Robert L. Orander D.D.S., F.A.G.D., P.A.

2301 Rexwoods Drive, Ste. 112 • Raleigh, NC 27607
(919) 787-3365 • roboranderdentistry.com

TODAY'S DATE: | HOME PH _____ WORK PH _____ CELL PH _____

PATIENT'S SOCIAL SECURITY NUMBER
– –

PLEASE PRINT ALL INFORMATION CLEARLY

PATIENT NAME Last | First | Middle | TITLE (Check one) ☐ MRS. ☐ MS. ☐ MR. ☐ DR. ☐ OTHER____

DATE OF BIRTH Month Day Year | SEX (Check one) FEMALE ☐ MALE ☐

HOME ADDRESS (Number, Street, Route, Etc.)

CITY | STATE | ZIP

PLEASE PROVIDE THE FOLLOWING INFORMATION IF THE PATIENT IS UNDER 18 YEARS OF AGE OR HAS A LEGAL GUARDIAN

FATHER First	Last	Occupation	DAYTIME PHONE ( ) –
MOTHER First	Last	Occupation	DAYTIME PHONE ( ) –

MARITAL STATUS OF PARENTS
MARRIED ☐ SINGLE ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED ☐

WHO DO WE CONTACT IN CASE OF EMERGENCY?

NAME First	Last	DAYTIME PHONE ( ) –

REFERRED TO OUR OFFICE BY:

WHO WILL BE RESPONSIBLE FOR PAYMENT?

NAME First	Last	SOCIAL SECURITY NUMBER – –

MAILING ADDRESS (If different from Patient)
(Number, Street, Box, Route, Etc.)

CITY | STATE | ZIP

WHERE EMPLOYED | NUMBER OF YEARS EMPLOYED

EMPLOYER'S MAILING ADDRESS (Number, Street, Box, Route, Etc.) | DAYTIME PHONE ( ) –

CITY | STATE | ZIP

PAYMENT METHOD (Check one)
CASH ☐ CHECK ☐ INSURANCE ☐ VISA ☐ MASTER CARD ☐

DRIVER'S LICENSE NUMBER | STATE

PLEASE ANSWER THE FOLLOWING QUESTIONS IF THE PATIENT HAS DENTAL INSURANCE

WHAT IS THE RELATIONSHIP OF THE PATIENT TO THE POLICYHOLDER?

POLICYHOLDER'S NAME: First	Last	SOCIAL SECURITY NUMBER – –

POLICYHOLDER'S EMPLOYER

EMPLOYER'S ADDRESS (Number, Street, Box, Route, Etc.) | EMPLOYER'S PHONE ( ) –

CITY | STATE | ZIP

NAME OF INSURANCE COMPANY

ADDRESS TO SUBMIT CLAIMS (Number, Street, Box, Route, Etc.)

CITY | STATE | ZIP

POLICY/GROUP NUMBER OR NAME

POLICY HOLDER'S ID NUMBER

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MEDICAL DENTAL HEALTH HISTORY QUESTIONNAIRE

PATIENT NAME: _____
RECORD NO.: _____
BIRTH DATE: _____/ _____/ _____

DATE: _____/_____/_____

DIRECTIONS TO THE PATIENT: The following information about your health history is very important for us to provide you with the best possible dental care in a safe way. Incorrect information may be dangerous to your health. ALL questions must be answered completely and accurately. If you don't understand a question, or are unsure to answer, or want to discuss it with the dentist, circle its number or letter. This Health History Questionnaire will become a part of the patient's dental treatment record and will be considered confidential information.

MEDICAL HISTORY

Name of your physician or place where you received medical care: _____

Physician's Office Phone: _____ Office Address: _____

1. Are you in good health? ☐ Yes ☐ No ☐ Don't Know
2. Has there been any change in your health in the past year? ☐ Yes ☐ No ☐ Don't Know
   If Yes, Please explain: _____
3. Have you ever been hospitalized, had a major operation or serious illness? ☐ Yes ☐ No ☐ Don't Know
   If Yes, Please explain: _____
4. Date of your last visit to your doctor? _____ Reason for last visit _____
5. Are you currently receiving treatment or regular medical care by your doctor? ☐ Yes ☐ No ☐ Don't Know
   If Yes, for what condition(s)? _____
6. Are you taking any of the following medications?
   a. Antibiotics or sulfa drugs ☐ Yes ☐ No ☐ Don't Know
   b. Anticoagulants (blood thinners) ☐ Yes ☐ No ☐ Don't Know
   c. Medicine for high blood pressure ☐ Yes ☐ No ☐ Don't Know
   d. Cortisone (steroids) ☐ Yes ☐ No ☐ Don't Know
   e. Tranquilizers ☐ Yes ☐ No ☐ Don't Know
   f. Antihistamines ☐ Yes ☐ No ☐ Don't Know
   g. Aspirin ☐ Yes ☐ No ☐ Don't Know
   h. Insulin, tolbutamide (Orinase) or other drugs for diabetes ☐ Yes ☐ No ☐ Don't Know
   i. Digitalis or drugs for heart trouble ☐ Yes ☐ No ☐ Don't Know
   j. Nitroglycerine ☐ Yes ☐ No ☐ Don't Know
   k. Birth control pills or other hormones ☐ Yes ☐ No ☐ Don't Know
   l. Pain medications such as Advil, Nuprin, Motrin, or Naprosyn ☐ Yes ☐ No ☐ Don't Know
   m. Synthroid or other thyroid medication ☐ Yes ☐ No ☐ Don't Know
   n. Others, please list: _____
7. Are you allergic to or have you had any unusual reaction to any medications? ☐ Yes ☐ No ☐ Don't Know
   If Yes, what medications and reactions? _____

