



Dr. James J. Richart, DMD, LLC
1164-A Northbridge Ave.
Charleston, SC 29407
843-852-3401

Patient Information

<p>Patient Information</p> <p>Today's Date _____</p> <p>Patient Name _____</p> <p style="padding-left: 40px;">Last First MI</p> <p>What you prefer to be called? _____</p> <p>Birthdate _____ Age: _____ Male/Female</p> <p>SS# _____</p> <p>Mailing Address: _____</p> <p>_____</p> <p>City State ZIP</p> <p>Home Phone: _____</p> <p>Work Phone: _____</p> <p>Other Phone: _____</p> <p>E-Mail Address: _____</p> <p>Would you like to be e-mailed confirmations and appointment reminders? Yes / No</p> <p>Employer: _____</p> <p>Occupation: _____</p> <p>Employer's Address: _____</p> <p>_____</p> <p>Status (Circle one) Married Single Divorced Separated Widowed</p> <p>Spouses Name: _____</p> <p>Do you have any children? Yes/No How many? _____</p> <p>Who may we thank for referring you? _____</p> <p>_____</p> <p>Account Information</p> <p>Person ultimately responsible for account (if different from above): _____</p> <p>Relation: _____</p> <p>Billing Address: _____</p> <p>_____</p> <p>City State ZIP</p> <p>SS# _____</p> <p>Drivers License #: _____</p> <p>Work Phone#: _____</p> <p>_____ : I hereby authorize assignment of my rights</p> <p>Initials _____ and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid for by my insurance company.</p>	<p>Insurance Information:</p> <p>Primary Dental Insurance</p> <p>Employers Name: _____</p> <p>Insurance Company Name: _____</p> <p>Mailing Address for Claims: _____</p> <p>_____</p> <p>Phone #: _____</p> <p>Insured's SS#: _____</p> <p>Group #: _____</p> <p>Insured's Name: _____</p> <p>Relation: _____ Date of Birth _____</p> <p>Secondary Dental Insurance:</p> <p>Employers Name: _____</p> <p>Insurance Company Name: _____</p> <p>Mailing Address for Claims: _____</p> <p>_____</p> <p>Phone #: _____</p> <p>Insured's SS#: _____</p> <p>Group #: _____</p> <p>Insured's Name: _____</p> <p>Relation: _____ Date of Birth _____</p> <p>Emergency Information:</p> <p>In the event of an emergency who should we contact?</p> <p>_____</p> <p>Relation: _____</p> <p>Phone: _____ Phone: _____</p> <p>Who is your Medical Doctor? _____</p> <p>Dr.'s Phone: _____</p> <p>Pharmacy Information:</p> <p>What Pharmacy do you use:</p> <p>_____</p> <p>Phone # of Pharmacy:</p> <p>_____</p>
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To our patients with dental insurance:

Welcome to our practice! As a courtesy to our patients, we will gladly file your primary insurance once your coverage has been confirmed. At the time of service, we will ask you for an estimated co-payment and any deductible which may apply.

Since we can only estimate what your insurance company will pay, you may be left with either a credit or a balance due. You can apply a credit to your other treatment or request a refund. If you have a balance due, we will send you a statement.

If your insurance company has not paid your claim within 30 days, we will re-file your claim. If it is not paid after 60 days, or if the claim is denied, the full balance will become your responsibility.

We cannot file secondary insurance, but we will be happy to help you by giving you a statement and instructions on how to file the claim.

Please ask us if you have any questions about your insurance. We will try to help you as much as we can.

Thank you,

Dr. James Richart

NOTICE OF PRIVACY PRACTICES
THIS NOTICE DESCRIBES HOW MEDICAL/DENTAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
Please review it carefully.

The Health Insurance Portability & Accountability Act of 1996 (“HIPAA”) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. “HIPAA” provides penalties for covered entities that misuse personal health information.

As required by “HIPAA”, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related service by one or more health care providers. An example of this would include teeth cleaning services.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conduction quality assessment and improvement activities, auditing functions, cost-management analysis and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and service that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a request restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of APRIL 1, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

1164-A Northbridge Ave.
Charleston, SC 29406

For more information about HIPAA Or to file a complaint: 1-877-696-6775

The U.S. Dept. of Health & Human Services- Office of Civil Rights
200 Independence Ave. S.W., Washington, DC 20201

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

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I understand that, under the Health Insurance Portability & Accountability Act of 1996 (“HIPAA”), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain Payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices*.

I understand that I may request in writhing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient’s signature in acknowledgement on this notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:	

Dental/Medical History Form

Name: _____ Date: _____

Sex: Male / Female Height: _____ Weight : _____ DOB ____/____/____

If you are completing this form for another person, what is your relationship to that person: _____

1. What is your primary dental complaint? _____
 2. When was your last dental cleaning? _____ Your last complete dental exam? _____ Your last Full mouth X-Ray? _____
 3. Do you have an uncompleted treatment from your last dental visit? _____
 4. Are you satisfied with your simile? Yes /No If No, Why? _____
5. Have you ever been told you have, or have symptoms of gum disease (bleeding gums, sore gums, bad taste or odor in the mouth, loose teeth)? Yes/ No
6. Do you suffer from frequent migraine headaches or have problems with your Jaw Joint? Yes No

For the following questions please circle all answers that apply, if none apply please check none.

Do you have, or have you ever had any of the following: Circle all that apply

Heart Murmur	Rheumatic Fever	Vascular Shunt	High Blood Pressure	Coronary Occlusion
Arteriosclerosis	Stroke	Heart Attack	Chest Pain	Artificial Heart Valves
Heart Defect	Pacemaker	Heart Surgery	Congestive Heart Failure	
AIDS/ HIV	Hepatitis	Tuberculosis	Sexually Transmitted Disease	NONE

Are you allergic to any of the following: Circle all that apply

Penicillin	Sulfa	Erythromycin	Local Anesthetics	Other Medicine _____
Codeine	Nickel/Other Metals	Latex		No Allergies

Do you have, or have you had, any problems with the following: Circle all that apply

Sinus Trouble	Asthma	Bronchitis	Emphysema	Other Respiratory Problems
Diabetes	Thyroid Disorder	Liver Problems	Kidney or Adrenal Problems	Jaundice
Digestive Problems	Colitis	Stomach Ulcer	Hiatal Hernia	
Neurological Problems	Fainting	Seizures	Epilepsy	Mental Health Problems
Depression	Abnormal Bleeding	Clotting Problems	Phlebitis	Anemia Transfusions
Cancer	Tumor(s)	Cyst	Biopsy	
Arthritis	Artificial Joints	Muscle or Bone Disease		NONE
Are you Pregnant?	Taking Birth Control?	Nursing?		

Do you: Circle all that apply

Smoke	Drink Alcohol	Use Illegal Drugs	Use Chewing Tobacco/Snuff			
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Have you ever been : Hospitalized Operated on
Treated for any other conditions not on this form? _____

Are you currently taking any of the following:
 Steroids Tranquilizers Asprin Blood Pressure Medication Thyroid Medicine

List All Medications you are currently taking: _____

I understand that this medical history is a legal document and that I have answered all of the above questions to ht e best of my ability and knowledge and I will not hold my dentist or any other staff members responsible for any errors or omissions I have made in the completion of this form.

Signature of Patient or Legal Guardian **X** _____