



Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

- Are you under a physician's care now? O Yes O No If yes, please explain:
Have you ever been hospitalized or had a major operation? O Yes O No If yes, please explain:
Have you ever had a serious head or neck injury? O Yes O No If yes, please explain:
Are you taking any medications, pills, or drugs? O Yes O No If yes, please explain:
Do you take, or have you taken, Phen-Fen or Redux? O Yes O No If yes, please explain:
Are you on a special diet? O Yes O No If yes, please explain:
Do you use tobacco, vape, or e-cigarettes? O Yes O No If yes, please explain:
Do you use controlled substances? O Yes O No If yes, please explain:

Women: Are you Pregnant/Trying to get pregnant? O Yes O No Taking oral contraceptives? O Yes O No Nursing? O Yes O No

Are you allergic to any of the following? O Aspirin O Penicillin O Codeine O Acrylic O Metal O Latex O Local Anesthetics O Other - If yes, please explain:

Do you have, or have you had, any of the following?

- AIDS/HIV Positive O Yes O No Cortisone Medicine O Yes O No Hemophilia O Yes O No Renal Dialysis O Yes O No
Alzheimer's disease O Yes O No Diabetes O Yes O No Hepatitis A O Yes O No Rheumatic Fever O Yes O No
Anaphylaxis O Yes O No Drug Addiction O Yes O No Hepatitis B or C O Yes O No Rheumatism O Yes O No
Anemia O Yes O No Easily Winded O Yes O No Herpes O Yes O No Scarlet Fever O Yes O No
Angina O Yes O No Emphysema O Yes O No High Blood Pressure O Yes O No Shingles O Yes O No
Arthritis/Gout O Yes O No Epilepsy or Seizures O Yes O No Hives or Rash O Yes O No Sickle Cell Disease O Yes O No
Artificial Heart Valve O Yes O No Excessive Bleeding O Yes O No Hypoglycemia O Yes O No Sinus Trouble O Yes O No
Artificial Joint O Yes O No Excessive Thirst O Yes O No Irregular Heartbeat O Yes O No Spina Bifida O Yes O No
Asthma O Yes O No Fainting Spells/Dizziness O Yes O No Kidney Problems O Yes O No Stomach/Intestinal Disease
Blood Disease O Yes O No Frequent Cough O Yes O No Leukemia O Yes O No Stroke O Yes O No
Breathing Problem O Yes O No Frequent Diarrhea O Yes O No Liver Disease O Yes O No Swelling of Limbs O Yes O No
Bruise Easily O Yes O No Frequent Headaches O Yes O No Lung Disease O Yes O No Thyroid Disease O Yes O No
Cancer O Yes O No Genital Herpes O Yes O No Mitral Valve Prolapse O Yes O No Tonsillitis O Yes O No
Chemotherapy O Yes O No Hay Fever O Yes O No Pain in Jaw Joints O Yes O No Tuberculosis O Yes O No
Chest Pains O Yes O No Heart Attack/Failure O Yes O No Parathyroid Disease O Yes O No Tumors or Growths O Yes O No
Cold Sores/Fever Blisters O Yes O No Heart Murmur O Yes O No Psychiatric Care O Yes O No Ulcers O Yes O No
Congenital Heart Disorder O Yes O No Heart Pace Maker O Yes O No Radiation Treatments O Yes O No Venereal Disease O Yes O No
Convulsions O Yes O No Heart Trouble/Disease O Yes O No Recent Weight Loss O Yes O No Yellow Jaundice O Yes O No

Have you ever had any serious illness not listed above? O Yes O No - If yes, please explain:
Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent, Guardian Date

