Health History & Registration

PATIENT INFORMATION

Name (full legal)________________________________Nickname________________________________Birth Date ____________

(Please Check Your Answer) Sex: Male Female Marital Status: Single Married Separated Divorced Widowed

Mailing Address________________________________City________________________Zip Code ______________

EMAIL:________________________________Home #________________ Cell#________________

Employer: ________________ Work Number:________________________

Social Security Number________________________ **Who can we thank for referring you?** ________________

In case of emergency, who should be notified?

1) Name________________Phone ______________ 2) Name________________Phone ______________

Names of family members who are patients here:____

PERSON RESPONSIBLE FOR THIS ACCOUNT

(If patient is a child, please complete the next 2 sections for the child's parents)

Name________________________________Relationship to Patient____________________Birth Date ____________

Home Address (if different from above)____Home Phone ____________

Employer____**Social Security #** ________________

Business Address____Work Phone____________

PATIENT'S SPOUSE OR OTHER PARENT

Name________________________________Relationship to Patient____________________Birth Date ____________

Home Address (if different from above)____Home Phone ____________

Employer________________________________**Social Security #** ________________________

Work Phone________________________________

INSURANCE INFORMATION

PRIMARY INSURANCE

Dental Insurance_____Yes_____No Effective Date____________

Subscriber's Name ____________ Subscriber's Birth Date ________

Employer ________________________

Insurance Co.________________________

Subscriber ID#________________________

Group No.________________________

SECONDARY INSURANCE

Dental Insurance_____Yes_____No Effective Date____________

Subscriber's Name ____________ Subscriber's Birth Date ________

Employer ________________________

Insurance Co.________________________

Subscriber ID#________________________

Group No. ________________________

We are glad to assist you in securing payment of dental claims from your insurance company; however, benefits must assigned to us. If your company requires their own claim form, you must bring that form at each visit.

I understand that I am financially responsible for all charges incurred, including those outstanding with the insurance company (if not paid in a timely manner).

If the account becomes a past due and is referred to an attorney for collection, I agree to pay an attorney 33.3% attorney fees and or court costs. If I default on payment of this account, entire balance shall be due at the discretion of the creditor.

Date ________________**Signature**____

Patient NAME: ____ MEDICAL HISTORY

Name of Your Physician __________________________ Phone ____________ Date of last physical ____________________

PREMEDICATION PRIOR TO DENTAL CLEANING/PROCEDURES? _______ YES ________ NO

Are you taking any MEDICATION now (PRESCRIPTION AND/OR OVER-THE-COUNTER)? ________YES ________NO

If yes, please list____

Are you pregnant? YES NO Do you take hormones? YES NO Do you take birth control pills? YES NO

Do you have a history of any of the following (please circle yes or no)?

Rheumatic Heart Disease	Yes	No	Liver Disease	Yes	No	Stomach or Intestinal Illness	Yes	No
Rheumatic Fever	Yes	No	tested hiv positive/aids	Yes	No	Ulcer	Yes	No
Heart Murmur	Yes	No	Anemia	Yes	No	Cancer	Yes	No
Open Heart Surgery	Yes	No	Sickle Cell Anemia	Yes	No	Nervous or psychiatric care	Yes	No
Mitral Valve Prolapse	Yes	No	Leukemia	Yes	No	Seizures	Yes	No
Heart Attack	Yes	No	Any Bleeding Problems	Yes	No	Skin Disease		
Pace Maker	Yes	No	Thyroid Disease	Yes	No	Cold sores/fever Blisters	Yes	No
Stroke	Yes	No	Diabetes	Yes	No	Genital herpes	Yes	No
High Blood Pressure	Yes	No	Kidney Disorders	Yes	No	Frequent Headaches	Yes	No
Low Blood Pressure	Yes	No	Tuberculosis	Yes	No	Any Chronic	Yes	No
Any Joint Replacement	Yes	No	Emphysema	Yes	No	Inflammatory Disease		
Arthritis	Yes	No	Asthma	Yes	No	i.e. Lupus		
Hepatitis	Yes	No	Osteoporosis	Yes	No			

DO YOU HAVE A HISTORY OF ALLERGIES TO THE FOLLOWING?

MEDICATIONS (PRESCRIPTION OR OVER THE COUNTER) YES NO IF YES, PLEASE LIST:

____

____

LOCAL ANESTHESIA YES NO ______________________________

OTHER (FOODS, RESPIRATORY, FLUORIDE, LATEX) YES NO ______________________________

ADDITIONAL INFORMATION ABOUT YOUR HEALTH:____

DENTAL HISTORY

LAST DENTAL CLEANING APPROX:_____6 mos. ______ 1-2 yrs. _____5+yrs _____10+ yrs.

