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3610-A Boulevard, St. A Colonial Heights, VA 23834 (804) 526-0937 Info@drbatesdds.com

**PATIENT INFORMATION**

*Patient Name:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *Preferred Name*:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *Date:* \_\_\_\_\_\_\_

*Last, First Middle*

*Marital Status:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_ *Birth Date*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ *Social Security Number*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Address*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Street Address City State Zip*

*Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Cell Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_*

*Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*In case of an emergency, who should be notified? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**Referral Information**

*Name of the person, office, or other source that referred you to our practice: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**Responsible Party**

*Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Last, First Middle*

*Birth date: \_\_\_\_\_\_\_\_\_\_\_\_ Social Security #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Cell Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Driver’s License Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Street Name City State Zip*

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**Insurance Information**

**(Primary)**: *Name of Insurance Company \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Name of Policy Holder:*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Employer (If through Occupation):*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_ SSN : \_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_\_*

*Group Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**(Secondary** *if applicable***)**: *Name of Insurance Company*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Name of Policy Holder:*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Employer (If through Occupation):*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_ SSN : \_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_\_*

*Group Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**Access of Information**

***Please complete the section below and include anyone who may access personal, financial, or medical information.***

*I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* ***(print your name)*** *hereby authorize Richard W. Bates, D.D.S and Katrina A. Thatch, D.D.S to discuss my personal, financial, and medical information with those listed below.*

*Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

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**Medical History**

***Physician’s name****:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

***Have you had any serious illnesses or operations****? \_\_\_\_Yes \_\_\_\_ No*

*If yes, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

***Are you taking any medication?*** *\_\_\_ Yes \_\_\_ No*

*If yes, please list current medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

***Do you have any allergies?*** *\_\_\_Yes \_\_\_ No*

*If yes, please list allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

***Check any of the medical conditions below that you have had or currently have:***

*\_\_\_\_ AIDS \_\_\_\_ Chronis Sinus \_\_\_\_ Hemophilia \_\_\_\_ Psychiatric Care*

*\_\_\_\_ Anemia \_\_\_\_ Circulatory Problems \_\_\_\_ Hepatitis \_\_\_\_ Radiation Treatment*

*\_\_\_\_ Artificial Valves \_\_\_\_ Cortisone Treatments \_\_\_\_ High Blood Pressure \_\_\_\_ respiratory disease*

*\_\_\_\_ Artificial Joins \_\_\_\_ Diabetes \_\_\_\_ HIV \_\_\_\_ Rheumatic Fever*

*\_\_\_\_ Asthma \_\_\_\_ Epilepsy \_\_\_\_ Jaw Pain/TMJ \_\_\_\_ Shortness of Breath*

*\_\_\_\_ Blood Disease \_\_\_\_Excessive Bleeding \_\_\_\_ kidney disease \_\_\_\_ Thyroid Problems*

*\_\_\_\_ Cancer \_\_\_\_ Fainting \_\_\_\_ Liver Disease \_\_\_\_ Tobacco Habit*

*\_\_\_\_ Cerebral Palsy \_\_\_\_ Heart Murmur \_\_\_\_ Mitral Valve Prolapse \_\_\_\_ Tuberculosis*

*\_\_\_\_ Chemotherapy \_\_\_\_ Heart Problems \_\_\_\_ Nervous Problems \_\_\_\_ Ulcers*

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

***If you have any artificial joints/bones, please list below:***

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

***Does your Orthopedic doctor require pre-medication for dental procedures****? \_\_\_\_ Yes \_\_\_\_ No*

*If yes, please list the antibiotic: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

***When was your last dental visit?*** *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

***(Women)*** *Are you pregnant? \_\_\_\_ Yes \_\_\_\_ No* ***(Women)*** *Are you taking birth control? \_\_\_\_ Yes \_\_\_\_ No*

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**Authorization and Release**

**History**

I hereby authorize the release of medical information to any of my health care providers or insurance companies that may be pertinent to my case. I hereby authorize direct payment of insurance benefits that are otherwise payable to me. I hereby authorize the release of my medical records to the third-party insurers or other persons to whom disclosure is necessary to establish or collect a few for services provided. I understand that I am financially responsible for all charges arising from the treatment of myself (or the above-named patient, if applicable). I understand that payment in full is due at the time services are rendered; however, I agree to pay a FINANCIAL CHARGE of 1.5% per month of balances over thirty (30) days past due, which is an ANNUAL PERCENTAGE RATE of 18%. If my account is referred to an attorney for collection, I agree to pay all collection and court costs, including attorney fees in the amount of thirty-three and one-third percent (33 1/3%) of the total indebtedness then due. A photocopy of this contract shall be considered as valid as the original.

