Gastonia FAMILY DENTISTRY
2557 Pembroke Rd.
Gastonia, NC 28054

Please fill out this form as completely as you can. Failure to provide correct information can delay and alter your treatment. If you have any questions, we would be glad to assist you!

Patient's Name _____ **Date** _____/_____/_____

PATIENT INFORMATION

Preferred Name: _____

Address: _____
City, State, Zip: _____
E-mail: _____
Home Phone: (____) _____
Work Phone: (____) _____ext____
Cell Phone: (____) _____

Sex: ☐ Male ☐ Female
Birth Date: ____/____/_____
Age: ___ years old
Marital Status: _____
Social Security #:____-___-____
Driver's License#: _____

Do you preferred to receive: ☐ calls at home ☐ calls at work ☐ calls on cell ☐ e-mails

Emergency Contact: _____ Phone: (____) _____
Name of Employer: _____ Phone: (____) _____
Primary Care Physician: _____ Phone: (____) _____
How did you hear about us? _____

RESPONSIBLE PARTY / GUARDIAN

☐ **Patient Is Responsible Party (SKIP)**

Name: _____
Address: _____
City, State, Zip: _____
E-mail: _____
Home Phone: (____) _____
Work Phone: (____) _____
Cell Phone: (____) _____

☐ Responsible Party is the Parent or Guardian of the Patient
☐ Responsible Party is the Primary Insurance Policy Holder
Birth Date: ____/____/_____
Social Security #: ____-____-____
Driver's License#: _____

DENTAL INSURANCE INFORMATION

☐ **Patient does NOT have insurance (SKIP)**

Name of Insured: _____
Birth Date: ____/____/_____
Social Security #: _____-____-_____
Name of Employer: _____
Address: _____
City, State, Zip: _____
Phone: (____) _____

Relationship to Patient: ☐ self ☐ spouse ☐ child ☐ other
Insurance Co: _____
Group/Policy # _____
Address: _____
City, State, Zip: _____
Phone: (____) _____

MEDICAL INSURANCE INFORMATION

☐ **Patient does NOT have insurance (SKIP)**

Name of Insured: _____
Birth Date: ____/____/_____
Social Security #: _____-____-_____
Name of Employer: _____
Address: _____
City, State, Zip: _____
Phone: (____) _____

Relationship to Patient: ☐ self ☐ spouse ☐ child ☐ other
Insurance Co: _____
Group/Policy # _____
Address: _____
City, State, Zip: _____
Phone: (____) _____

Medical History

Patient Name: _____ Date of Birth: _____

	YES	NO	
Are you under a physician's care now?	☐	☐	If Yes: _____
Have you been hospitalized or had a major operation?	☐	☐	If Yes: _____
Have you ever had a serious head or neck injury?	☐	☐	If Yes: _____
Are you taking any medications, pills, or drugs?	☐	☐	If Yes: _____
Do you take, or have you taken Phen-Fen or Redux	☐	☐	If Yes: _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	☐	☐	If Yes: _____
Are you on a special diet?	☐	☐	If Yes: _____
Do you use tobacco?	☐	☐	If Yes: _____
Do you use controlled substances?	☐	☐	If Yes: _____
Do you snore or have been told you snore?	☐	☐	If Yes: _____
Have you ever been diagnosed with sleep apnea?	☐	☐	If Yes: _____
Do you wear a C-PAP or have you in the past?	☐	☐	If Yes: _____
Have you had a sleep study or been told to get one?	☐	☐	If Yes: _____

Women: Are you ☐ Pregnant ☐ Taking Oral Contraceptives ☐ Nursing

Are you allergic to any of the follow? ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics
☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Other: _____

Do you have, or have you had any of the following?

