WELCOME

Dr. Hilary Craddock & Dr. Sarah Malley are pleased to welcome you to our family here at Richland Dental. Our staff looks forward to working with you in maintaining your dental needs.

Patient Information

Date_____ Sex M F Married Single Widowed Separated Divorced

Patient's Name_____ Preferred Name_____

Home Address_____City_____ State_____Zip_____

Mailing Address_____City_____ State_____ Zip_____

Home Phone_____Work Phone_____ Cell Phone_____

Patient's Social Security _____ Date of Birth_____ Age_____

Email Address_____ Preferred method of contact: Text ___ Email ___ Call ___

Employer/School Name_____Employer/School Phone _____

Employer/School Address_____

Who referred you to our office? _____ Internet ____ Facebook ____ Other _____

In case of Emergency Call_____ Relationship_____ Phone_____

Responsible Party

Person Responsible for Account_____

Relation to Patient_____ Date of Birth_____ SS#_____

Address (if different from patient) _____ Phone_____

City _____ State _____Zip _____

Responsible Party Employer_____Employer Phone_____

Business Address_____

Primary Insurance

Name of Insured_____ Relation to Patient_____ Date of Birth_____

Address (if different from patient) _____Phone _____

City _____ State _____ Zip _____

Employer _____ Business Phone _____ Subscriber SS# _____

Insurance Company _____ Group # _____ Subscriber ID# _____

Secondary Insurance

Name of Insured_____ Relation to Patient_____ Date of Birth_____

Address (if different from patient)_____Phone _____

City _____ State _____ Zip _____

Employer _____ Business Phone _____ Subscriber SS# _____

Insurance Company _____ Group # _____ Subscriber ID# _____

Medical History

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

Who is your family doctor? _____

Do you see a specialist? _____

Are you under medical care now? Yes _____ No _____ If yes, for what? _____

WOMEN

Are you Pregnant? ____ Yes ____ No If so, what month? _____ Dr.'s Name_____ Phone _____

ALLERGIES

Please check if you are you allergic to any of the following?

_____ Penicillin _____ Codeine _____ Aspirin _____ Metal _____ Erythromycin _____ Latex

_____ Sulfa Drugs _____ Local Anesthetics _____ Acrylic _____ Darvon _____ Nitrous Oxide Other _____

MEDICAL CONDITIONS

Please check if you have or have had any of the following conditions:

___High Blood Pressure
___ Diabetes
___ High Cholesterol
___ Heart Trouble, Heart Attack, Angina, Surgery
___ Congenital Heart Lesion (Murmur)
___ Artificial Heart Valve, Pacemaker
___ Neurological Problems
___ Excessive Bleeding following Extractions
___Radiation or Chemotherapy: When _____
___ Anemia or Blood Problems (Hemophilia)
___ Arthritis or Rheumatism
___ Thyroid Problems
___ Rheumatic or Scarlet Fever
___ Chemical Dependency (Alcohol, Drugs, Etc.)
___Do you smoke or use tobacco products?

___ Fainting or Dizzy Spells
___ Alzheimer's or Parkinson's Disease
___ Ulcer or Colitis
___ Stroke
___ Asthma
___ Kidney Problems
___ Malignancies
___ Psychiatric Problems
___ Sinus Problem
___ Eye Disorders or Glaucoma
___ Tuberculosis
___ Venereal Disease
___ Epilepsy or Seizures
___ AIDS/HIV+
___ Hepatitis (type: ___), Liver Disease or Jaundice

___ Artificial Joints: if yes, which joint was replaced: _____ When: _____

Dr.'s Name that replaced joint: _____Address:_____Phone_____

Please list all medications you are currently taking_____

If no medications are listed above please sign below:

I am not taking any medications prescribed by a physician or any over the counter products at this time. I will notify Richland Dental and its staff if this changes in the future. _____ (Signature)

Is there any other Medical information that you feel we should know about?_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that provided 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.

Parent or Patient's Signature_____Date_____

Dental History

Reason for Today's Visit_____ Date of Last Dental Exam_____

Former Dentist _____ Date of Last Dental X-rays _____

Are you having any dental problems at this time? _____

Circle if you have any of the following:

Bad Breath	Grinding or Clenching Teeth	Broken Fillings
Loose Teeth	Sensitivity to Sweets (Hot or Cold)	Clicking or Popping Jaw
Periodontal/Gum Treatment	Food Collection between Teeth	Infection (pus) between Teeth
Sores or Growths in Mouth	Existing Dentures or Partials	Bleeding or Swollen Gums

Have you had bad dental experiences in the past? _____

Are you apprehensive about dental treatments? _____

Is there any other dental information you feel we should be aware of? _____

Have you ever had Botox treatments for headaches/migraines? Y___ N___ Would you like information on this today? Y___ N___

Authorization

I authorize release of any information concerning my (or my child's) dental care for the purpose of evaluating and administering claims for insurance benefits.

I authorize my physician or physicians to release pertinent information to this office for the purpose of fully evaluating my medical conditions for dental purposes. The undersigned hereby authorizes doctor to order x-rays, study model, photographs or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis for the patient's dental needs.

I authorize the release of x-rays and other information pertinent to my (or my child's) dental care to any referring dentist or doctor.

I authorize Dr. Hilary Craddock, DMD/Dr. Sarah Malley, DMD to perform all recommended treatment mutually agreed upon by me and to use appropriate medication and therapy indicated for such treatment.

I grant my permission to you or your assignee, to telephone me at home or my work to discuss matters related to my (or my child's) dental care.

