

# Office Policies

Timothy C. Swing, DMD  
1300 Bridge Barrier Rd.  
Carolina Beach, NC 28428  
910.458.9401

## Scheduling

- **Appointment Confirmation** – Our office will call you approximately 24 to 48 hours prior to your scheduled appointment. Unless you tell us otherwise, we will leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.
- **Timeliness** – Please make every effort to arrive at your appointment at least five minutes before the scheduled time. We make every effort to keep our schedule on time and begin your treatment at the scheduled time. If you arrive more than 15 minutes late for your appointment you may need to be rescheduled for a different day.
- **Rescheduling and Cancelling Appointments** – When rescheduling or cancelling an appointment, please provide us the courtesy of at least 24 hours notice.
- **Failure to Make Appointments without Notification** – In the unlikely event of two failures to make a scheduled appointment without notification, you may be dismissed from the practice.

## Patient Privacy

- Please read the accompanied document titled “Notice of Privacy Practices”.

## Financial

- **Payment** – The patient’s portion which includes deductibles, co-pays, and/or a percentage of each procedure is due in full at the time of service. We accept cash, check, Visa, and MasterCard.
- **Insurance** – Please present your current insurance verification to the front desk representative every time you visit the office. Our office files all patient insurance claims with their respective insurance provider. However, filing insurance claims with the insurance provider is not a guarantee of payment. For uncovered services or fees, the patient (or their legal guardian) is ultimately responsible for all fees incurred. Also, for claims not paid within 60 days of our filing date, the patient becomes responsible for the balance due.

I verify that I have read, understand, and agree to all of the above policies.

Signed: \_\_\_\_\_

Date: \_\_\_\_\_

### Health and Dental History Questionnaire

Directions to the Patient of Patient's Guardian: The following information allows us to provide 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 do not understand a question, are unsure of the answer, or would like to discuss it with the dentist, check it. This Health History Questionnaire will become a part of the patient's dental treatment record and will be considered *CONFIDENTIAL* information.

#### Demographic Information

Patient's Name:	Date:	
Date of Birth:	Social Security Number:	
Street Address/City/State/ZIP:		
Home Phone:	Cell Phone:	
Employed by:	Work Phone:	
Sex: M F Drivers License Number and State where issued:		
Person Responsible for Payment:	Relationship:	
Phone Number		
Mailing Address/City/State/ZIP		
Emergency Contact (Name and Relationship):		
Home Phone:	Work Phone:	Cell Phone:
How did you find out about our office? Sign Yellow pages Internet Newspaper Other _____		
If referred by another patient please list them _____. We like to thank patients who refer others.		

#### Dental History

What is your major dental concern?
How often do you brush your teeth? _____ per day How often do you floss your teeth _____ per week
Date of your last visit to a dentist? Reason for your last visit:
Date of your last dental x-rays:
Have you ever needed to take an antibiotic before dental work? Yes No Don't know
If yes, explain why:
Have you ever experienced an unusual reaction to dental medication or treatment? Yes No Don't know
If yes, explain why:
Have you had any complications following dental treatment? Yes No Don't know
If yes, explain why:
Have you ever fainted during a dental visit? Yes No
Are you happy with the appearance of your teeth? Yes No
Are any of your teeth sensitive to hot, cold or pressure? Yes No Sometimes
How anxious are you about receiving dental treatment? Not Slightly Extremely
Do you wear any dental appliances such as dentures, partials, retainers, night guards/bleaching trays/snore guards?
Do you have any other dental concerns or complaints?

### Health History

Name of your physician or place you receive medical care:

Are you in good health? Yes No

Has there been any change in your health in the last year? Yes No

If yes, please explain

Have you been hospitalized, had a major operation, or serious illness in the last ten years? Yes No

If yes, please explain

Are you currently receiving treatment by your physician? Yes No

If yes, please explain

Are you currently taking any medications?

If yes, please list their name / amount:

**Do you have any allergies, or allergies to medications? Yes No Don't know**

If yes, please list:

Do you use any form of tobacco? Yes No If so, how much?

How many drinks of alcohol? Per day Per week

#### Systemic Health:

Have you ever been treated by a doctor for any of the following:

Breathing problems, emphysema, tuberculosis, or other lung problems Yes No Don't know

Asthma, hay fever, or hives Yes No Don't know

Sinus problems Yes No Don't know

Damaged heart valves or artificial heart valves, hear murmurs Yes No Don't know

Rheumatic fever, rheumatic heart disease, mitral valve prolapse, or pacemaker Yes No Don't know

Heart trouble, heart attack, high blood pressure Yes No Don't know

Blood disorders such as anemia or hemophilia Yes No Don't know

Diabetes, family history of diabetes, or blood sugar problems Yes No Don't know

Thyroid condition of goiter Yes No Don't know

Artificial joints, arthritis or rheumatism Yes No Don't know

Phobias, severe anxieties, depression, unusual fears, or other mental problems Yes No Don't know

Severe or frequent headaches Yes No Don't know

Stroke, seizures, fainting spells, numbness or other neurological problems Yes No Don't know

Kidney infections, frequent urination, or kidney dialysis Yes No Don't know

Syphilis, gonorrhea, or any other sexual transmitted disease Yes No Don't know

For women: are you pregnant, or do you think you may be pregnant Yes No Don't know

Stomach or intestinal problems, or ulcers Yes No Don't know

Hepatitis, jaundice, or liver disease Yes No Don't know

AIDS, AIDS related complex, or HIV Yes No Don't know

Tumors or growths Yes No Don't know

Cancer, radiation therapy, or chemotherapy Yes No Don't know

Person completing this form (If other than patient, indicate relationship):

## NOTICE OF PRIVACY PRACTICES

Timothy Swing, DMD

### **THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

#### **TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS**

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; examining your teeth; prescribing medications and faxing them to be filled; referring you to another doctor or clinic for other health care or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or dental care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we usually will not ask you for special written permission.

#### **USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION**

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- when a state or federal law mandates that certain health information be reported for a specific purpose;
- for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
- disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
- disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
- disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- uses or disclosures for health related research;
- uses and disclosures to prevent a serious threat to health or safety;
- uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
- disclosures of de-identified information;
- disclosures relating to worker's compensation programs;
- disclosures of a "limited data set" for research, public health, or health care operations;
- incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information;

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your dental care.

#### **APPOINTMENT REMINDERS**

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

## NOTICE OF PRIVACY PRACTICES

#### **OTHER USES AND DISCLOSURES**

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours. If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this Notice.

## **YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION**

The law gives you many rights regarding your health information. You can:

- ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address, fax or E Mail shown at the beginning of this Notice.
- ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E mail to your personal E Mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30 day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

## **OUR NOTICE OF PRIVACY PRACTICES**

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our Web site.

## **COMPLAINTS**

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or E mail shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

## **FOR MORE INFORMATION**

If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this Notice.