	YES	NO		YES	NO		YES	NO		YES	NO
AIDS/HIV Positive	☐	☐	Cortisone Medicine	☐	☐	Hemophilia	☐	☐	Radiation Treatments	☐	☐
Alzheimer's Disease	☐	☐	Diabetes	☐	☐	Hepatitis A	☐	☐	Recent Weight Loss	☐	☐
Anaphylaxis	☐	☐	Drug Addiction	☐	☐	Hepatitis B or C	☐	☐	Renal Dialysis	☐	☐
Anemia	☐	☐	Easily Winded	☐	☐	Herpes	☐	☐	Rheumatic Fever	☐	☐
Angina	☐	☐	Emphysema	☐	☐	High Blood Pressure	☐	☐	Rheumatism	☐	☐
Arthritis/Gout	☐	☐	Epilepsy or Seizures	☐	☐	High Cholesterol	☐	☐	Scarlet Fever	☐	☐
Artificial Heart Valve	☐	☐	Excessive Bleeding	☐	☐	Hives or Rash	☐	☐	Shingles	☐	☐
Artificial Joint	☐	☐	Excessive Thirst	☐	☐	Hypoglycemia	☐	☐	Sickle Cell Disease	☐	☐
Asthma	☐	☐	Fainting/Dizziness	☐	☐	Irregular Heartbeat	☐	☐	Sinus Trouble	☐	☐
Blood Disease	☐	☐	Frequent Cough	☐	☐	Kidney Problems	☐	☐	Spina Bifida	☐	☐
Blood Transfusion	☐	☐	Frequent Diarrhea	☐	☐	Leukemia	☐	☐	Stomach/Intestinal Disease	☐	☐
Breathing Problem	☐	☐	Frequent Headaches	☐	☐	Liver Disease	☐	☐	Stroke	☐	☐
Bruise Easily	☐	☐	Genital Herpes	☐	☐	Low Blood Pressure	☐	☐	Swelling of Limbs	☐	☐
Cancer	☐	☐	Glaucoma	☐	☐	Lung Disease	☐	☐	Thyroid Disease	☐	☐
Chemotherapy	☐	☐	Hay Fever	☐	☐	Mitral Valve Prolapse	☐	☐	Tonsillitis	☐	☐
Chest Pains	☐	☐	Heart Attack/Failure	☐	☐	Osteoporosis	☐	☐	Tuberculosis	☐	☐
Cold Sores/Fever Blisters	☐	☐	Heart Murmur	☐	☐	Pain in Jaw Joints	☐	☐	Tumors or Growths	☐	☐
Congenital Heart Disorder	☐	☐	Heart Pacemaker	☐	☐	Parathyroid Disease	☐	☐	Ulcers	☐	☐
Convulsions	☐	☐	Heart Trouble/Disease	☐	☐	Venereal Disease	☐	☐	Yellow Jaundice	☐	☐
Depression	☐	☐	Fibromyalgia	☐	☐	Acid Reflux /GERD	☐	☐	Periodontal Disease	☐	☐

Have you ever had any serious illness not listed above? Yes No If Yes: _____

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 Date

ACKNOWLEDGEME NT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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

Please Print Name	Signature	Date

FOR OFFICE USE ONLY

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

- ☐ Individual refused to sign
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Unable to communicate with the patient for the following reason: _____
- ☐ Other: _____

Prepared by: _____

Signature: _____

Date: _____

AUTHORIZATION FOR RELEASE OF INFORMATION

Name of Patient: _____ Date of Birth: _____

Gastonia Family Dentistry 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
☐ Voice Mail	☐ Results of lab test / x-rays ☐ Other: _____
☐ Spouse (Provide Name and Phone Number) _____	☐ Financial ☐ Medical
☐ Parent (Provide Name and Phone Number) _____	☐ Financial ☐ Medical
☐ Email (Provide email address) _____	☐ Financial ☐ Appointment Reminders ☐ Medical ☐ Breach Notification

☐ For email communication I understand that if email is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email communication.

☐ Communication about treatment alternatives even if this office is being compensated for making the communication.

The information is released at the patient's request and this authorization will remain in effect until revoked by the patient.

Signature of Patient or Personal Representative: Date:

Financial Policy

(Please initial each paragraph)

-Insurance: As a courtesy to all patient we will verify your dental insurance benefits, but you are responsible to know your plan coverage, exclusions and limitations. Furthermore you should be aware of non-covered benefits such as a missing tooth, crown/bridge/denture, restorations, bruxism, downgraded limitations for fillings and porcelain on crowns on molar teeth, frequency limits for exam, prophylaxis, fluoride and x-rays, etc. The estimated amount not covered by your insurance is due at the time of treatment and may be paid by cash, personal check, Visa, MasterCard, or Discover. To help you accept an extensive treatment plan, we are offering a Care Credit dental treatment and financing program.