**PATIENT DEMOGRAPHICS**

DATE OF COMPLETION (mm/dd/yyyy): \_\_\_\_\_

<b>Legal Name (Last, First, MI):</b>		<b>Preferred Name:</b>		<b>Primary Doctor:</b>	
<b>Date of Birth (mm/dd/yyyy):</b> ____/____/____		<b>Birth Sex:</b> <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Other <input type="checkbox"/> Undefined			
<b>SSN:</b> _____		<b>Sexual Orientation –</b> <input type="checkbox"/> Straight or Heterosexual <input type="checkbox"/> Lesbian, gay or homosexual <input type="checkbox"/> Bisexual <input type="checkbox"/> Something else <input type="checkbox"/> Don't know <input type="checkbox"/> Choose not to answer		<b>Gender Identity: (Check one):</b> <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Male/ Trans Man/ Female-to-Male (FTM) <input type="checkbox"/> Transgender Female/ Trans Woman/ Male-to-Female <input type="checkbox"/> GenderQueer (neither exclusively male nor female) <input type="checkbox"/> Additional gender category/ Other. Please specify: _____ <input type="checkbox"/> Chose not to answer	
<b>Race:</b> <input type="checkbox"/> Black / African American <input type="checkbox"/> White <input type="checkbox"/> American Indian /Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> More than one race <input type="checkbox"/> Unreported /Refuse to report race		<b>Marital Status:</b> <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widow / Widower			
<b>Ethnicity:</b> <input type="checkbox"/> Hispanic <input type="checkbox"/> Non- Hispanic		<b>Disabled:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Homeless:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Veteran:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No			
<b>Home Address:</b>			<b>City</b>	<b>NC</b>	<b>Zip code</b>
<b>Home Phone:</b>	<b>Cell Phone:</b>	<b>Work Phone:</b>	<b>Email Address:</b>		
<b>Preferred method of communication:</b> <input type="checkbox"/> Postal Mail <input type="checkbox"/> Phone <input type="checkbox"/> Email / Text					
<b>Emergency Contact 1:</b>		<b>Relationship:</b>		<b>Home Phone:</b>	
<b>Emergency Contact 2:</b>		<b>Relationship:</b>		<b>Home Phone:</b>	
<b>Responsible Party:</b>		<b>Relationship:</b>		<b>Date of Birth (mm/dd/yyyy):</b> ____/____/____	
<b>Responsible Party Home Address:</b>		<b>City</b>		<b>NC</b>	<b>Zip code</b>
<b>Employer / School:</b>					

Would you like information on advance directives? (Living Will, Health Care Power of Attorney, etc.)  Yes     No

**Footnote:** Kintegra Health, with headquarters in Gastonia, North Carolina, includes Kintegra Medical, Dental, Integrated Medicine, and Behavioral Health Practices throughout North Carolina. **Affiliate:** Local Health Departments: Catawba, Davie, Davidson, Forsyth, Gaston, Iredell, Lincoln, Mecklenburg.

**INSURANCE INFORMATION**

<b>Primary Insured's Name:</b> _____		<b>Secondary Insured's Name:</b> _____	
<b>Date of Birth (mm/dd/yyyy)   SSN:</b> _____ - _____ - _____ ____ / ____ / ____		<b>Date of Birth (mm/dd/yyyy)   SSN:</b> _____ - _____ - _____ ____ / ____ / ____	
<b>Primary Insurance:</b>	<b>Employer:</b>	<b>Secondary Insurance:</b>	<b>Employer:</b>
<b>Insurance ID Number:</b>	<b>Group Number:</b>	<b>Insurance ID Number:</b>	<b>Group Number:</b>
<b>Primary Insurance Address:</b>		<b>City</b>	<b>NC</b>   <b>Zip code</b>
<b>Secondary Insurance Address:</b>		<b>City</b>	<b>NC</b>   <b>Zip code</b>

**FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS:****Consent for Healthcare and Release of Personal Health Information:**

I voluntarily consent to healthcare treatment (i.e., Dental, Medical Care and/or Behavioral Health) from the providers and staff of Kintegra Health and all its affiliates. I consent to all necessary treatment of illness and injuries and preventative care including screenings, lab work (including HIV testing), immunizations and referrals. I am aware that neither the practice of medicine nor the delivery of mental/behavioral health treatment are an exact science. No guarantees have been made to me regarding the results of treatments or examinations by my caregivers. I understand that Kintegra employs a "team based" approach to the delivery of healthcare and that health information may be exchanged between Kintegra providers and staff members involved in my care to ensure appropriate treatment planning and adequate care. I consent to the use and disclosure of Protected Health Information (PHI) about me for treatment, payment and healthcare operations. If covered by Medicare or Medicaid, I certify that the information provided by me in applying for payment under Title's V, XVIII and/or XIX of the Social Security Act is correct. I understand that I am automatically enrolled in the Health Information Exchange, but at any time can opt-out by completing an Opt-out form provided by my provider. I certify that I have read and understand this form.

**Signature of Patient or Authorized Person:** \_\_\_\_\_ **Date/Time** \_\_\_\_\_

**Insured Party or Financial Guarantor (if different from above):** \_\_\_\_\_ **Date/Time** \_\_\_\_\_

**FOR STAFF USE ONLY:**

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date / Time

- Patient refused to sign
- Patient was initially treated for an emergency. Patient was either: (Choose One)
- Given the notice after stabilization *Or*
  - Will be given the notice after transfer

If limited English proficient or hearing impaired, offer interpreter at no additional cost:

LEP: Interpreter accepted \_\_\_\_\_  LEP: Interpreter Refused: \_\_\_\_\_

Name / Number of Person/Services Chosen/Used



# Permission to Communicate - Authorization for Release of Information

Name of Patient \_\_\_\_\_ Date of Birth (MM/DD/YYYY) \_\_\_\_\_

\_\_\_\_\_ is authorized to release protected health information about the Facility Name above named patient in the following manner and to identified persons.

So that Kintegra Health may serve you better, you have the option of providing us with a list of caregivers with whom we may discuss your appointments, referrals, test, lab results and any other health information you desire us to share.

### Describe how information will be received.

### Describe the information to be released.

Check each person/entity that you approve to receive information.

