Richard L Gore, D.D.S., P. A
Sean Z. Gore, D.D.S
11OfficePark
Little Rock, AR 72211

PLEASE PRINT

Name____Phone#_______________Ext___________

Home Address____Apt#____________________

City____State__________Zip_______________

Patient\Parent Employer____

Work Address___________________________ Work Phone# ________________Ext______________

Driver's License#____________________ Patient's Date of Birth_________-_______-_______________

Social Security# _______ - ________-___________ Mobile\Pager #____________________________

Marital Status (Circle One) S M D W SEP SEX (Circle One) MALE FEMALE

Spouse's\ Parent's Name ______________________________Date Of Birth _____-_______-_________

Spouse's \ Parent's Employer_________________________ Work Phone______________ Ext_______

Whom may we thank for referring you? ____

Nearest relative not living with you.____

Address and Phone____

DENTAL INSURANCE INFORMATION

Primary Carrier___________________________ ___________________ ______________________
(Name of Insurance Company) (Employee Name) (Employer)

Subscriber Date of Birth ____________________Subscriber's ID#________________________________

Secondary Carrier__________________________ ____________________ ______________________
(Name of Insurance Company) (Employee Name) (Employer)

Subscriber Date of Birth____________________ Subscriber ID#__________________________________

Financial Arrangement

Payment is expected at the time of service, for you convenience we will be happy to file your insurance for you but we ask that you pay your **estimated balance** at the time of your appointment.

We offer the following methods of payment. Please check the option that you prefer.

_____Cash_____Check______Charge Card_________

We offer CARE CREDIT and CITI HEALTHCARDS for Financial Assistance. Please ask the office Staff for details and applications for these services **before treatment is performed**.

HEALTH HISTORY

Please list any medications or substances that you may be allergic to. ___________________________

____

Are you Pregnant? ________________________________Nursing________________________________

Have you been under the care of a medical doctor during the past two years? _____________________

Physician's Name __________________________________Phone No.______________________________

Please list all the medication that you are taking at this time. ____________________________________

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Please CIRCLE and DATE when you have been diagnosed with any of the following:

Heart (surgery, disease, attack)	YES	NO	Diabetes	YES	NO
Chest Pains	YES	NO	Stomach Ulcers	YES	NO
Heart Murmur	YES	NO	Thyroid Problems	YES	NO
High Blood Pressure	YES	NO	Glaucoma	YES	NO
Mitral Valve Prolapse	YES	NO	Emphysema	YES	NO
Artificial Heart Valve	YES	NO	Chronic Cough	YES	NO
Heart Pace Maker	YES	NO	Tuberculosis	YES	NO
Rheumatic Fever	YES	NO	Asthma	YES	NO
Artificial Joints	YES	NO	Hay Fever	YES	NO
Chemotherapy\Radiation	YES	NO	Swollen Ankles	YES	NO
Stroke	YES	NO	Allergies/Hives	YES	NO
Latex Sensitive	YES	NO	Sinus Trouble	YES	NO
Arthritis/Rheumatism	YES	NO	Cortisone Medicine	YES	NO
Kidney Trouble	YES	NO	Tumors	YES	NO
Hepatitis	YES	NO	A.I.D.S.	YES	NO
Cold Sores/Fever Blisters	YES	NO	H.I.V. Positive	YES	NO
Blood Transfusion	YES	NO	Bleeding Problems	YES	NO
Diet Pills\Fen-Phen	YES	NO	Bruise Easily	YES	NO
Liver Disease	YES	NO	Jaundice	YES	NO
Neurological Disorders	YES	NO	Epilepsy	YES	NO
Seizures	YES	NO	Dizzy Spells	YES	NO

If you have or have had any disease or condition not listed above please describe in detail.__

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If I fail to give a 24 hour notice of appointment cancellation, I agree to billed $30.OO for that appointment time. I agree to be personally responsible for payment of all dental services to be paid the day that services are rendered. I shall as for a quotation of fees for services or I waive my right to the latter claim the fee exceeded the value of services rendered. If delinquent, I agree to pay for all collection and attorney fee, which will be an additional 50% of my account balance.

Patient/Parent Signature______________________________________ Date______________________

DENTAL HISTORY

What prompted you to seek dental care at this time? ____

How long since your last dental exam? ____

Did you have your teeth cleaned? ____

Were x-rays taken of all your teeth? ____

Do you go to the dentist every (6) months for cleaning\exam?____

Name of Previous Dentist____

Circle Yes or No

- Y N Are any teeth sensitive to Hot__Cold__Sweets___
- Y N Do any of your teeth feel loose?
- Y N Do you gums bleed when brush?
- Y N Does food collect between your teeth?
- Y N Would you like to change anything about your smile?
- Y N Do you use smokeless tobacco?
- Y N Do you smoke?
- Y N Healing Complications
- Y N Fainting Spells
- Y N Pain in region of ear
- Y N Allergy to Novocaine
- Y N Dental Injections
- Y N Bleeding Problems
- Y N Have had Nitrous Oxide (laughing gas)
- Y N Does your jaw pop when you open or close your mouth?
- Y N Do you clench or grind your teeth?
- Y N Do you habitually chew on anything?
- Y N Snoring\Sleep Apnea

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, which may release such information to you. I will notify the doctor of any changes in my health or medication at each appointment.

____ ____________________________________

Patients Signature (parent if minor) Date

ASAP SMILE CENTER OF LITTLE ROCK

RICHARD L. GORE D.D.S.,P.A.

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.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect (04/14/2003), 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. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available 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.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

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 official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.25 for each page and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. 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 these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

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.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

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.

