur, accept the disclosure below:

For **email and/or text communication** I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected.

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.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization will remain in effect until revoked by the patient.

Date _____

Signature of Patient or Personal Representative

*Description of Personal Representative's Authority (attach necessary documentation)