HAVE YOU EVER HAD OR BEEN TREATED BY A DOCTOR FOR: *(Circle your response or underline any condition(s) that apply)*

8. Damaged heart valves or artificial heart valves , including heart murmur, rheumatic fever, rheumatic heart disease: ☐ Yes ☐ No ☐ Don't Know
9. Congenital heart problems ☐ Yes ☐ No ☐ Don't Know
10. Heart trouble, heart attacks, high blood pressure, stroke ☐ Yes ☐ No ☐ Don't Know
    a. Do you have pain in your chest upon exertion? ☐ Yes ☐ No ☐ Don't Know
    b. Are you ever short of breath after mild exercise? ☐ Yes ☐ No ☐ Don't Know
    c. Do your ankles swell? ☐ Yes ☐ No ☐ Don't Know

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11. Severe or frequent headaches? Sinus problems? ☐ Yes ☐ No ☐ Don't Know
12. Blood disorders such as anemia or hemophilia? ☐ Yes ☐ No ☐ Don't Know
13. Blood transfusion? ☐ Yes ☐ No ☐ Don't Know
14. Breathing problems, emphysema, tuberculosis or other lung problems? ☐ Yes ☐ No ☐ Don't Know
15. Asthma, hay fever or hives? ☐ Yes ☐ No ☐ Don't Know
16. Stomach or intestinal disease, or ulcers? ☐ Yes ☐ No ☐ Don't Know
17. Cancer, x-ray treatments, or chemotherapy? ☐ Yes ☐ No ☐ Don't Know
18. Diabetes or blood sugar problems? ☐ Yes ☐ No ☐ Don't Know
19. Hepatitis, jaundice, or liver disease? ☐ Yes ☐ No ☐ Don't Know
20. Kidney infections, frequent urination, or renal (kidney) dialysis? ☐ Yes ☐ No ☐ Don't Know
21. Stroke, seizures, fainting spells, numbness or other neurologic problems? ☐ Yes ☐ No ☐ Don't Know
22. Syphilis, gonorrhea or genital herpes? ☐ Yes ☐ No ☐ Don't Know
23. AIDS, AIDS-related condition or HIV positive? ☐ Yes ☐ No ☐ Don't Know
24. Tumors or growths? ☐ Yes ☐ No ☐ Don't Know
25. Arthritis or rheumatism? ☐ Yes ☐ No ☐ Don't Know
26. Phobias, severe anxieties, depression, psychoses, unusual fears, or other mental problems? ☐ Yes ☐ No ☐ Don't Know
27. Psoriasis, seborrhea, or other skin diseases? ☐ Yes ☐ No ☐ Don't Know
28. Have you lost weight without dieting or gained weight in recent months? ☐ Yes ☐ No ☐ Don't Know
29. Do you have complaints regarding your eyes, ears, or nose? ☐ Yes ☐ No ☐ Don't Know
    If Yes, explain: _____
30. Do you wear contact lenses? ☐ Yes ☐ No ☐ Don't Know
31. Do you now use or have even used recreational drugs? ☐ Yes ☐ No ☐ Don't Know
32. How many packs of cigarettes do you smoke per day? _____ packs per day
33. How many drinks of beer, wine or liquor do you drink per day? _____ drinks per day
34. For women, are you pregnant or do you think you may be pregnant? ☐ Yes ☐ No ☐ Don't Know
35. Are there any other problems about your health that you know of? ☐ Yes ☐ No ☐ Don't Know
    If Yes, describe: _____

DENTAL HISTORY

36. What is your major dental concern? _____
37. Date of last visit to a dentist? _____
38. Reason for your last visit or series of visits? _____
39. Date you last had dental x-rays taken? _____
40. Have you always had your teeth cleaned at least once a year? ☐ Yes ☐ No ☐ Don't Know
41. Do you use dental floss once a day? ☐ Yes ☐ No ☐ Don't Know
42. Is there fluoride in your drinking water? ☐ Yes ☐ No ☐ Don't Know
43. Do you brush your teeth at least once a day? ☐ Yes ☐ No ☐ Don't Know
44. Do you use a toothpaste that contains fluoride? ☐ Yes ☐ No ☐ Don't Know
45. Do you or have you used any form of fluoride? ☐ Yes ☐ No ☐ Don't Know
46. Have you ever fainted during a dental visit? ☐ Yes ☐ No ☐ Don't Know
    If Yes, explain: _____
47. Have you experienced an unusual reaction to dental medication or anesthetic? ☐ Yes ☐ No ☐ Don't Know

