

## Patient Information

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Last First MI (Preferred Name)  
Gender: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
Address: \_\_\_\_\_  
Street Apartment #  
City State Zip Code  
E-mail: \_\_\_\_\_  
Phone (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ Ext \_\_\_\_\_ (Cell) \_\_\_\_\_  
Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

## Health Information

Date of Last Dental Visit: \_\_\_\_\_ Reason for this visit: \_\_\_\_\_

**Have you ever had any of the following? Please check those that apply:**

- |   |   |  |   |
|---|---|--|---|
| <input type="checkbox"/> Acid Reflux            | <input type="checkbox"/> Environmental Allergies    | <input type="checkbox"/> Hormone Replacement   | <input type="checkbox"/> Pre-Medicate prior to dental treatment |
| <input type="checkbox"/> AIDS/HIV               | _____   | <input type="checkbox"/> Hypoglycemia          | <input type="checkbox"/> Radiation/Chemo                        |
| <input type="checkbox"/> Anemia                 | <input type="checkbox"/> Epilepsy                   | <input type="checkbox"/> IBS                   | <input type="checkbox"/> Recent Weight Loss                     |
| <input type="checkbox"/> Anxiety                | <input type="checkbox"/> Ever Taken Bisphosphonates | <input type="checkbox"/> Immunosuppression     | <input type="checkbox"/> Respiratory Disease                    |
| <input type="checkbox"/> Arthritis              | <input type="checkbox"/> Excessive Bleeding         | <input type="checkbox"/> Jaundice              | <input type="checkbox"/> Rheumatic Fever                        |
| <input type="checkbox"/> Artificial Valve/Joint | <input type="checkbox"/> Fainting                   | <input type="checkbox"/> Kidney Disease        | <input type="checkbox"/> Rheumatism                             |
| <input type="checkbox"/> Asthma                 | <input type="checkbox"/> Glaucoma                   | <input type="checkbox"/> Latex Allergy         | <input type="checkbox"/> Sinus Problems                         |
| <input type="checkbox"/> Autoimmune Disorder    | <input type="checkbox"/> Head Injuries              | <input type="checkbox"/> Liver Disease         | <input type="checkbox"/> Stroke                                 |
| <input type="checkbox"/> Back Problems          | <input type="checkbox"/> Headaches                  | <input type="checkbox"/> Low Blood Pressure    | <input type="checkbox"/> Swollen Neck Glands                    |
| <input type="checkbox"/> Blood Disease          | <input type="checkbox"/> Heart Murmur               | <input type="checkbox"/> Mental Disorders      | <input type="checkbox"/> Thyroid Disorder                       |
| <input type="checkbox"/> Cancer                 | <input type="checkbox"/> Heart Problems             | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tuberculosis                           |
| <input type="checkbox"/> Chemical Dependency    | <input type="checkbox"/> Hemophilia                 | <input type="checkbox"/> Nervous Disorders     | <input type="checkbox"/> Tumors/Growths                         |
| <input type="checkbox"/> Circulatory Problems   | <input type="checkbox"/> Hepatitis, Type _____      | <input type="checkbox"/> Osteopenia            | <input type="checkbox"/> Ulcers                                 |
| <input type="checkbox"/> Diabetes, Type _____   | <input type="checkbox"/> High Blood Pressure        | <input type="checkbox"/> Osteoporosis          | <input type="checkbox"/> Venereal Disease                       |
| <input type="checkbox"/> Dizziness              | <input type="checkbox"/> High Cholesterol           | <input type="checkbox"/> Pacemaker             | <input type="checkbox"/> Other                                  |
| <input type="checkbox"/> Drug Allergies         |   |  |   |

• Have you ever had any complications following dental treatment?  Yes  No

If yes, please explain: \_\_\_\_\_

• Have you been admitted to a hospital or needed emergency care during the past two years?  Yes  No

If yes, please explain: \_\_\_\_\_

• Are you now under the care of a physician?  Yes  No

If yes, please explain: \_\_\_\_\_

• Name of Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

• Are you taking any medications at this time?  Yes  No If yes, please list \_\_\_\_\_