I hereby authorize payment directly to Richland Dental. I understand I am responsible for all cost of my or (my child's) dental treatment. I understand that my insurance is a contract between me and my insurance company and I agree to pay Richland Dental for all my services within 60 days if my bill has not been paid in full. In the case of default of payment, I promise to pay any legal cost incurred in order to collect my balance.

Payment is due at time of service unless prior arrangements have been made

Parent or Patient Signature_____ Date _____

Richland Dental

Hilary Craddock, DMD & Sarah Malley, DMD
125 West Harper Street
Richland, MS 39218

CONSENT FOR DENTAL TREATMENT AND ACKNOWLEDGMENT OF RECEIPT OF INFORMATION

State law requires us to obtain your consent for contemplated dental treatment. Please ask about anything you do not understand. We will be happy to explain. I hereby authorize and direct Dr. Hilary G. Craddock/Dr. Sarah Malley with associates and assistants of her choice to perform needed dental treatment. This includes any necessary or advisable anesthetics.

RISK ASSOCIATED WITH THE RECOMMENDED DENTAL TREATMENT:

I understand that dentistry is not an exact science and that complications may occur despite the best efforts. Partial listings of the risks know to be associated with this treatment and with the associated anesthetics are:

*Swelling & bruising which may necessitate staying home for several days
*Breakage of root(s)
*Paresthesia (Permanent or transient numbness of the cheeks, gums, teeth, lips, tongue, chin, and face)
*TMJ dysfunction or worsening of condition
*Stretching of mouth, which may result in cracking or bruising?
*Instrument breakage
*Infection
*Pain
*Loss of taste
*Sinus involvement
*Bleeding may be heavy enough to stop the procedure
*Loss/damage to adjacent teeth and/or bone
*Change in the bite
*Truisms (Jaw pain or difficulty opening mouth)
*Failure of the treatment to its purpose
*Dry socket
*Swallowing of object
*Fracture or breakage of jaw
*Further surgery or treatment
*Blindness (Partial or complete in both eyes)
*Cheek, tongue, floor of the mouth or other tissue damage from instruments.

State law also requires that we specifically advise you that, although vary rare, death, brain damage, quadriplegia, paraplegia, loss of organ(s), loss of function of an organ(s), loss of function of face, arm(s), or leg(s), and disfiguring scars could occur.

CONSENT FOR TREATMENT

A requirement facing all practitioners providing dental care is that the patient or legal representatives of the patient give the practitioner informed consent. Informed consent indicates your awareness of the possible risks involved in dental procedures, for there are risks in all procedures done for the human body, both medical and dental. For instance, it is possible that doing fillings and crowns on teeth can cause the tooth to become sensitive, requiring root canal therapy or extraction. Some teeth that seem to be successfully restored still may abscess later with the above mentioned complications. This is due to the fact that not all people respond the same way to generally accepted procedures, some of which may be due to, but not limited to, unsuspected allergies, etc. For this reason, we will provide informed consent forms prior to certain dental procedures. You have our assurance that even though an informed consent is a legal requirement of all practitioners of medicine and dentistry, we will endeavor to keep these possible negative occurrences of dental treatment to a minimum. I do hereby authorize Dr. Hilary Craddock/Dr. Sarah Malley to administer local anesthetics and provide dental treatment as may be necessary for the patient named herein. I also understand that I am free to ask any questions regarding procedures and possible risks involved.

I understand that this office requires 48 hours notice to reschedule an appointment and charges $75.00 for patient no shows or short notice cancellations.

Parent or Patient's Signature_____ Date _____

RICHLAND DENTAL

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.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other that photocopies. We will use the format you request unless we cannot practicably do so. 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 the 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 the notice. If you request copies, we will charge you $1.00 of each page, $10.00 per hour for staff time to locate and copy you health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost – based fee for providing your health information in that format. 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 place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in emergency).

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 you by alternative means or at alternative locations, you must make your complaints to the US Department of Health and Human Services. We will provide you with the address to file your complaint with the US 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 US Department of Health and Human Services.

Contact Officer: Kim Williamson, Office Manager

Telephone: 601-932-5100 Fax: 601-939-3080

Address: 125 West Harper Street, Richland, MS 39218

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____have read this document concerning Richland Dental's Notice of Privacy Practices and understand that I may receive a copy of it at any time.

_____

Please Print Name

_____

Signature

_____

Date

RICHLAND DENTAL

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 the notice while it is in effect. This notice takes effect April 14, 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. We reserve the right to make the changes in our privacy practices and the new terms or our notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new 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 and 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, conduction training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in the 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 incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment 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 without your written authorization.

Requirement 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 reasonable 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 to avert a serious threat to your health or safety or the health or 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 authorize 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 of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

Parent or Patient Signature _____ Date _____

Richland Dental
COMPLETE CARE DENTISTRY

Hilary Craddock, DMD Sarah Malley, DMD

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

PATIENT CONSENT

Name: _____Social Security #:_____

Address: _____

Please list all phone numbers where our office may contact you: _____

_____

Please list the names of ALL people (e.g. spouse, parents, etc.) you authorize us to release your health information to, including any copies of your records if needed: _____

_____

Email: _____

TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS

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

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities, and health care operations, 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 our 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, at any time by contacting: **Richland Dental**
125 West Harper Street
Richland, MS 39218
601-932-5100

Right to Revoke: I understand that I may revoke/cancel this authorization by notifying Richland Dental in writing of my intent to revoke authorization or change the name(s) of the individuals to whom information is to be released.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. By signing, I authorize Richland Dental to leave messages and discuss any of my pertinent health information to the listed above people and numbers.

Signature: _____ Date: _____