CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT (PARENT OR GUARDIAN IF PATIENT IS A MINOR)

NAME: ______________________________

ADDRESS: ______________________________

TELEPHONE: ______________________________ EMAIL: ______________________________

SOCIAL SECURITY#: ______________________________ DATE OF BIRTH: ______________________________

SECTION B: TO THE PATIENT - PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide to sign this Consent. Our Notice provides a description of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of this Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

CONTACT PERSON: Joseph Curley, DMD, FAGD
TELEPHONE: 910-463-2267
FAX: 910-660-8135
E-MAIL: drcurley@drcurley.dental
ADDRESS: 143 Poole Road, Suite C, Leland, NC 28451

Right To Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgment

__________ initial — I have read a copy of this office's Notice of Privacy Practices and am aware that a copy of this Notice is available upon request.

____
PLEASE PRINT NAME

____
SIGNATURE

SECTION C: Authorization to disclose to Third Party. I authorize Dr. Curley & Associates, PA to disclose my protected health information to the following individual or company.

NAME: ______________________________ RELATIONSHIP: ______________________________

COMPANY OR ENTITY: ______________________________

ADDRESS: ______________________________

CITY: ______________________________ STATE: ______________ ZIP: ______________

PHONE: ______________________________ FAX: ______________________________

PATIENT INFORMATION

First Name: ______________________ MI: _____ Last: ______________________ Nick Name: ______________

Home Phone: ____________________ Work Phone: ____________________ Cell Phone: ____________________

Date of Birth: ______________________ ☐ Male ☐ Female SS#: ______________________

Address: ______________________________ City: ____________________ State: ______ Zip: ______

Employer: ____

State ID/Driver's License #: ____________________ E-Mail Address: ______________________________

Name of Physician: ______________________________ Physician Phone: ______________________

In case of Emergency Contact: ____________________ Relationship: ______________ Phone: ______________

How did you hear about our office? ______________________________

Patient Health History

Do you have a history of:

	Yes	No
A.I.D.S/HIV Positive	☐	☐
Alcoholism	☐	☐
Allergies	☐	☐
Alzheimer's Disease/Dementia	☐	☐
Anemia	☐	☐
Angina	☐	☐
Arthritis	☐	☐
Artificial Heart Valve	☐	☐
Artificial Joint	☐	☐
Asthma	☐	☐
Blood Disease	☐	☐
Bone Disease	☐	☐
Breathing Problem	☐	☐
Bruise Easily	☐	☐
Cancer	☐	☐
Chemical Dependency	☐	☐
Chemotherapy	☐	☐
Chest Pain	☐	☐
Circulatory Problems	☐	☐

	Yes	No
Cold Sores/Fever Blisters	☐	☐
Congenital Heart Disorder	☐	☐
Convulsions/Seizures	☐	☐
Diabetes	☐	☐
Easily Winded	☐	☐
Emphysema	☐	☐
Excessive Bleeding	☐	☐
Epilepsy	☐	☐
Frequent Headaches	☐	☐
Genital Herpes	☐	☐
Glaucoma	☐	☐
Hay Fever	☐	☐
Head Injuries	☐	☐
Hearing Impaired	☐	☐
Heart Disease	☐	☐
Heart Pacemaker	☐	☐
Heart Valve, Murmur	☐	☐
Hepatitis/Liver Disease Type(s)	☐	☐

	Yes	No
Hepatitis Carrier	☐	☐
High Blood Pressure	☐	☐
Hip or Joint replacement	☐	☐
HPV	☐	☐
Irregular Heart Beat	☐	☐
Kidney Disease	☐	☐
Kidney Dialysis	☐	☐
Latex Sensitivity	☐	☐
Leukemia	☐	☐
Lupus	☐	☐
Low Blood Pressure	☐	☐
Malignancies	☐	☐
Mitral Valve Prolapse	☐	☐
Neck & Back Problems	☐	☐
Nervous Problems/Disorders	☐	☐
Osteoporosis	☐	☐
Pacemaker	☐	☐
Pain in jaw joints	☐	☐
Prosthetic Joints	☐	☐

	Yes	No
Psychiatric Care	☐	☐
Radiation Treatment	☐	☐
Recent Weight Loss	☐	☐
Respiratory Problems/ Disorders	☐	☐
Rheumatic Fever	☐	☐
Rheumatism	☐	☐
Scarlet Fever	☐	☐
Seizures/Fainting Spells	☐	☐
Shingles	☐	☐
Sickle Cell	☐	☐
Sinus Problems	☐	☐
Stomach Ulcers	☐	☐
Stroke	☐	☐
Thyroid Disease	☐	☐
Tuberculosis	☐	☐
Tumors or growths	☐	☐
Ulcers	☐	☐
Venereal Disease	☐	☐
Yellow Jaundice	☐	☐