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48. Have you experienced prolonged bleeding following dental treatment? ☐ Yes ☐ No ☐ Don't Know
    If Yes, explain: _____
49. Have you had any other complications following dental treatment? ☐ Yes ☐ No ☐ Don't Know
    If Yes, explain: _____
50. Have you had any injury to your teeth, jaws or face? ☐ Yes ☐ No ☐ Don't Know
    If Yes, explain: _____
51. Are you happy with the appearance of your teeth? ☐ Yes ☐ No ☐ Don't Know
52. Do your gums bleed when you brush your teeth or when you eat? ☐ Yes ☐ No ☐ Don't Know
53. Does food or dental floss catch between your teeth? ☐ Yes ☐ No ☐ Don't Know
54. Are some of your teeth becoming loose? ☐ Yes ☐ No ☐ Don't Know
55. Are there spaces between your teeth now where there were none before? ☐ Yes ☐ No ☐ Don't Know
56. Are any of your teeth sensitive to hot, cold or pressure? ☐ Yes ☐ No ☐ Don't Know
57. Do any of your teeth ache? ☐ Yes ☐ No ☐ Don't Know
58. Do you experience pain or clicking in your jaws joints? ☐ Yes ☐ No ☐ Don't Know
59. Are there any sores or growths in your mouth? ☐ Yes ☐ No ☐ Don't Know
60. Are you worried about receiving dental treatment? ☐ Yes ☐ No ☐ Don't Know
61. Do you have any other dental concerns or complaints? ☐ Yes ☐ No ☐ Don't Know
    If Yes, explain: _____

_____

SIGNATURE OF PATIENT: *I understand the need for these questions to be answered truthfully. To the best of my knowledge, the answers I have given are accurate. I also understand it is very important to report any changes in my medical or dental status to the dentist at the earliest possible time, and I agree to do so. I give permission to the dentist to obtain from my physician any additional information regarding my medical history needed to provide me the best dental treatment possible.*

PERSON COMPLETING THIS FORM: Signature _____Date_____
If other than patient, indicate relationship: _____

PATIENT, DO NOT WRITE BELOW THIS LINE

SUMMARY OF HISTORY AND NOTATION OF SIGNIFICANT FINDINGS

_____
_____
_____
_____
_____
_____
_____
_____

SIGNATURES AND DATES:

_____Date _____

_____Date _____

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PRIVACY PRACTICES OF ROBERT L. ORANDER, DDS, FAGD, PA

We do not give, share or sell ANY personal information to any outside entity of this office with the EXCEPTION of (if applicable) your personal insurance company or if we are referring you to a specialist for dental treatment. (Please keep in mind that your personal insurance company already has your basic information and we only supply to them via paper claim the proper American Dental Association Codes for work that was completed in this office on the date of service).

We do not file claims electronically.

If we are calling your pharmacy for a prescription for you, we will give the pharmacist your personal information (please keep in mind that your pharmacist already has your personal and insurance information) and also the prescription you need.

Your dental records are secured in this office at all times and should another medical doctor or dentist need or request your information, we will send that information to them only with your written consent.

Robert L. Orander, DDS, FAGD, PA

ACKNOWLEDGMENT OF THE PRIVACY PRACTICES OF ROBERT L. ORANDER, DDS, FAGD, PA

This is to acknowledge that I have received a copy of the Privacy Practices of Robert L. Orander, DDS, FAGD, PA.

Signature Date

Witness

Print Name

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 READ CAREFULLY.

We are required by law to maintain the privacy of protected health information to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. The notice takes effect **9 / 23 / 13** 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, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice 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.

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HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing collections, claims management and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.

Required by Law. We may use or disclose your health information when we are required to do so by law.

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

. Prevent or control disease, injury or disability;

. Report child abuse or neglect;

· Report reactions to medications or problems with products or devices;

. Notify a person of a recall, repair, or replacement of products or devices;

. Notify a person who may have been exposed to a disease or condition; or

. Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence.

OTHER USES AND DISCLOSURES OF PHI

Your authorization is reviewed, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

YOUR HEALTH INFORMATION RIGHTS

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the dental reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. 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 the additional requests.

Right to Request a Restriction. You have the right to request additional restrictions

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 official having lawful custody the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health informat1on to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.
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Health Oversight Activities. We may d1sclose your PHI loan oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health informat1on about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. **We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment** or health care operations, and the information pertains solely to ,a health care system or service for which you or a person on your behalf (other than the health plan) has paid our practice in full. ·

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or locations you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

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. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (email).

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 if 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 you 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.

Our Privacy Official: **Robert Orander**

Telephone: **(919) – 787 – 3365** Fax: **(919) – 787 – 3219**

Address: **2301 Rexwoods Drive, Suite 112 Raleigh NC 27607**

Email: info@roboranderdentistry.com