• Do you have any health problems that need further clarification?  Yes  No

If yes, please explain: \_\_\_\_\_

• Do you use tobacco?  Yes  No If yes, how used? \_\_\_\_\_ How much? \_\_\_\_\_ How long? \_\_\_\_\_

• **Women:** Are you pregnant?  Yes  No If yes, due date? \_\_\_\_\_ Are you nursing?  Yes  No

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Date: \_\_\_\_\_

Signature of patient, parent or guardian

## Referral Information

Whom may we thank for referring you to our practice:

## Dental Information

Reason for today's visit:     Exam     Consultation     Emergency     Cleaning and Exam

Please indicate any of the following problems or concerns:

- Cosmetic questions or concerns     Broken/chipped filling/tooth     Sensitive to hot, cold or sweets
- Discomfort, clicking or popping jaw     Teeth clenching/grinding     Red, swollen or bleeding gums
- Sensitivity when biting     Bad Breath     Periodontal Disease

Times a day you brush? \_\_\_\_\_ Times a week you floss? \_\_\_\_\_

What type of tooth brush bristles do you use?     Soft     Medium     Hard

How would you rate your smile? 1 2 3 4 5 6 7 8 9 10

## Party Responsible for Payment

Self     Spouse     Parent     Other \_\_\_\_\_  
(Relation)

Responsible Party Information (only if different from patient)

Name: \_\_\_\_\_  
Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ Ext: \_\_\_\_\_ (Cell) \_\_\_\_\_  
Address: \_\_\_\_\_  
Street City State Zip Code

## Insurance Information

Patient's relationship to Insurance Subscriber:     Self     Spouse     Child     Other \_\_\_\_\_  
(Relation)

Insurance Subscriber Information (only if different from patient or party responsible for payment)

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Address (if different from patient's): \_\_\_\_\_  
Street City State Zip Code

Insurance Carrier

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Group #: \_\_\_\_\_ Insured's ID #: \_\_\_\_\_

## Consent for Services

**Patients without dental insurance:** As a condition of treatment, you are responsible for all charges at the time of service. If you cannot make payment in full at the time of service, payment arrangements must be agreed upon in writing prior to any treatment being performed.

**Patients with dental insurance:** We are not contracted with any insurance company and do not participate in any insurance networks. You will need to contact your dental insurance company to ensure your out of your network benefits. We can; however, submit your claims to the insurance company on your behalf.

We estimate the amount, if any, that will not be covered by your dental insurance, and payment of that amount is due at the time of service. Once insurance has paid your claim, you will be billed for any difference or refunded any overage. The balance is due within 30 days. If your insurance company has not paid your claim within 60 days, you will be responsible for the entire amount of service at that time.

I agree to the above conditions of treatment and payment. I understand that any breach of these conditions may result in damage to my credit rating and no further treatment by this office. I grant permission to you or an assignee on your behalf to telephone me at work to discuss matters related to payment.

\_\_\_\_\_  
Signature of party responsible for payment    Date: \_\_\_\_\_

## HIPAA Acknowledgement

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

\_\_\_\_\_  
Signature of Patient (if 18 and older) or Guardian    Date: \_\_\_\_\_

Robert H. Lloyd, DDS

# NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

## OUR LEGAL DUTY

Federal and state law requires us to maintain the privacy of your health information. That law also requires us 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 we describe 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 applicable law permits the changes. 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 changes. 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 health care operations. For example:

**Treatment:** We may use your health information for treatment or disclose it to a dentist, physician or other health care provider providing treatment to you.

**Payment:** We may use and disclose your health information to obtain payment for services we provide to you. We may also disclose your health information to another health care provider or entity that is subject to the federal Privacy Rules for its payment activities.

**Health Care Operations:** We may use and disclose your health information for our health care operations. Health care operations include quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities. We may disclose your health information to another health care provider or organization that is subject to the federal privacy rules and that has a relationship with you to support some of their health care operations. We may disclose your information to help these organizations conduct quality assessment and improvement activities, review the competence or qualifications of health care professionals, or detect or prevent health care fraud and abuse.

