REVE W. CHASTON, D.D.S, M.S.D, P.C. | PERIODONTICS & IMPLANT DENTISTRY

NEW PATIENT INFORMATION

The following information is confidential and for our records only.

Today's Date: _____
Month Day Year (select drop down)

Patient's (legal) Name: _____ **Preferred Name**: _____

Social Security # _____**Age**: _____ **Birth Date**: _____ / _____ / _____ **Gender**: Choos

Work Phone: (_____) _____ **Email:** _____

Cell Phone: (_____) _____

Home Phone: (_____) _____

Home Address: _____ _____
Street Apt #

_____
City State Zip Code

Employer: _____

Spouse's Name *(if applicable)*: _____ **Birth Date**: _____ / _____ / _____

Spouse's Employer: _____

Emergency Contact Person: _____ **Phone:** (_____) _____

Individual responsible for this account: *(if different from above patient):*

Name: _____ **Relationship**: _____

Cell: (_____) _____ **Home:** (_____) _____ **Work:** (_____) _____

Primary Dental Insurance Subscriber's Name: _____

Social Security #_____ **Birth Date:** _____ / _____ / _____

Dental Insurance Company: _____ **Member ID#** _____

Secondary Dental Insurance Subscriber's Name: _____

Subscriber's Social Security #_____ **Birth Date:** _____ / _____ / _____

Dental Insurance Company: _____ **Member ID#** _____

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DENTAL HISTORY

The following information is confidential and for our records only.

Today's Date: _____
Select drop down (month, day, year)

Patient's Name: _____ **Birth Date:** _____ / _____ /_____

General Dentist: _____ **Phone:** (_____) _____

Primary Physician: _____ **Phone:** (_____) _____

Other Physician: _____ **Phone:** (_____) _____

Reason For Your Visit: _____

Referring Dentist: _____

PLEASE ANSWER THE FOLLOWING QUESTIONS:

YES☐ NO☐ **Have you ever had periodontal (gum) treatment?**

YES☐ NO☐ **Have you ever had periodontal disease?**

YES☐ NO☐ **Are you experiencing pain from your mouth at this time?**

YES☐ NO☐ **Have you recently had swollen gums or abscesses?**

YES☐ NO☐ **Do your gums bleed?**

YES☐ NO☐ **Do you have any loose teeth?**

YES☐ NO☐ **Do you have gum recession?**

YES☐ NO☐ **Are you missing one or more teeth?**

YES☐ NO☐ **Are you dissatisfied with the appearance of your teeth?**

YES☐ NO☐ **Do you brush your teeth every day?**

YES☐ NO☐ **Do you floss your teeth every day?**

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MEDICAL HISTORY

The following information is confidential and for our records only.

Do you have any heart problems:

Yes No

- ☐ ☐ Heart Attack
- ☐ ☐ High Blood Pressure
- ☐ ☐ Heart Murmur
- ☐ ☐ Artificial Heart Valve
- ☐ ☐ Arrhythmia
- ☐ ☐ Pacemaker
- ☐ ☐ Congenital Heart Defect
- ☐ ☐ History of Endocarditis
- ☐ ☐ Chest Pain (Angina)

Other _____

Do you have any central nervous system problems:

Yes No

- ☐ ☐ Stroke
- ☐ ☐ Seizure/Epilepsy

Other_____

Do you have any lung problems:

Yes No

- ☐ ☐ Asthma
- ☐ ☐ Bronchitis/Emphysema
- ☐ ☐ Shortness of Breath
- ☐ ☐ Tuberculosis
- ☐ ☐ Sinusitis

Other _____

Do you have any liver problems:

Yes No

- ☐ ☐ Hepatitis
- ☐ ☐ Cirrhosis

Other_____

Do you have Kidney Problems?

Yes ☐ No ☐

Do you have Thyroid or Adrenal Problems?

Yes ☐ No ☐

Have you ever taken Cortisone (steroids)?

Yes ☐ No ☐

Do you have Diabetes? Yes ☐ No ☐

Type1 ☐ Type2 ☐

Do you have skeletal or muscle problems:

Yes No

- ☐ ☐ Arthritis
- ☐ ☐ Artificial Joints

Have you ever taken medication for Osteoporosis:

Yes No

- ☐ ☐ Actonel (Risedronate)
- ☐ ☐ Fosamax (Alendronate)
- ☐ ☐ Boniva (Ibandronate)
- ☐ ☐ Reclast (Zoledronic)
- ☐ ☐ Aredia (Pamidronate
- ☐ ☐ Other Bisphosphonates: _____

_____

Any psychological or emotional problems:

Yes ☐ No ☐ (explain) _____

_____

Do you take MAOIs medications (antidepressant):

Yes ☐ No ☐ (name)_____

Do you have any medication allergies:

Yes No

- ☐ ☐ Penicillin/Amoxicillin
- ☐ ☐ Other Antibiotics_____
- ☐ ☐ Codeine/other Narcotics
- ☐ ☐ Dental Anesthetic

Other_____

Can You Take:

Yes ☐ No ☐ **Aspirin/Ibuprofen**

Yes ☐ No ☐ **Tylenol**

Do you have any other allergies:

Yes ☐ No ☐ Seasonal

Yes ☐ No ☐ Food

Yes ☐ No ☐ Latex

Other_____

Do you have any of the following?