-All estimates are subject to final approval by your dental insurance plan: therefore the amount due is subject to change after final explanatior of benefits have been paid. _____ **(Initial)**

-INITIAL PAYMENT FOR DENTAL TREATMENT: Most plans are covered for routine clinical exam and cleaning, no deductible is due for diagnost or preventative treatment unless otherwise stated. There are some plans with co-insurance payment for x-ray and dental exam. Deductible foi basic/major services customarily include fillings, crowns, extraction, root canal therapy, periodontal treatment.

- Deductibles are usually $50 per individual up to $150 per family annually
- 20% co-payment for all basic services
- $175 for any build-up &crown procedure. Most plans do not allow separate benefits for crowns and build-up. In such a case the patient is responsible for the full cost of a build-up
- Lab fees are included in the cost of your treatment with the EXCEPTION of cases where we have to redo a crown which was placed over 90 days prior. In these situations, there will be a separate lab fee of $250 per tooth.

_____ **(Initial)**

-RESIN-BASED COMPOSIT RESTORATIONS (Fillings): Most dental insurance plans do not allow full benefits for composites (white fillings) performed on posterior teeth (back molars). The plan benefit will customarily pay for less expensive treatment – AMALGAM (silver/mercury based restoration). For the best of our patients, we recommend and we place only composite-based (white) fillings. The difference is usually $15 per filling and the patient is responsible for the difference in cost. Please ask our front desk or doctors if you need more information about composite-based (white) fillings. _____ **(Initial)**

-PULP-CAP TREAMTENT (Medicament to protect the pulp chamber): Most dental plans do not allow additional benefits for pulp-cap treatmen (this procedure in which the filling is very deep and the nearly exposed pulp is covered with a protective medication to help with healing and repair via formation for secondary dentin). The cost of this treatment is $275 per tooth (depends on your insurance coverage) and the patient responsible for payment at the time of treatment. If your insurance does not cover it or does not allow separate benefits you will be charged a contracted fee (between us a provider and the insurance). _____ **(Initial)**

-FINANCIAL CHARGES: All return checks are subject to a $25 fee. We reserve the right to apply $20 rebilling fee and $25 late charges toward overdue financial agreements. We have the option to report your balance with us to any credit reporting agency and credit bureau.

_____ **(Initial)**

-PAST DUE ACCOUNTS: In the event that your account is turned over to a Collection Agency or attorney, you agree to pay all fees including anc not limited to attorney fees, court costs, and collection agency fees. _____ **(Initial)**

-FMLA FORMS: There will be a $20 fee for completing FMLA associated paperwork. All requests will be processed within 5 business days.

_____ **(Initial)**

-MISSED APPOINTMENTS: Please give us a call in advance if you need to reschedule or cancel your appointment. If you repeatedly miss scheduled appointments without giving us a prior notice you may be discharged from our practice. _____ **(Initial)**

-TRANSFERRING RECORDS: You will need to request in writing if you would like us to mail, fax, email, etc any part of your records with Gastoni Family Dentistry. We need at least 8 working hours in advance to prepare your record to be transferred. _____ **(Initial)**

This is an Agreement between Gastonia Family Dentistry, as a provider of professional services and creditor, and the Patient/debtor named on this form. By reading and signing this Agreement, you are agreeing and accepting this Policy in full.

I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION; ALL MY QUESTIONS WERE ANSWERED TO MY SATISFACTION; I UNDERSTAND AND AGREE TO ALL POLICIES OF GASTONIA FAMILY DENTISTRY.

PRINT NAME (PATIENT/SUBSCRIBER, if minor-GUARDIAN) _____

SIGNATURE _____ DATE _____

Assignment of Benefits Form

Patient Name: _____ **Date of Birth:** _____

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangemen have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits: I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to Gastonia Family Dentistry

For Medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance or the agreed amount for services rendered.

Authorization to Release Information I hereby authorize Gastonia Family Dentistry To:

(1) Release any information necessary to insurance carriers regarding my illness and treatments;

(2) Process insurance claims generated in the course of examination or treatment; and

(3) Allow a photocopy of my signature to be used to process insurance claims for the period of lifetime.

This order will remain in effect until revoked by me in writing. I have requested medical services from Gastonia Family Dentistry

On behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I hereby affirm that any payment made to me by my Insurance Carrier will be immediately transferred to Gastonia Family Dentistry upon receipt for services rendered.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charge incurred in full immediately upon presentation of the appropriate statement EOB or Check.

A photocopy of this assignment is to be considered as valid as the original.

Patient/Responsible Party Signature /Date

_____