FORSYTH FAMILY DENTAL

Jeffrey M. Gallisdorfer, DDS
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Sarah E. Simpson, DMD

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116 Jonestown Road
Winston-Salem, NC 27104
forsythfamilydentalnc.com

OFFICE USE ONLY
G B C S
ACCT.#

— PATIENT REGISTRATION —

PLEASE PRINT

ID:_____ CHART ID:_____

NAME _____ PREFERRED NAME _____
LAST FIRST MIDDLE

PATIENT IS POLICY HOLDER( ) RESPONSIBLE PARTY( )

RESPONSIBLE PARTY (IF SOMEONE OTHER THAN THE PATIENT)

NAME _____
LAST FIRST MIDDLE

ADDRESS _____
RESIDENCE & BOX IF APPLICABLE CITY STATE ZIP

HOME PHONE _____ WORK PHONE _____ CELL _____

DATE OF BIRTH _____ SOCIAL SECURITY # _____ DRIVER'S LICENSE _____

RESPONSIBLE PARTY IS POLICY HOLDER FOR PATIENT ( ) PRIMARY INSURANCE POLICY HOLDER ( )
SECONDARY INSURANCE POLICY HOLDER ( )

PATIENT INFORMATION

ADDRESS _____
RESIDENCE & BOX IF APPLICABLE CITY STATE ZIP

HOME PHONE _____ WORK PHONE _____ CELL _____

MALE ☐
FEMALE ☐ SINGLE ( ) MARRIED ( ) SEPARATED ( ) DIVORCED ( ) WIDOW OR WIDOWER ( )

DATE OF BIRTH _____ SOCIAL SECURITY # _____ DRIVER'S LICENSE _____

E-MAIL _____ I WOULD LIKE TO RECEIVE CORRESPONDENCES VIA E-MAIL ( )

EMPLOYMENT STATUS: FULL TIME ( ) PART TIME ( ) RETIRED ( ) STUDENT STATUS: FULL TIME ( ) PART TIME ( )

MEDICAID ID _____ EMPLOYER ID _____ CARRIER ID _____

PREF. DENTIST _____ PREF. PHARMACY _____ PREF. HYG. _____

EMERGENCY CONTACT _____

PRIMARY INSURANCE INFORMATION

NAME OF INSURED _____ RELATIONSHIP TO INSURED _____

INSURED SOC. SEC. _____ INSURED BIRTH DATE _____

EMPLOYER _____ INS. COMPANY _____

ADDRESS _____ ADDRESS _____

ADDRESS _____ ADDRESS _____

REM. BENEFITS _____ REM. DEDUCT _____

SECONDARY INSURANCE INFORMATION

NAME OF INSURED _____ RELATIONSHIP TO INSURED _____

INSURED SOC. SEC. _____ INSURED BIRTH DATE _____

EMPLOYER _____ INS. COMPANY _____

ADDRESS _____ ADDRESS _____

ADDRESS _____ ADDRESS _____

TIME _____ **Charlotte C. Broughton,** DDS DATE _____

PATIENT NAME _____ **BIRTH DATE** _____ **DATE CREATED** _____

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, _____

Have you ever been hospitalized or had a major operation? ◯Yes ◯No If yes, _____

Have you ever had a serious head or neck injury? ◯Yes ◯No If yes, _____

Are you taking any medications, pills, or drugs? ◯Yes ◯No If yes, _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯Yes ◯No If yes, _____

Are you on a special diet? ◯Yes ◯No

Do you use tobacco? ◯Yes ◯No

Do you use controlled substances? ◯Yes ◯No If yes, _____

Women: Are you...

◯ Pregnant/Trying to get pregnant? ◯ Nursing? ◯ Taking oral contraceptives?

Are you allergic to any of the following?

◯ Aspirin ◯ Penicillin ◯ Codeine ◯ Acrylic

◯ Metal ◯ Latex ◯ Sulfa Drugs ◯ Local Anesthetics

◯ Other? _____

Do you have, or have you had, any of the following?

