

New Patient Registration

Patient's Name: _____ Date: _____

Likes to be called: _____ Date of Birth: _____

SSN: _____ E-mail: _____

☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partner

Address: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Cell: _____ Work: _____

Employer: _____ Occupation: _____

How did you hear about us? _____

Responsible Party (if different from patient)

Name: _____ Date of Birth: _____

Address (if different from patient): _____

City: _____ State: _____ Zip: _____

Relationship to Patient: _____

Home phone: _____ Cell: _____ Work: _____

Patient Dental Insurance

Primary Carrier:

Subscriber Name: _____ Date of Birth: _____

Employer: _____ Insurance Company: _____

Insurance Address: _____

City: _____ State: _____ Zip: _____

Insurance Phone Number: _____

Group #: _____ Member ID #: _____

Subscriber SSN: _____ Relationship to Patient: _____

Secondary Carrier:

Subscriber Name: _____ Date of Birth: _____

Employer: _____ Insurance Company: _____

Insurance Address: _____

City: _____ State: _____ Zip: _____

Insurance Phone Number: _____

Group #: _____ Member ID #: _____

Subscriber SSN: _____ Relationship to Patient: _____

Emergency Contact Information

Patient Name: _____

Primary Emergency Contact Name: _____

Relationship to Patient: _____

Home phone: _____ Cell: _____ Work: _____

Secondary Emergency Contact Name: _____

Relationship to Patient: _____

Home phone: _____ Cell: _____ Work: _____

Preferred Local Hospital: _____

Preferred Pharmacy: _____

Comments (include any special medical or personal information you would want an emergency care provider to know – or special contact information):

Patient Signature: _____ 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?	☐ Yes ☐ No	If yes	
Have you ever been hospitalized or had a major operation?	☐ Yes ☐ No	If yes	
Have you ever had a serious head or neck injury?	☐ Yes ☐ No	If yes	
Are you taking any medications, pills, or drugs?	☐ Yes ☐ No	If yes	
Do you take, or have you taken, Phen-Fen or Redux?	☐ Yes ☐ No	If yes	
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	☐ Yes ☐ No	If yes	
Are you on a special diet?	☐ Yes ☐ No		
Do you use tobacco?	☐ Yes ☐ No		
Do you use controlled substances?	☐ Yes ☐ No	If yes	

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

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

Other? ☐ If yes

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 Problems ☐ 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 If yes

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: _____

X _____ Date: _____

Cancellation and Broken Appointment Policy

We understand that illness, emergencies, flat tires, and bad weather do occur. We ask our patients to give us 48 hours' notice whenever possible, if they cannot keep an appointment. This allows us time to fill our schedule with other patients that may be waiting.

Policy and Fees:

Cancellation or rescheduling of an appointment ***with 48 hours or more*** notification – ***no charge***.

Cancellation or rescheduling of an appointment ***less than 48 hours and up to 24 hours*** may or may not be considered a broken appointment which will be at our discretion.

Failure to give 24 hour advance notice:

A broken appointment fee will be charged:

- \$75 for a hygiene appointment
- \$150 for a doctor's appointment scheduled for one hour or less, each additional hour incurs an additional fee of \$50

Definition of a "Broken Appointment":

- **Canceling** or **rescheduling** an appointment with ***less than 24 hour notice***.
- **Do not show up** for the scheduled appointment.

If you are scheduled on a Monday morning, we will need notification of the cancellation the afternoon of our last work day of the week prior to be considered a 24 hours notice.

Our number one concern is our patient's dental health. Providing services in a timely manner is critical to accomplish that goal. Our other goal is to keep the cost of dental services as economical as possible. The appointment you schedule for treatment is **reserved** for you and your treatment only. When you fail to keep your appointment without providing us adequate notice it adds to the overall cost of care, as trained professionals and dental facilities are not being utilized. We appreciate your understanding and consideration regarding our appointment policy and if you have any questions or concerns, never hesitate to ask us.

I have read and understand the above mentioned policy.

Patient Signature: _____ Date: _____

Financial Policy

In order to enhance communication and promote understanding regarding this office's financial policy, please read through the following information. After reading, provide your signature at the bottom indicating that you fully understand this policy. If you have any questions or concerns, please speak to the office manager and/or Dr. Putman. Thank you.

