PATIENT REGISTRATION

First Name:	Last	t Name:	Middle Initial:			
Patient Is: Policy Holder	olicy Holder Preferred Name:					
Responsible Party	the section of the section of					
Responsible Party (if someone other						
			Middle Initial:			
			Pager:			
			Cellular:			
Birth Date:	Soc Sec:	Dri	vers Lic:			
O Responsible Party is also a Pol	cy Holder for Patient O Prima	ry Insurance Policy Holder	O Secondary Insurance Policy Holder			
Patient Information						
Address:		Address 2:				
City:	State / Zip:		Pager:			
Home Phone:	Work Phone:	Ext:	Cellular:			
Sex: 🔿 Male 🔿 Fei	nale Marital Status	: O Married O Single	O Divorced O Separated O Widowed			
Birth Date:	Age: Soc. Sec		Drivers Lic:			
E-mail:		I would like to receive	correspondences via e-mail.			
Section 2			Section 3			
Employment Status: O Full Time	O Part Time O Retired	d	Additional Comments:			
Student Status: () Full Time	 Part Time 					
Medicaid ID:	Pref. Dentist:					
Employer ID:	Pref Pharmacy:					
Carrier ID:	Pref. Hyg.:					
Primary Insurance Information						
Name of Insured:		Relationship to Ins	sured: Self Ospouse Ochild Other			
Insured Soc. Sec:		n Date:				
Employer:		Ins. Company:				
Address:		Address:				
		Address 2:				
City,State,Zip:						
Rem. Benefits: .00						

MEDICAL HISTORY

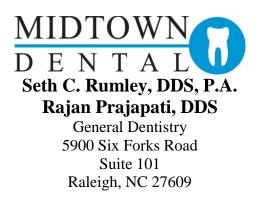
PATIENT NAME	Birth Date

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 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?					No	If yes, please explain:					_
Have you ever been hospitalized or had a major operation? Yes			Yes	No							
			Yes	No							
Are you taking any medications, pills, or drugs? Yes					No	If yes, please explain:If yes, please explain:					
					No						
Do you take, or	nave you			Yes							
		-	ou on a special diet?	Yes	No						
			Do you use tobacco?	Yes	No						
	Do you	use co	ntrolled substances?	Yes	No						
	Do	you n	eed to pre-medicate?	Yes	No	If yes, please explain:					
Women: Are you Pre	egnant/Tr	ying to	get pregnant? Yes		No	Taking oral contrace	ptives?	Yes	No Nursing?	Yes	No
Are you allergic to ar	nv of the f	ollowir	la?						-		
, ,	Penicillin		•	crylic		Metal Latex		Local	Anesthetics		
Other If yes, ple	ase expla	ain:									
Do you have, or have	you had,	, any o	f the following?								
AIDS/HIV Positive	Yes	No	Cortisone Medicine	Yes	No	Hemophilia	Yes	No	Renal Dialysis	Yes	No
Alzheimer's Disease	Yes	No	Diabetes	Yes	No	 Hepatitis A 	Yes	No	Rheumatic Fever	Yes	No
Anaphylaxis	Yes	No	Drug Addiction	Yes	No	 Hepatitis B or C 	Yes	No	Rheumatism	Yes	No
Anemia	Yes	No	Easily Winded	Yes	No	Herpes	Yes	No	Scarlet Fever	Yes	No
Angina	Yes	No	Emphysema	Yes	No	 High Blood Pressure 	Yes	No	Shingles	Yes	No
Arthritis/Gout	Yes	No	Epilepsy or Seizures	Yes	No	Hives or Rash	Yes	No	Sickle Cell Disease	Yes	No
Artificial Heart Valve	Yes	No	Excessive Bleeding	Yes	No	Hypoglycemia	Yes	No	Sinus Trouble	Yes	No
Artificial Joint	Yes	No	Excessive Thirst	Yes	No	Irregular Heartbeat	Yes	No	Spina Bifida	Yes	No
Asthma	Yes	No	Fainting Spells/Dizziness	s Yes	No	 Kidney Problems 	Yes	No	Stomach/Intestinal Disease	e Yes	No
Blood Disease	Yes	No	Frequent Cough	Yes	No	Leukemia	Yes	No	Stroke	Yes	No
Blood Transfusion	Yes	No	Frequent Diarrhea	Yes	No	Liver Disease	Yes	No	Swelling of Limbs	Yes	No
Breathing Problem	Yes	No	Frequent Headaches	Yes	No	Low Blood Pressure	Yes	No	Thyroid Disease	Yes	No
Bruise Easily	Yes	No	Genital Herpes	Yes	No	Lung Disease	Yes	No	Tonsillitis	Yes	No
Cancer	Yes	No	Glaucoma	Yes	No	Mitral Valve Prolapse	Yes	No	Tuberculosis	Yes	No
Chemotherapy	Yes	No	Hay Fever	Yes	No	Pain in Jaw Joints	Yes	No	Tumors or Growths	Yes	No
Chest Pains	Yes	No	Heart Attack/Failure	Yes	No	Parathyroid Disease	Yes	No	Ulcers	Yes	No
Cold Sores/Fever Blisters	s Yes	No	Heart Murmur	Yes	No		Yes	No	Venereal Disease	Yes	No
Congenital Heart Disorde	r Yes	No	Heart Pace Maker	Yes	No	Radiation Treatments	Yes	No	Yellow Jaundice	Yes	No
Convulsions	Yes	No	Heart Trouble/Disease	Yes	No	Recent Weight Loss	Yes	No			
Have you ever had ar	ny serious	illnes	s not listed above?	Yes	No	lf yes, please explain	:				
Cold Sores/Fever Blisters Congenital Heart Disorde Convulsions	s Yes r Yes Yes	No No No	Heart Murmur Heart Pace Maker Heart Trouble/Disease	Yes Yes Yes	No No No	Psychiatric Care Radiation Treatments Recent Weight Loss	Yes Yes Yes	No No No	Venereal Disease	Yes Yes	No No
Have you ever had ar	ny serious	illnes:	s not listed above?	Yes	No	If yes, please explain	I:				
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, or GUARDIAN ______



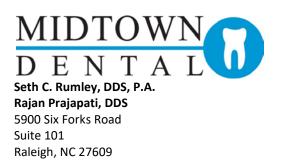
We would like our patients to be informed about the various procedures involved in general dentistry and have their consent before starting treatment. The following discusses possible risks that may occur from various treatment procedures.