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ACKNOWLEDGEMENT OF HIPPA NOTICE OF PRIVACY PRACTICES**

**History**

**Our Notice of Privacy Practices provides information about how we may use and disclose Protected Health Information about you. As provided in our notice, the terms of our notice may change. If we change, you may obtain a revised copy.**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (**print your name)** have received a copy of Richard W. Bates, D.D.S and Katrina A. Thatch, D.D.S Notice of Privacy Practice.

**I understand that I may ask questions of Richard W. Bates, D.D.S and Katrina A. Thatch, D.D.S Notice of Privacy Practices if I do not understand any information provided.**

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**MISSED APPOINTMENT POLICY**

**History**

**Due to the high cost of no-show appointments, we will be obligated to charge you (not your insurance) a fee of thirty-eight dollars ($38.00) if you do not call or cancel your appointment twenty-four (24) hours in advance.**

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**HIPPA NOTICE OF PRIVACY PRACTICES**

**History**

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION under the HIPAA Omnibus Rule of 2013.**

**PLEASE REVIEW INFORMATION BELOW CARFULLY**

For purposes of this Notice "us" "we" and "our" refers to the Name of this Healthcare Facility: Richard W. Bates DDS, and "you" or "your" refers to our patients (or their legal representatives as determined by us in accordance with state informed consent law). When you receive healthcare services from us, we will obtain access to your medical information (i.e. your health history). We are committed to maintaining the privacy of your health information and we have implemented numerous procedures to ensure that we do so.

The Federal Health Insurance Portability & Accountability Act of 2013, HIPAA Omnibus Rule, (formally HIPAA 1996 & HI TECH of 2004) require us to maintain the confidentiality of all your healthcare records and other identifiable patient health information (PHI) used by or disclosed to us in any form, whether electronic, on paper, or spoken. HIPAA is a Federal Law that gives you significant new rights to understand and control how your health information is used. Federal HIPAA Omnibus Rule and state law provide penalties for covered entities, business associates, and their subcontractors and records owners, respectively that misuse or improperly disclose PHI.

Starting April 14, 2003, HIPAA requires us to provide you with the Notice of our legal duties and the privacy practices we are required to follow when you first come into our office for healthcare services.

Our doctors, clinical staff, employees, Business Associates (outside contractors we hire), their subcontractors and other involved parties follow the policies and procedures set forth in this Notice. If at this facility, your primary caretaker / doctor is unavailable to assist you (i.e. illness, on-call coverage, vacation, etc.), we may provide you with the name of another healthcare provider outside our practice for you to consult with. If we do so, that provider will follow the policies and procedures set forth in this Notice or those established for his or her practice, so long as they substantially conform to those for our practice.

**OUR RULES ON HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION**

Under the law, we must have your signature on a written, dated Consent Form and/or an Authorization Form of Acknowledgement of this notice before we will use or disclose your PHI for certain purposes as detailed in the rules below.

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**HIPPA NOTICE OF PRIVACY PRACTICES**

**History**

**Documentation** - You will be asked to sign an Authorization / Acknowledgement form when you receive this Notice of Privacy Practices. If you did not sign such a form or need a copy of the one you signed, please contact our Privacy Officer. You may take back or revoke your consent or authorization at any time (unless we already have acted based on it) by submitting our Revocation Form in writing to us at our address listed above. Your revocation will take effect when we receive it. We cannot give it retroactive effect, so it will not affect any use or disclosure that occurred in our reliance on your Consent or Authorization prior to revocation (i.e. if after we provide services to you, you revoke your authorization / acknowledgement in order to prevent us billing or collecting for those services, your revocation will have no effect because we relied on your authorization/ acknowledgement to provide services before you revoked it).

**General Rule** - If you do not sign our authorization/ acknowledgement form or if you revoke it, as a general rule (subject to exceptions described below under "Healthcare Treatment, Payment and Operations Rule" and "Special Rules"), we cannot in any manner use or disclose to anyone (excluding you but including payers and Business Associates) your PHI or any other information in your medical record. By law, we are unable to submit claims to payers under assignment of benefits without your signature on our authorization/ acknowledgement form. You will however be able to restrict disclosures to your insurance carrier for services for which you wish to pay "out of pocket" under the new Omnibus Rule. We will not condition treatment on you signing an authorization / acknowledgement, but we may be forced to decline you as a new patient or discontinue you as an active patient if you choose not to sign the authorization/ acknowledgement or revoke it.

**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 may complain to us using the contact information listed at the end of this notice. You also may submit a written complaint to the U.S Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S 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 U.S Department of Health and Human Services.

**Katrina A. Thatch, DDS, PLLC**

**Richard W. Bates, DDS, PLC**

**3610-A Boulevard**

**Colonial Heights, VA 23834**