Payment is due at the time services are rendered. For larger cases, 50% of the patient portion is due at the start of treatment, including any deductible, and the remaining 50% is due at the last appointment. We accept cash, debit cards, MasterCard, Visa and Discover credit cards. We also offer **Care Credit** and **Cherry** as an option. Balances over 60 days will incur an interest charge of 1.5% per month after 90 days and an additional \$5.00 rebilling fee per statement will be charged. If we make an exception and accept a check, returned checks will have an additional fee of \$25.00 added to the amount of the returned check.

- For payments of \$3,000 or more a 3% service charge will apply when using a credit card.
- For payments using Care Credit there will be a 10% service charge each time and must be over \$1000 to use.
- For Cherry the amount must be over \$1000 to use in office and there will be a 10% service fee to use.
- There is no service charge when using cash or checks.

Insurance: We are happy to bill your primary insurance carrier as a courtesy. There will be a 3% service charge for billing a secondary insurance carrier due to the extra filing fees and paperwork. Please understand that each patient is ultimately responsible for the cost of services rendered. ***Your insurance policy is a contract between you, your employer, and the insurance company.*** We are NOT a party to that contract. Our financial relationship is with you.

- All charges are your responsibility whether your insurance pays or not. Not all services are covered benefits in all contracts.
- If the insurance company does not pay in full within 30 days, we will ask that you contact the carrier to help speed things up.
- If the insurance company does not pay in full within 60 days, we will require you to pay the balance due with cash, debit card, MasterCard, Discover, or Visa.
- We will do our best to estimate insurance coverage and the patient portions due. For services over \$500 we will send a pre-estimate request to your insurance at your request. If the insurance company does not pay the full amount anticipated **the patient is responsible for the difference.** Payment is expected within 10 days after the statement date.

Refunds for Unfinished Treatment: Please understand that if a patient decides to discontinue treatment after it has been started, a full refund will not be given. Individual circumstances may be discussed with the office manager and/or Dr. Putman.

Our office reserves the right to make changes without notice.

Patient Signature: _____ Date: _____

E-mail and Text Messaging Program Consent Form

We are happy to provide our patients with the option to participate in our online patient communication system. Some of the features include the ability to:

- Requests appointments via e-mail
- Confirm appointments via e-mail and text message
- Receive text message appointment reminders
- Submit patient satisfaction surveys
- Refer your friends online

You may choose to discontinue your participation in our online communication system at any time simply by clicking on the “unsubscribe” link found at the bottom of each e-mail, or by replying “STOP” to a text message from us. Standard text messaging rates may apply.

We use this information strictly for the purposes of communicating with you more efficiently. Our goal is to provide you with excellent treatment as well as overall service and satisfaction. We may disclose patient health information (PHI) to third parties that perform services for this practice in the administration of your benefits in accordance with HIPAA. These parties are required by law to sign a contract agreeing to protect the confidentiality of your PHI. Your PHI may be disclosed to an affiliate that performs services for this practice in the administration of your benefits. Our affiliates do not sell, share, or rent our user’s personally identifiable information unless required by law. They do not send any e-mail or other communications without your permission nor do they not send spam.

Please provide us with the following contact information:

Cell phone for text message communication: _____

E-mail address: _____

Please sign below to indicate that you agree to allow us to use this information in providing your services.

Patient Signature: _____ Date: _____

Authorization Form for Use or Disclosure of Patient Information

Patient Name: _____ DOB: _____

I hereby authorize the use and disclosure of the patient information as described below. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPAA Privacy regulations.

I authorize the following person(s) to receive my information:

Name: _____ Name: _____

Relationship: _____ Relationship: _____

Phone number: _____ Phone number: _____

I authorize the following information to be used or disclosed on my behalf:

- ☐ Treatment diagnosis and procedures
- ☐ Scheduling
- ☐ Financial
- ☐ Insurance
- ☐ Health history/medications
- ☐ All of the above

I understand that I may revoke this authorization at any time, and that my revocation is not effective unless it is in writing and received by the dental practice's Privacy Official at 200 New Stock Rd Asheville, NC 28804, Dr Pamela Putman,DMD, PLLC . If I revoke this authorization, my revocation will not affect any actions taken by the dental practice before receiving my written revocation.

I understand that I may refuse to sign this authorization, and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits.

This authorization does not expire unless revoked by the patient.

Patient Signature: _____ Date: _____

Acknowledgement of Receipt of Notice of Privacy Practices

“You may refuse to sign this acknowledgement”

I, _____, have received a copy of this office’s Notice of Privacy Practices.

