Date: _____

axiUm #: _____

Patient Registration Packet

Patient Legal Name: _____ Gender:_____

Date of Birth: _____ SSN#: _____

Address, City, St, Zip:_____

Mobile#: _____ Home/Work/Other: _____

Email Address: _____ _____

Place of Employment: _____Phone#: _____

Race: _____ Ethnicity:_____

Do you consent to the use of your information for research purposes?: _____

Do you consent to the educational use of any images taken for clinical purposes?: _____

Name of previous dentist/location: _____

Why are you changing dentist/locations?: _____

Date of last dental examination: _____

Date of last cleaning: _____

Date of X-Rays: _____

Why have you come to see us today; chief dental concern (e.g. pain, checkup, etc.)? _____

_____

Insurance Information

Dental Insurance Carrier (if any): _____

Policy or ID #: _____

Medical Insurance Carrier (if any): _____

Policy or ID #: _____

Guarantor/Subscriber Name & Relationship: _____

Date of Birth: _____ SSN#: _____

Status: _____ Gender: _____

(Policy Holder, Primary Guarantor, Secondary Guarantor, Emancipated Minor)

_____

I have received a copy of this office's Notice of Privacy Practices.

Print Name:_____

Signature:_____

Date: _____

axiUm #: _____

Patient Registration Packet

Electronic Communication Consent:

We communicate with our patients in the following ways.

Text Messages, Emails, & Phone Calls

You can opt out of all but one of any of these options at any time by calling your clinic and requesting to opt-out.

Participation is not required.

CONSENT FOR E-PRESCRIBING & MEDICATION HISTORY

ePrecribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. ePrescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an ePrescribe program. These include:

Formulary and benefit transactions --- Gives the prescriber information about which drugs are covered by the drug benefit plan.

Medication history transactions --- Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.

Fill status notification --- Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or partially filled.

By signing this consent form you are agreeing that ECU SoDM can request and use your prescription medication history from other healthcare providers and/or third-party pharmacy benefit payors for treatment purposes.

Understanding all of the above, I hereby provide informed consent to ECU SoDM to enroll me in the ePrescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

□ I hereby provide informed consent to enroll me in the ePrescribe program.

Unfortunately, if you do not consent to this policy, we are not able to be your provider, as we are not able to limit what we have access to. Please ask to speak with a Clinic Manager if you have questions.

In the event of an emergency please contact:

Name: _____ _____

Relationship: _____ _____

Address: _____ _____

Phone: _____ _____

Date: _____

axiUm #: _____

Patient Registration Packet

Authorized Representatives for Protected Health Information (PHI)

Authorized representatives are the people **you choose** and **give us permission** to communicate with about your health information or payment for your dental care.

This form allows **ECU School of Dental Medicine** to provide limited protected health information to your authorized contacts.

You can decide the type of information that we may share with each of them:

1) Your appointments
2) Your dental/medical information, which includes your treatment and your prescriptions, or
3) Your billing information.

To protect your privacy, please provide the names of people you allow us to communicate with about your care or payment for your care. You can make changes at any time simply by filling out a new form at our front desk. You can also cancel your authorized representatives by giving us a notice in writing.

The Office is authorized to communicate with the people listed below.

Name	Relationship to the patient	Phone number	What can be released to this person

- **I am allowing** the disclosure of my protected health information to individuals I chose as my authorized representatives.
- **I have the right to cancel this authorization at any time by notifying this office in writing**. I understand that if I cancel this authorization it will not have any effect on any actions the office may have taken before it received the cancellation.
- **The information shared as a result of this authorization may be re-disclosed by the person who receives the information,** in which case it may no longer be protected under the HIPPA Privacy Rule. This means that any protected health information shared with my authorized representatives may not be protected under the HIPPA Privacy Rule in the future.
- **This authorization is voluntary.** I have the right to refuse to sign this authorization. My treatment or payment will not change if I do not sign this form.

Date: _____

axiUm #: _____

Patient Registration Packet

Consent to Participate in Tele-Dentistry Consultations When Appropriate

1. I understand that my health care provider wishes me to engage in a tele-dentistry consultation.
2. My health care provider has explained to me how the video conferencing technology will be used to affect such a consultation will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider.
3. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my health care provider or I can discontinue the telemedicine consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
4. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation other than my health care provider and consulting health care provider in order to operate the video equipment. The above-mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following:
    1. Omit specific details of my medical history/dental examination that are personally sensitive to me;
    2. Ask non-medical personnel to leave the telemedicine examination room;
    3. And/or terminate the consultation at any time.
5. I have had the alternatives to a tele-dentistry consultation explained to me, and in choosing to participate in a tele-dentistry consultation, I understand that some parts of the exam must be done in person.
6. In an emergent consultation, I understand that the responsibility of the telemedicine consulting specialist is to advise my local practitioner and that the specialist's responsibility will conclude upon the termination of the video conference connection.
7. I understand that billing will occur for this type of appointment from the ECU facility in which my provider is based out of.
8. I have had a direct conversation with my dentist, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

By signing this form, I certify:

- That I have read or had this form read and/or had this form explained to me
- That I fully understand its contents including the risks and benefits of the procedure(s).
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

□ I hereby provide informed consent to participate in tele-dentistry consultations.