Medical Questions

List any medications you are taking including nonprescription drugs:

____
____
____

Are you allergic to any medications? ☐Yes ☐No If yes, please list below:

____
____

Are you in good health? ☐Yes ☐No

Date of last medical exam:

Have you ever been hospitalized? ☐Yes ☐No If yes, what was the problem?

____
____

Do you have any disease/problem you think we should know about? ☐Yes ☐No

____
____
____
____

Have you had a transplant operation that has depressed your immune system? ☐Yes ☐No

Are you pregnant or nursing? If yes, how many weeks? ☐Yes ☐No

____

Do you smoke or chew tobacco? ☐Yes ☐No

Have you had Heart Surgery? ☐Yes ☐No

Are you currently under the care of an MD? ☐Yes ☐No

Are you taking or have you ever taken bisphosphonates? (Fosamax or Actonel for osteoporosis, chemotherapy, etc.) ☐Yes ☐No

Dental History Information

Date of last dental visit?____________________

Name of your previous dentist ____________________

Reason for today's visit?____________________

How often do you floss your teeth?____________________

Have you or a family member ever been treated for periodontal disease? ☐Yes ☐No

Have you ever had complications from an extraction? ☐Yes ☐No

Have you ever had a popping or clicking near your ear when you chew? ☐Yes ☐No

Are you prone to frequent headaches? ☐Yes ☐No

Do you grind your teeth? ☐Yes ☐No

Do you snore? ☐Yes ☐No

Do you have problems with bad breath? ☐Yes ☐No

Have you ever had an allergic reactions to a crown, metal filling or dental appliance? ☐Yes ☐No

Are your teeth sensitive to hot, cold or pressure? ☐Yes ☐No

On a scale from 1 to 10, with 10 being the highest, how important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

If you could change anything about your smile, what would it be:

- ☐ Whiter
- ☐ Straighter
- ☐ Close Gaps
- ☐ Replace silver mercury fillings
- ☐ Repair chipped teeth
- ☐ Replace missing teeth
- ☐ Less gums showing
- ☐ Replace old crowns or caps that don't match

I certify that I have read and understand the questions above. I acknowledge that my questions have been answered to my satisfaction. I will not hold my dentist or and other members of his/her staff responsible for any errors that I have made in the completion of this form.

Patient: ____________________ Date: __________

Parent/Guardian (if patient is a minor):____________________ Date: __________

Reviewed by: ____________________ Date: __________

Doctor Signature:____________________ Date: __________

Thank you for choosing Curley Implant & General Dentistry. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of this mission is making the cost of optimal care as easy and manageable as possible for our patients. We offer easy and convenient payment options and accept all dental insurance.

We accept the following forms of payment:

* Cash
* Credit Card (Visa, Mastercard, Discover & American Express)
* Check
* CareCredit

Dental Insurance:

Great news, we accept all dental insurance and are in-network with many dental insurance companies. In preparation for your appointment with us, we will contact your insurance company to verify your eligibility and obtain a breakdown of benefits. (We do not accept Medicaid or bill Medical plans).

At your appointment, we will provide a treatment plan with an **ESTIMATE** of your current coverage and file the claim to your insurance company for you.

All co-payments are due at the time the service is provided. It is important to provide us with accurate insurance information and keep us updated on any changes so claims process smoothly. ***Please note that if your insurance company pays less than estimated, you are responsible for the balance.***

Appointment Confirmations & Cancellations:

Our goal is to provide treatment in a timely manner with as few visits as necessary. We understand your time is very valuable. We will be placing a phone call to you 48 hours before your scheduled appointment as a reminder. This is also a great time to ask us any questions regarding your visit and provide updated information as necessary. We understand that unforeseen circumstances may arise, which may result in you canceling your appointment. We do require at least a ***24 hour notice***, if you need to cancel your appointment.

Acknowledgment:

I understand that co-payments including plan deductibles are due at the time of service. I agree that while the Practice will file claims with my insurance company on my behalf, I remain responsible to the practice for what is not paid by my insurance company.

______________________________ ________________________

Patient, Parent or Guardian Signature Date