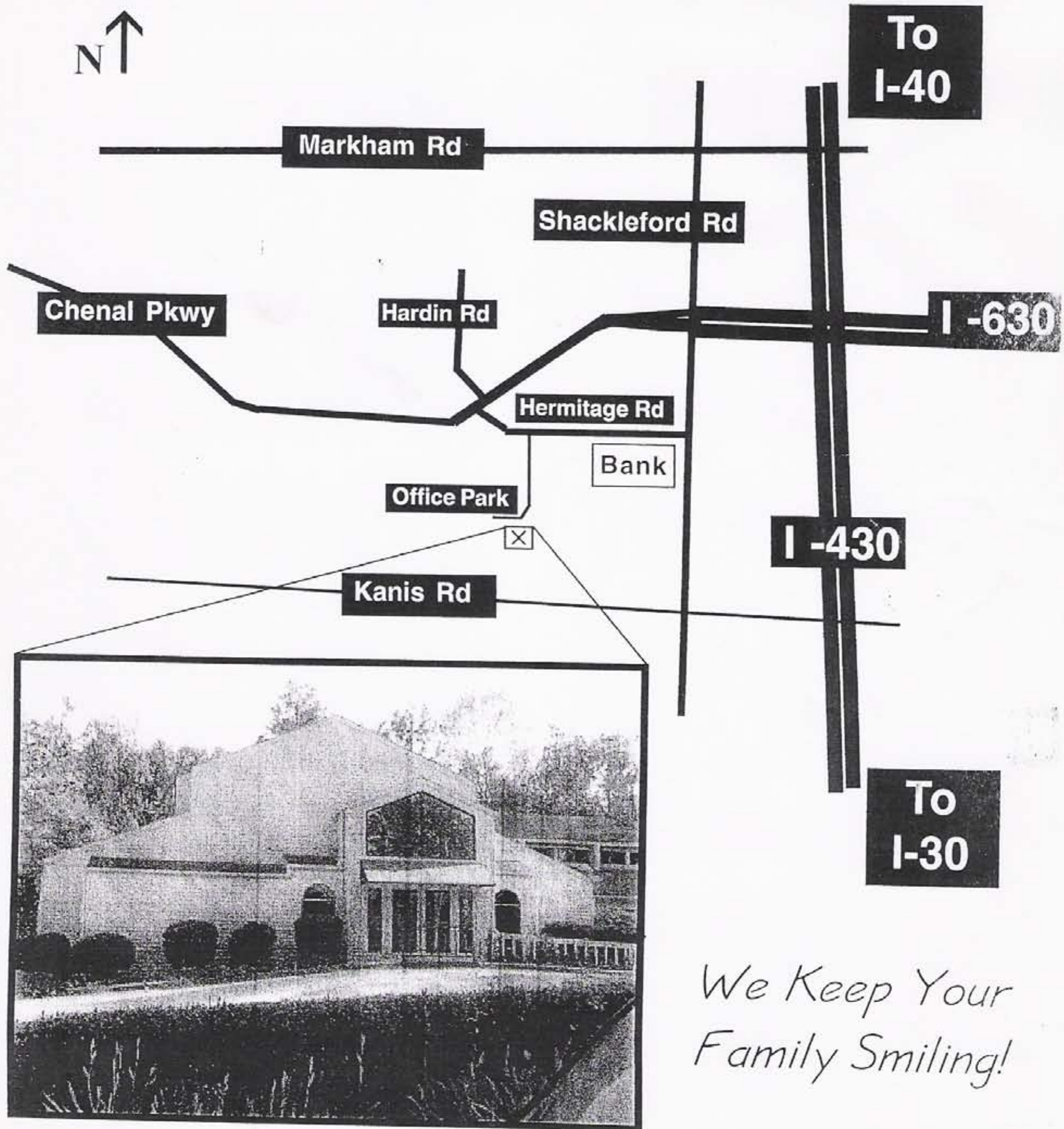
Contact Officer: Richard Gore DDS

Telephone: 501-225-2929

Fax: 501-228-6646

Address: 11 Office Park Drive, Little Rock, AR 72211

RICHARD L. GORE D.D.S., P.A.
ASAP SMILE CENTER OF LITTLE ROCK



We Keep Your Family Smiling!

11 Office Park • Little Rock, Arkansas 72211
(501) 225-2929 • Fax (501) 228-6646 • www.ASAPSmileCenter.Com

Dr. Richard L. Gore
Dr. Sean Z. Gore
11 Office Park
Little Rock, AR 72211
(501)225-2929

We would like to Welcome you to our dental practice and explain a little about our office policies. To help us prepare for your appointment we ask a few things from you:

~ Plan to arrive 10 minutes prior to your appointment time.

~ Have the attached patient information forms **completed** before you arrive. You may also fax (501) 228-6646 or email dr.richardgore@gmail.com them to us prior to your appointment.

~ Please list all medications that you are taking on the patient info form.

~ Please advise us **before** your appointment if you need to be premedicated with antibiotics or have any other special needs.

~ If you have insurance, please call, fax or email your information to us at least 2 days prior to your appointment. You may have already given us this information when you made your appointment.

We will be happy to file your insurance for you, but we ask that you pay your estimated balance at the time of service (%, deductibles, co pays etc). For your convenience we accept Visa, MasterCard, Discover, personal checks and cash. We also provide applications for Care Credit and CitiHealth Care for patients that need financing.

We look forward to helping you achieve a beautiful smile!

Dr. Richard Gore, Dr. Sean Gore and Staff