RISKS: Included (but not limited to) are complications resulting from the use of dental instruments, drugs, sedation, medicines, analgesics (pain killers), anesthetics, and injections. These complications include: swelling; sensitivity; bleeding; pain; Infection; numbness and tingling sensation in the lip, tongue, chin, gums, cheeks and teeth, which is transient but on infrequent occasions may be permanent; reaction to injections; changes in occlusion (biting); jaw muscle cramps and spasms; temporomandibular (jaw) joint difficulty; loosening of teeth; referred pain to ear, neck and head; nausea; vomiting; allergic reactions; delayed healing; sinus perforations and treatment failure.

MEDICATIONS: Prescribed medications for discomfort may cause drowsiness, nausea and lack of awareness and coordination (which may be influenced by the use of alcohol, tranquilizers, sedatives or other drugs). It is not advisable to operate any vehicle or hazardous device until recovered from their effects. Antibiotics used in dentistry may cause swelling, itching, nausea, diarrhea and yeast infection on occasion.

CONSENT: I, the undersigned, being the patient (parent or guardian of minor patient) understand the information presented above and accept the potential risks in the event that I consent to the performing of procedures decided upon to be necessary or advisable in the opinion of the doctor.

Witness By



Patient Financial Policy

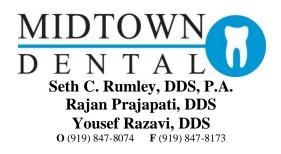
Midtown Dental, the office of Doctors Rumley, Whitehurst, and Maness, thanks you for selecting us to provide your dental care. Midtown Dental is committed to your treatment being acceptable to you and successful. We ask that you review your financial obligations to our office.

Payment is expected in full on the day treatment is performed. This includes any insurance co-pays and deductibles. We accept cash, check, Money Orders, Visa, MasterCard, Discover and Care Credit. (There is a \$30 returned check fee)

Broken Appointment/No-Show Policy

If you are unable to keep your appointment, you must notify the office within 24 hours of your appointment time. There is a \$25 No-Show fee for cleaning and exam appointments that are not cancelled in advance of 24 hours of your appointment time. There is a \$50 No-Show fee for restorative appointments that are not cancelled in advance of 24 hours of your appointment time. If you miss multiple appointments, you may be dismissed from the practice.

As a service to our patients, our practice will submit your insurance claims for you. Our staff will prepare the necessary forms for your dental benefits. We will provide an estimate of your insurance benefits prior to treatment, but realize it is only an estimate. Our staff will gladly submit a pre-treatment estimate to your insurance company so that you will know what your benefits will be. However, we remind you that your specific policy is an agreement between you and your insurance company. Please keep in mind that you are responsible for your total obligation should your insurance benefits result in less coverage than anticipated.



Release of Dental Records (if applicable)

I, ____

_____ hereby authorize

(Please Print Patient's Name)

(Former Dentist's Name)

to provide **Midtown Dental** with copies of my dental records with respect to my dental care and treatment that I have received.

I understand that the specific type of information disclosed includes x-rays and/or all other records which pertain to me.

Signature____

(Signature of Patient or POA of patient) or (Parent/Guardian if minor)

Date_____

Address or Email to where records should be sent:

5900 Six Forks Road, Suite 101 Raleigh, NC 27609 info@raleighmidtowndental.com

A 1996 North Carolina Dental Board rule mandates the transfer of original or copies of xrays and at least a summary of the patient's record at the patient's request. A fee may be charged for the cost of duplicating records, but this fee may NOT be demanded prior to the release of the records.

or

Authorization for Release of Information Seth C. Rumley DDS, PA Rajan Prajapati, DDS

Name of Patient	Date of Birth			
<u>Midtown Dental</u> is authorized to release protected health information about the above named patient in the following manner and to identified persons.				
Entity to Receive Information. Check each person/entity that you approve to receive information.	Description of information to be released. Check each that can be given to person/entity on the left in the same section.			
U Voice Mail	Results of lab tests/x-rays			
	• Other			
Other person (s) (provide name and phone number)	 Financial Medical 			
Email communication-Provide email address*	☐ Financial ☐ Medical			
*For email communication to occur, please accept the disclosure below:	 Appointment reminders 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.				
D Photo of patient received by patient or legal guardian	☐ May be posted in office			
D Photo taken by staff (Example: pre/post procedure)	☐ May be posted on website			
□ Other	• 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.

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)

Seth C. Rumley DDS, PA

Rajan Prajapati DDS

Acknowledgement of Receipt Of Notice of Privacy Practices

Patient Name & Address: _____

I have received a copy of the Notice of Privacy Practices for the above named practice.

Signature

Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- □ An emergency existed & a signature was not possible at the time.
- **D** The individual refused to sign.
- □ A copy was mailed with a request for a signature by return mail.
- **u** Unable to communicate with the patient for the following reason:
- □ Other:_____

Prepared By _____

Signature _____