David M. Fisher, Jr., DDS, PA

www.fisherdds.com

☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Dr. _____ AGE _____ BIRTHDATE_____

☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED ☐ SEPARATED

RESIDENCE ADDRESS_____ CITY_____ STATE _____ ZIP_____

HOME PHONE #_____ CELL #_____ EMAIL_____

EMPLOYED BY _____ BUSINESS PHONE # _____

PRESENT POSITION _____ YOUR SOCIAL SECURITY NUMBER _____

NAME OF SPOUSE _____ SPOUSE'S SOCIAL SECURITY NUMBER _____

NUMBER WE CAN CALL IN DAYTIME TO CONFIRM YOUR APPOINTMENT _____

WHO IS RESPONSIBLE FOR PAYMENT OF DENTAL SERVICES (If different from above) _____

IN CASE OF EMERGENCY, NAME OF NEAREST FRIEND OR RELATIVE _____ PHONE # _____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE _____

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain _____

Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____

Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____

Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____

Are you on a special diet? ◯ Yes ◯ No

Do you use tobacco? ◯ Yes ◯ No

Do you use controlled substances? ◯ Yes ◯ No

Women: Are you

Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs

☐ Other If yes, please explain: _____

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

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

Have you ever had any serious illness not listed above? ◯ Yes ◯ No _____

Comments: _____

PATIENT SIGNATURE _____ DATE _____

How may we help you? _____

If you could change anything regarding your smile, what would you change? _____

Are you having any discomfort at this time? _____

Do you have any fears concerning dentistry? _____

	YES	NO
Do you want to save your natural teeth for the rest of your life?	☐	☐
Do you feel you have neglected your teeth?	☐	☐
Are you satisfied with your past dentistry?	☐	☐
Are you self conscious about the appearance of your teeth?	☐	☐
Do your gums ever bleed or hurt at any time?	☐	☐
Are you aware of any swelling or lumps in your mouth or neck?	☐	☐
Have you ever been instructed in homecare procedures in a dental office?	☐	☐

Do you feel your teeth are in good _____ fair _____ poor _____ condition?

PLEASE CIRCLE ANY ITEM ABOUT WHICH YOU HAVE A QUESTION, INTEREST OR CONCERN.

Difficulty Chewing	Bleeding/Sore gums	Sensitive teeth
Uncomfortable Partial/Full Denture	Crowning or capping teeth	Jaw popping/Soreness
Dental Implants	Mercury in silver fillings	Oral Cancer
Whiter/Brighter teeth	Bridgework	Sealants to prevent decay
Improve appearance of teeth	Dental Implants	Diet & Nutrition
Keeping my natural teeth	NTI- Appliance for migraines/headaches	Itchy stuffy or ringing ears
Health Centered Dentistry	Sleep Apnea/ Sleep appliance	Nitrous Oxide (laughing gas)
Replacing missing tooth/teeth	Bonding teeth	Stale mouth taste or bad breath