Check each that can be given to person/entity on the left in the same section.

Voice Mail

Medical (Appointments, referrals, test and lab results and any other health information)

Mail

Financial

Other \_\_\_\_\_

Other person(s):

Medical (Appointments, referrals, test and lab results and any other health information)

Name / Phone Number / Relationship

Financial

Other \_\_\_\_\_

Email communication-Provide email address\*

Medical (Appointments, referrals, test and lab results and any other health information)

\*For email communication to occur, please accept the disclosure below:

Financial

Breach notification

Text communication - Provide number \*

Appointment reminder

\*For text communication to occur, accept the disclosure below:

Other: \_\_\_\_\_

\*For email and/or text communication I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected.

<input type="checkbox"/> Photo of patient received by patient or legal guardian	<input type="checkbox"/> May be posted in office
<input type="checkbox"/> Photo taken by staff (Example: pre/post procedure)	<input type="checkbox"/> May be posted on website
<input type="checkbox"/> Other	<input type="checkbox"/> Other _____

**Patient Rights:**

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.
- I understand I am automatically enrolled in the Health Information Exchanges, but at any time can opt-out by completing an Opt-Out form provided by my provider.

This authorization will remain in effect until revoked by the patient.

\_\_\_\_\_  
Date  
Signature of Patient or Personal Representative

\*Description of Personal Representative's Authority (attach necessary documentation)

\_\_\_\_\_

I am revoking my authorization to disclose the previously requested protected health information.

\_\_\_\_\_  
Date  
Signature of Patient or Personal Representative

Revised January 2020



## **Kintegra Health Office Policies for all Dental Practices**

**New Patients:** Please arrive thirty (30) minutes early for patient registration.

**Emergencies:** Patients are only allowed one (1) emergency appointment as a new patient. The next appointment will be for an exam, cleaning, and x-rays.

**Sliding Fee Scale:** Proof of income is required at the first appointment. If this is not provided, you will be charged our full fee until income information has been provided to us. All information needs to be updated yearly.

**Late Arrivals:** If you arrive more than ten (10) minutes late for your appointment, you may be asked to reschedule your appointment so that we will have enough time to complete your treatment. This is up to the discretion of the dentist.

**Cancellations:** When canceling an appointment, you must give at least twenty-four (24) hours' notice. Anything less than six (6) hours is viewed as a missed appointment. When a patient misses an appointment, we miss the opportunity to care for that patient as well as another patient who could have used that appointment slot.

### **NO CALL/NO SHOW**

- First missed appointment: A note will be placed in the chart and the patient verbally reminded of our office policy.
- Second Missed appointment: A note will be placed in the chart, the patient verbally reminded again of our office policy, and the patient will not be allowed to reschedule for three (3) months.

**Adults only:** A letter must be written to our Dental Director stating the following:

1. Why you missed the last appointment
  2. Why you feel you need another appointment
  3. Also that you realize you took time where someone else could have been seen.
  4. Also that you realize that if you miss another appointment, it will result in your discharge from the practice for 1 year.
- Third Missed appointment: The Patient will not be allowed to make advance appointments for a period of one (1) year, except for emergencies.
  - If a patient is scheduled with another family member and they both fail to show for their appointments, the family will no longer be able to schedule multiple appointments on the same day.

**Children's escorts:** We appreciate your trust in our dental staff as we provide dental treatment to your child. Our rooms are small and we prefer that only one parent come back with a young child. Children age 6 and over may be escorted to the treatment room by our staff. Before your child is taken back, our staff will discuss with you any dental problems your child is experiencing and any changes in their medical history. Parents of older children are encouraged to allow their children some independence at the dentist's office, but are never prohibited from coming back with their children. In addition, parents that have dental anxiety themselves may find that their children have a more positive experience without them in the back. Our ultimate goal is to give your child the most chances to succeed in their dental treatment so that they may carry this confidence throughout the rest of their lives.

**Photography:** Please discuss taking photos and video for your personal use with the dentist. We do take photos of our patients at times, but only with your advance permission.

**I understand and agree to abide by this no-show policy.**

Patient/Parent signature \_\_\_\_\_ Date: \_\_\_\_\_



Patient label

NOTICE OF PRIVACY PRACTICE
ACKNOWLEDGEMENT FORM

We are required by law to provide you with our Notice of Privacy Practices which explains how we use and disclose your health information. We are also required to obtain your signature acknowledging that this notice has been made available to you as follows:

- http://www.kintegra.org
By writing to the Kintegra Health Privacy Officer, 200 E. Second Avenue, Gastonia, NC 28052
Or by requesting one at any GFHS provider locations

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

(Patient or Authorized Representative)

Relationship to Patient: [ ] Self [ ] Spouse [ ] Parent/Guardian [ ] Other: \_\_\_\_\_

Reason patient unable / unwilling to sign: \_\_\_\_\_

\_\_\_\_\_