Print Name: _____

Patient Signature: _____

Date: _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify): _____

Pamela S. Putman, D.M.D.

200 New Stock Road, Asheville, NC 28804

Phone: (828) 645-3797 Fax: (828) 645-2948 E-mail: office@drputmandmd.com

Release of Records

Patient Name: _____ DOB: _____

Previous Dentist Name: _____

Address: _____

Phone: _____

I give permission for my x-rays and pertinent dental records to be released to the practice of
Dr. Pamela Putman, DMD.

Patient Signature: _____ Date: _____

Notice of Privacy Practices

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

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect February 16, 2026, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance use- disorder treatment records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

- **Treatment.** We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.
- **Payment.** We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care.
- **Payment activities** include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.
- **Healthcare Operations.** We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities. Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends, or any other individual identified by you when they participate in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

- **Disaster Relief.** We may use or disclose your health information to assist in disaster relief efforts. Required by Law. We may use or disclose your health information when we are required to do so by law.
- **Public Health Activities.** We may disclose your health information for public health activities, including disclosures to: • Prevent or control disease, injury or disability; • Report child abuse or neglect; • Report reactions to medications or problems with products or devices; • Notify a person of a recall, repair, or replacement of products or devices; • Notify a person who may have been exposed to a disease or condition; or • Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.
- **National Security.** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials' health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement officials having lawful custody the protected health information of an inmate or patient. Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.
- **Worker's Compensation.** We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.
- **Law Enforcement.** We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.
- **Health Oversight Activities.** We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.
- **Judicial and Administrative Proceedings.** If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.
- **Research.** We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.
- **Coroners, Medical Examiners, and Funeral Directors.** We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to perform their duties.
- **Fundraising.** We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.
- **ADA PRACTICAL GUIDE TO HIPAA COMPLIANCE ADA PRACTICAL GUIDE TO HIPAA COMPLIANCE SUD Treatment Information.** If we receive or maintain any information about you from a substance use disorder treatment program that is covered by 42 CFR Part 2 (a "Part 2 Program") through a general consent you provide to the Part 2 Program to use and disclose the Part 2 Program record for purposes of treatment, payment or health care operations, we may use and disclose your Part 2 Program record for

treatment, payment and health care operations purposes as described in this Notice. If we receive or maintain your Part 2 Program record through specific consent you provide to us or another third party, we will use and disclose your Part 2 Program record only as expressly permitted by you in your consent as provided to us. In no event will we use or disclose your Part 2 Program record, or testimony that describes the information contained in your Part 2 Program record, in any civil, criminal, administrative, or legislative proceedings by any Federal, State, or local authority, against you, unless authorized by your consent or the order of a court after it provides you notice of the court order.

- **OTHER USES AND DISCLOSURES OF PHI** Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already acted in reliance on the authorization.

Patient Rights

YOUR HEALTH INFORMATION RIGHT.

- **Access.** You have the right to look at or get copies of your health information, with limited exceptions.
- You must make the request in writing.
- You may obtain a form to request access by using the contact information listed at the end of this Notice.
- You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies.
- If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure. If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.
- **Disclosure Accounting.** With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to the additional requests.
- **Right to Request a Restriction.** You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.
- **Alternative Communication.** You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location and provide satisfactory explanation

of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested, we may contact you using the information we have.

- **Amendment.** You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.
- **Right to Notification of a Breach.** You will receive notifications of breaches of your unsecured protected health information as required by law.
- **Electronic Notice.** You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).
- **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 if 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.

Patient Name Printed: _____ DOB: _____

Patient Signature: _____ Date: _____

This material is educational only, does not constitute legal advice, and covers only federal, not state, law. Changes in applicable laws or regulations may require revision. Dentists should contact their personal attorneys for legal advice pertaining to HIPAA compliance, the HITECH Act, and the U.S. Department of Health and Human Services rules and regulations. Reproduction of this material by dentists and their staff is permitted. Any other use, duplication or distribution by any other party requires the prior written approval of the American Dental Association. This material is educational only, does not constitute legal advice, and covers only federal, not state, law. Changes in applicable laws or regulations may require revision. Dentists should contact their personal attorneys for legal advice pertaining to HIPAA compliance, the HITECH Act, and the U.S. Department of Health and Human Services rules and regulations. © 2010–2025 American Dental Association. All Rights Reserved.