Yes ☐ No ☐ Gastrointestinal Problems

Yes ☐ No ☐ Acid reflux or Ulcers

Yes ☐ No ☐ Crohns Disease

Other_____

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(continued) **MEDICAL HISTORY**

The following information is confidential and for our records only

Do you have any blood/bleeding disorders:
Yes ☐ No ☐ **Excessive bleeding**
Yes ☐ No ☐ **Hemophilia**
Yes ☐ No ☐ **Blood Thinners**
Yes ☐ No ☐ **Anemia**
Other_____

Yes ☐ No ☐ **Do you smoke tobacco?**
Yes ☐ No ☐ **Do you vape?**
Yes ☐ No ☐ **Do you use smokeless tobacco?**
Yes ☐ No ☐ **Do you drink alcohol?**
Yes ☐ No ☐ **Use or have a history of drug use?**

Yes ☐ No ☐ **Do you have Glaucoma?**
Yes ☐ No ☐ **Pregnant or nursing?**
Yes ☐ No ☐ **Taking birth control pills?**
Yes ☐ No ☐ **Do you have HIV/AIDS?**

Do you or have you had cancer? ☐ Yes ☐ No
☐ Chemotherapy ☐ Radiation
When: _____
Type: _____
_____

Have you ever been hospitalized? Yes ☐ No ☐
When: _____
Reason: _____
Were there complications: _____
_____

Do you have any other medical conditions not listed above? Yes ☐ No ☐ *(if yes explain):*
_____
_____
_____
_____

MEDICATIONS: *(Please list your current medications and supplements)*:
_____
_____
_____
_____
_____

To the best of my knowledge, all of the above answers are true and correct. If I ever have any changes in my medical history, I will inform Dr. Chaston at the next appointment.

Patient's Signature _____ **Date** _____
select drop down)

Doctor's Signature _____ **Date** _____

REVE W. CHASTON, D.D.S, M.S.D, P.C. | PERIODONTICS & IMPLANT DENTISTRY

Financial Policy

The following information is confidential and for our records only.

Thank you for choosing Dr. Reve W. Chaston D.D.S., M.S.D., P.C., for your periodontal needs. By signing this document, you are stating you understand payment of your treatment. The following is our financial policy, we require that you read and sign prior to treatment.

Cost of treatment will be explained to you and if you carry insurance, we will explain any estimates we receive from your insurance prior to treatment. At that time, we will also advise you of the amount that will be due up front on the day of your treatment.

- **Full payment of the procedure amount is due at the time of service.**
- **After treatment, claims will be submitted to your insurance and adjustments to your account balance will be made after claims have been submitted.**

Accepted forms of payment are cash, checks, Care credit cards and all major credit cards.

INSURANCE:

If we file your insurance, the difference in payment from your insurance and our charges for treatments are your responsibility. If your insurance company has not paid within 60 days of the treatment date, you will be responsible for paying the account balance in full.

USUAL AND CUSTOMARY RATES:

Our practice is committed to providing the best treatments and care for our patients. We charge the usual and customary in our area. You are responsible for full payment regardless of any insurance company's arbitrary determination of usual and customary rates. If we are a provider with your insurance, we will honor their fees and pricing. Insurance will be contacted, and once payment for treatment is received then adjustments can be made to the patient's balance. However, there is an out-of-pocket amount due that the patient is responsible for.

DELINQUENT ACCOUNTS:

By signing this document, you are stating you understand that if you do not keep this agreement and default on this agreement, your account will be placed with a collection agency where you will be responsible for any court costs, attorney fees, filing fees, late charges including commissions charges of 40% that may be assessed to us by a collection agency retained to pursue this account, with or without suit, and interest at 18% per annum.

Thank you for reading and acknowledging our financial policy, please let us know if you have any questions or concerns.

I, _____, have read and understand the financial Policy. I agree to comply with this financial policy.

X_____ _____

Signature of patient/responsible party ***Date of signature*** *(select drop down)*

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Cancellation, Rescheduling and No-Show Policy

We understand that situations arise in which you must cancel or reschedule your appointment. It is therefore requested that if you must cancel or reschedule your appointment you provide 2 business days' notice. We require 48 hours' notice to allow patients that are waiting for emergency treatment to be scheduled in that time slot.

Office Appointments which are cancelled or rescheduled with less than 2 business days' notification will be subject the following fees:

- **Surgery** cancellation or reschedule fee: **$50.00**
- **Hygienist** cancelation or reschedule fee: **$25.00**

The cancellation, last minute rescheduling and no-show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment

We understand that special unavoidable circumstances may cause you to cancel or reschedule within 24-hours. Fees in this instance may be waived/decreased but only with management approval.

Our practice firmly believes that good doctor/patient relationship is based upon understanding and good communication. Please sign that you have read, understand and agree to this Cancellation, Rescheduling and No-Show Policy.

X_____ _____

Signature of patient/responsible party ***Date of signature*** *(select drop down)*

REVE W. CHASTON, D.D.S, M.S.D, P.C. | PERIODONTICS & IMPLANT DENTISTRY

HIPAA PRIVACY NOTICE

Dr. Reve W. Chaston

THIS NOTICE DESCRIBES HOW DENTAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information"; is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your dentist, 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, to pay your health care bills, to support the operation of the dentist's practice, and any other use required by law.

Treatment
We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a dentist to whom you have been referred to ensure that the dentist has the necessary information to diagnose or treat you.

Payment
Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations
We may use or disclose, as needed, your protected health information in order to support the business activities of your Dentist's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your dentist. We may also call you by name in the waiting room when your dentist is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required by Law, Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors, and Organ Donation, Research, Criminal Activity, Military Activity and National Security, Workers' Compensation, Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization at any time, in writing, except to the extent that your dentist or the dentist's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Following is a statement of your rights with respect to your protected health information

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information.
This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your dentist is not required to agree to a restriction that you may request. If dentist believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e., electronically.

You may have the right to have your dentist amend your protected health information.
If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: _____

X_____ _____

Signature of patient/responsible party ***Date of signature*** *(select drop down)*