**On Your Authorization:** 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 uses 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 may disclose your health information to a family member, friend or other person to the extent necessary to help with your health care or with payment for your health care. Before we disclose your health information to these people, we will provide you with an opportunity to object to our use or disclosure. If you are not present, or in the event of your incapacity or an emergency, we will disclose your medical information based on our professional judgment of whether the disclosure would be in your best interest. We may use our professional judgment 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. We may use or disclose information about you to notify or assist in notifying a person involved in your care, of your location and general condition.

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

**Disaster Relief:** We may use or disclose your health information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

**Public Benefit:** We may use or disclose your medical information as authorized by law for the following purposes deemed to be in the public interest or benefit:

- as required by law;
- for public health activities, including disease and vital statistic reporting, child abuse reporting, FDA oversight, and to employers regarding work-related illness or injury;
- to report adult abuse, neglect, or domestic violence;

to health oversight agencies;  
in response to court and administrative orders and other lawful processes;  
to law enforcement officials pursuant to subpoenas and other lawful processes, concerning crime victims, suspicious deaths, crimes on our premises, reporting crimes in emergencies, and for purposes of identifying or locating a suspect or other person; to coroners, medical examiners, and funeral directors; to an organ procurement organizations;  
to avert a serious threat to health or safety;  
in connection with certain research activities;  
to the military and to federal officials for lawful intelligence, counterintelligence, and national security activities; to correctional institutions regarding inmates; and  
as authorized by state worker's compensation laws.

## 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 request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge you a reasonable cost-based fee that may include labor, copying costs, and postage. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we may-but are not required to-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 more information about fees.

**Disclosure Accounting:** You have the right to receive a list of instances in which we or our business associates disclosed your health information over the last 6 years (but not before April 14, 2003). That list will not include disclosures for treatment, payment, health care operations, as authorized by you, and for certain other activities. 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. Contact us using the information listed at the end of this notice for more information about fees.

**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). Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. Your request is not binding unless our agreement is in writing.

**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. You must specify in your request the alternative means or location, and provide satisfactory explanation how you will handle payment 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 we should amend the information. We may deny your request under certain circumstances.

## QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us using the information listed at the end of this notice.

If you believe that:

- we may have violated your privacy rights,
- we made a decision about access to your health information incorrectly,
- our response to a request you made to amend or restrict the use or disclosure of your health information was incorrect, or . we should communicate with you by alternative means or at alternative locations,

you may contact us using the information listed below. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with 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.

**Provider Contact Office: Robert H. Lloyd, DDS**

**Telephone: 704-540-5076**

**Address: 3121 Springbank Lane, Suite J**

**Fax: 704-540-5131**

**Charlotte, NC 28226**

**Dr. Robert H. Lloyd, DDS**  
**3121 Springbank Lane, Suite J**  
**Charlotte, NC 28226**

**From Matthews on Hwy. 51**

Take right on Providence Rd., then first left on Springbank Ln. Take 2<sup>nd</sup> left in the parking lot and go to 4<sup>th</sup> building on the right #3121. We are upstairs, Suite J.

**From Pineville on Hwy. 51**

Take a left on Providence Rd., then first left on Springbank Ln. Take 2<sup>nd</sup> left in the parking lot and go to 4<sup>th</sup> building on the right #3121. We are upstairs, Suite J.

**From downtown Charlotte on Providence Rd.**

Turn right on Springbank Ln. which is one block before the Providence Rd/Hwy 51 intersection. Take 2<sup>nd</sup> left in the parking lot and go to 4<sup>th</sup> building on the right #3121. We are upstairs, Suite J.

**From Weddington on Providence Rd.**

Take first left after Providence Rd/Hwy 51 intersection on Springbank Ln. Take 2<sup>nd</sup> left in the parking lot and go to 4<sup>th</sup> building on the right #3121. We are upstairs, Suite J.