X-RAYS last taken ______ 6 mos. ______1 yr. Dental concerns:

____

MEDICAL/DENTAL UPDATES

I have read my MEDICAL HISTORY DATED____and confirm that it adequately states past and present conditions.

DATE	**EXCEPTIONS**	**Patient Signature**
___________	______________________________NONE □	______________________________
___________	______________________________NONE □	______________________________
___________	______________________________NONE □	______________________________

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NOTICE OF PRIVACY PRACTICES

This office has provided a complete copy of the notice of privacy practice dated 07/30/2009.

______________________________ ______________________________

Signature **Date**

FINANCIAL POLICY

For your convenience we offer several options of payment: cash, check, debit or credit card (Visa, MasterCard, Discover). We also have companies willing to finance dental treatment with no money down. Payment arrangements must be agreed upon before procedures are initiated. If you have dental insurance, we will gladly file your claim for you; however, you are responsible for your account. Each patient will receive an estimate of their co-pays and deductibles. This is only an estimate and we are not responsible for amounts not paid by the insurance. We cannot guarantee what insurance will or will not pay. If your insurance company neglects to pay within 60 days the balance on the account becomes your responsibility. **If your account becomes delinquent your account will be turned over to a local collection agency and you will incur any collection costs and any related attorney's fees.** If you do not have dental insurance, we do have other payment options that you may discuss with our financial coordinator.

We are committed to superior service with the latest in technology, done in a timely fashion. We ask that if you need to cancel an appointment that you give us at least 24 hours notice or a cancellation fee of $50.00 may be incurred.

As our patient, we ask that you keep your account current to allow us to continue providing our highest level of care for you, your family and friends. Your account will be charged a return check fee in the amount of $35.00 for any check
returned unpaid.

Any questions, please ask our financial coordinator.

Please read carefully before signing and dating this agreement.

____

Signature

____

Date

Lifetime Guarantee

Our guarantee is unique among all dentists in the state of Virginia, and provides you with the peace of mind that comes from knowing we honor our commitments in writing. We want to spell out the specifics so you can view them freely and realize there are no gimmicks. Our chief desire is to foster lifelong relationships, and Dr. Hawkins believes the best way to do that is to prove his loyalty to you by standing behind his dentistry.

The guarantee applies to recommended fillings, permanent crowns and bridges and veneers. It protects you against breakage, debonding (becoming loose or falling out), and even decaying under the restoration! If such should occur, Dr. Hawkins will repair or replace the restoration free of charge for the rest of his career (estimated to be 25 years as of 2010, the time of this writing).

In order to maintain the guarantee, only two conditions apply:

1. First, any decay you have must be removed within two months of its diagnosis. Decay easily spreads from tooth to tooth, so your path to optimal health requires a continual and comprehensive approach to ensure success.
2. Second, you must return for your recommended hygiene visits (usually 6 months) within a 30-day grace period. This allows us to detect small problems before they progress to larger ones.

The only exception is a different procedure on the same tooth. In other words, the work performed is guaranteed, but the entire tooth is not. For instance, if you have a small filling that does not compromise the integrity of the tooth, and you later break the tooth such that it needs a crown, that procedure is not covered. Likewise, if you have a filling in one area of a tooth and later develop decay in an different area of the same tooth, that is not covered.

Also, if Dr. Hawkins recommends an occlusal guard/nightguard to protect the work, the patient must obtain it from Dr. Hawkins.

Only work performed by Dr. Hawkins is eligible for the guarantee and any replacements or repairs must be performed by him.

Patient signature____ Date_________________

Alexander N. Hawkins, 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

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 04/01/2003, 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. Before we make a significant change in our privacy practices, we will change this Notice and make the 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: Unless you give us additional 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 location, your general 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 judgment and disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also 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.

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

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.

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 and 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 officials having lawful custody 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, postcard, or letters).

Patient Rights

Access: You have the right to review or receive copies of your health information, with limited exceptions. 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 this 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 end of this Notice. If you request copies, we will charge you $.50 cents for each page 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 last 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 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 your 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. 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.

Contact Information

Contact Officer: Laurie Tate
Telephone: (804) 897-9800
Fax: (804) 419-0129
Address: 1310 Alverser Plaza
Midlothian, VA 23113
E-mail: alexhawkinsdds@aol.com