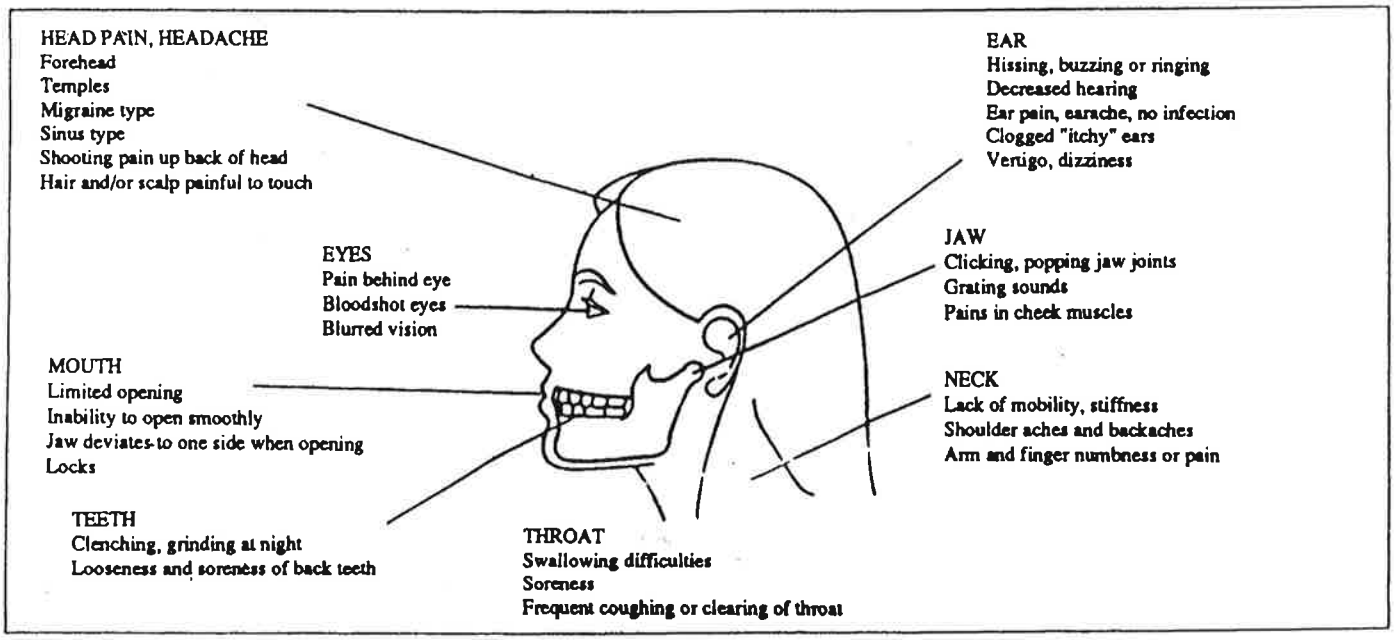
Sleeping through your dental treatment

Have you ever worn braces? YES NO Name of Orthodontist _____

Do you have problems: Sleeping on your back? YES NO Getting to sleep? YES NO Staying asleep? YES NO

Do you wake feeling tired? YES NO Do you wake with a headache? YES NO

Please circle on the chart below any of the problems that pertain to you:



David M. Fisher, Jr., DDS, PA

Notice of Privacy Practices

Effective September 23, 2013

This notice describes how medical information about you may be used and disclosed, and how you may have access to this information. Please review it carefully.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment for health care operations, and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses or disclosures of health information for treatment, payment and healthcare operations.

The following categories describe different ways that we use and disclose medical information. The information may be used in your care and treatment for the purpose of providing health care services to you, to pay your healthcare bills, to support the operation of the physician's practice and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party.

Payment: We may use and disclose medical information about you to determine eligibility for benefits and to facilitate payment for treatment and services you receive from health care providers.

Healthcare Operations: We may use or disclose your medical information in order to support the business activities of your physician's practice. We may use medical information in connection with quality assessment, submitting claims, for medical review, legal services, audit services and fraud and abuse programs.

We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or to recommend possible treatment options or alternatives that may be of interest to you.

As Required By Law: We will disclose medical information about you when required to do so by federal, state or local law. We may disclose information when required by a court order or subpoena.

No Other Uses or Disclosures without Your Written Authorization: Other disclosures will only be made with your consent, unless required by law. You may revoke this authorization at any time in writing.

Your Rights Regarding Medical Information About You:

Your Right to Request Restrictions:
You may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or health care operations. You may request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy. You may request that we not use or disclose PHI for marketing or selling of PHI. You have the right to request that your PHI not be used for fundraising. Your request must state the restrictions and to whom the restrictions apply. This request must be in writing.

Your Dentist is not required to agree to a restriction you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted.

Your Right to Inspect and Copy: You have the right to inspect and copy medical information. To inspect and copy the medical information that may be used to make medical decisions about you, you must submit in writing a request. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

Your Right to Amend: If you feel that the medical information about you is incorrect or not complete, you may ask the dentist to amend the information. To request an amendment your request must be in writing and you must provide a reason that supports your request. In addition, we may deny your request.

Your Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures" where such disclosure was made for any purpose other than treatment, payment or health care operations. This request must be submitted in writing. Your request must state a time period of no longer than 6 (six) years.

Your Right to Request Confidential Communications: You have the right to request that we communicate with you about your medical matters by alternative means or at an alternative location. This request must be in writing.

Your Right to be Notified if Your PHI has been breached. You have the right to know if there has been a security breach of your unsecured Protected Health Information by us or a Business Associate.

Your Right to Request Restrictions on disclosures to Health Plans. You have a right to request restrictions to disclosures to health plans for payment or healthcare operations regarding services where the individual has paid for the service out of pocket and in full.

All Other Uses and Disclosures. All other uses and disclosures of information not contained in this Notice of Privacy Practices will not be disclosed without your authorization. You may revoke your permission in writing at any time.

Your Right to a Copy of This Notice: You have the right to request a paper copy of this notice.

Changes:
We reserve the right to change the terms of this notice at any time and to apply the revised notice to all individually identifiable health information that it maintains.

Complaints:
If you believe your privacy rights have been violated, you may file a complaint to us or to the Secretary of the Department of Health and Human Services. All complaints must be in writing. **You will not be penalized for filing a complaint.** To file a complaint with the office, please contact the privacy officer at David M. Fisher, Jr., DDS, PA 3131 Battleground Avenue, Greensboro, NC 27408 at 336-288-1242, before you act.

Our privacy officer is Valeria Scales.

Her contact information is 336-288-1242.