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

Do you have, or have you had, any of the following? ◯Yes ◯No If yes, _____

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:

X

Jeffrey M. Gallisdorfer, DDS
Charlotte C. Broughton, DDS
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— Authorization for Release of Information — COMPOUND RELEASE —

NAME OF PATIENT _____ DATE OF BIRTH _____

Forsyth Family Dental _____ is authorized to release protected health information about the above name patient in the following manner and/or to selected persons.

Check each person/entity approved to receive information.	Check type of information that can be given to person/entity on the left in the same section.
☐ Voice Mail	☐ Results of lab test/x-rays ☐ Other: _____
☐ Other person(s) (provide name and phone number)	☐ Financial ☐ Medical
☐ Email Communication — Provide Email address* _____ *For email communication to occur, please accept the disclosure below:	☐ Financial ☐ Medical ☐ Appointment reminders ☐ Breach notification
☐ Text Communication — Provide number* _____ *For text communication to occur, accept the disclosure below:	☐ Appointment reminder Other: _____ _____
☐ For email and/or text communication I understand that if information is not sent in an encrypted manner there is a risk if could be accessed inappropriately. I still elect to receive email and/or text communication as selected.	
☐ Photo of patient received by patient or legal guardian ☐ Photo take by staff (Example: pre/post procedure) ☐ Other: _____	☐ May be posted in office ☐ May be posted on website ☐ Other: _____

PATIENT RIGHTS:

- I have the right to revoke this authorization at any time by contacting our office.
- 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)

Revised January 2020

Written Financial Policy

Thank you for choosing Forsyth Family Dental. Our mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

Our offices accepts:

- Cash or Check, Visa, MasterCard or Discover Card
- Special financing options with convenient monthly payments available with the CareCredit Healthcare Credit Card
    - Allow you to pay over time
    - No annual Fee

Please Note:

If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.

A fee of $50.00 is charged for patients who miss or cancel more than 3 times in a 12-month period without 24-hour notice.

Forsyth Family Dental charges $30.00 for returned checks.

If you have any questions, please do not hesitate to ask. We are happy to help you get the Dentistry you want and/or need.

Patient, Parent or Guardian Signature Date

Patient Name (Please Print) Date

CareCredit is a credit care offered by Synchrony Bank and is NOT and in-house credit program offered by Forsyth Family Dental or any other healthcare provider. You may apply for the CareCredit health care credit card and if approved, use it at Forsyth Family Dental. However, the CareCredit credit card is an agreement between you and Synchrony Bank. Subject to credit approval. However, if we do not receive payment from your insurance carrier within 50 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier. For new accounts: Purchase APR is 26.99%; Minimum Interest Charge is $2.00. Existing card holders should see their credit card agreements for their applicable terms. Subject to credit approval.

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CHARLOTTE C. BROUGHTON, DDS • ELIZABETH C. CORBIN, DDS • JEFFREY M. GALLISDORFER, DDS • SARAH E. SIMPSON, DMD

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCIRBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect **April 14, 2003** 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. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the change. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available 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.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing, or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment, or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care of your general location, your condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgement disclosing only health information that is directly relevant to the person's involvement in your health care. We will also use our professional judgement and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

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

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

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 of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters.)

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of the Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the endo of this notice. If you request copies, we will charge you $0.__ for each page, $_____ per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the next 6 years, but not before April 14, 2003. 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 these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency.)

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing,) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

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.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail,) you are entitled to receive this Notice in written form.

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 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 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.

Contact Officer: Cheryl Weathers Telephone: 336-768-7495 Fax: 336-768-7499 Email: frontdesk@broughtondds.com

Dr. Charlotte C. Broughton, DDS
Dr. Elizabeth D. Corbin, DDS
Dr. Jeffrey M. Gallisdorfer, DDS
Dr. Sarah E. Simpson, DMD

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: _____

Address: _____

_____

I have received a copy of the Notice of Privacy Practices for Forsyth Family Dental.

_____ _____

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 arose, and 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(s):

  _____

- ◯ Other:

  _____

  _____

Prepared By: _____

Signature: _____

Date: _____