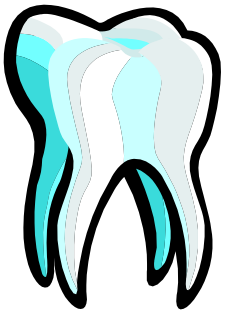
Welcome



Date: _____

Patient Information

Patient Name _____ Patient Date of Birth _____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Emergency Contact Name _____ Phone# ( ) -

How did you hear about us: _____

Responsible Party

The responsible party is the patient if over 18 yrs old. The responsible party is the parent or guardian if under 18 yrs old.

Name _____ Birth date _____ Relationship to Patient _____

Social Security# _____ Driver's License# _____ State _____

Employer Name _____ Employer Phone# ( ) -

Home Address _____ City _____ State _____ Zip _____

Home Phone# ( ) - Cell Phone# ( ) -

Must provide a valid Driver's License or State Issued Identification

Primary Insurance Information

Subscriber Name _____ Birth date _____

Subscriber SS# _____ Subscriber Individual ID# _____

Subscriber Employer Name _____

Name of Insurance Company _____ Group# _____

Dental Eligibility Phone# ( ) -

Must Provide a valid Insurance Card

Secondary Insurance Information

Subscriber Name _____ Birth date _____

Subscriber SS# _____ Subscriber Individual ID# _____

Subscriber Employer Name _____

Name of Insurance Company _____ Group# _____

Dental Eligibility Phone# ( ) -

Must Provide a valid Insurance Card

Fayetteville Family Dentistry
3416 Melrose Rd.
Fayetteville, NC 28304
www.familydentistrync.com

Office (910)484-5141 **Fax (910)481-8913**

FAYETTEVILLE FAMILY DENTISTRY

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 02/01/03, 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 anytime. 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, appointments, 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 location) 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 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 communication 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 the safety or the health 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, counter-intelligence, 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 HIPAA accepted letter to the address at the end of this Notice. 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 the additional requests.

Restrictions: You have the right to receive a list of instances in which we or our business associates disclosed 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:

Victoria Kush
3416 Melrose Rd
Fayetteville, NC 28304

(910)484-5141
(910)481-8913 fax

Fayetteville Family Dentistry Medical History Questionnaire

Last Name _____ First Name _____

Physician _____ Date of Last Physical _____

Former Dentist _____ Date of last dental visit _____

1. Please circle any of the following conditions which you have had or presently have:

Heart Disease or Condition	Rheumatic Fever	Hay Fever	Jaundice (Other than birth)	Alcohol or Substance Abuse
Angina Pectoris	Stroke	Emphysema	Thyroid Disease	Drug Addiction
Frequent Chest Pains	Hemophilia	Tuberculosis (TB)	Glaucoma	Psychiatric Treatment
High Blood Pressure	Prolonged or Unusual Bleeding	Diabetes	Epilepsy or Seizures	Caner
Swollen Ankles	Anemia	Ulcers	Fainting or Dizzy Spells	Radiation Therapy
Artificial Heart Valve	Blood Transfusion	Kidney Trouble	HIV Positive	Chemotherapy
Congenital Heart Disease	Arthritis	Liver Disease	AIDS	Unexpected Weight Loss
Heart Murmur	Asthma	Hepatitis	Cold Sores	Venereal Disease
				Latex Allergy

2. YES NO Are you presently or have you been under the care or a physician during the past year?

3. YES NO Are you presently taking any medicine or drugs? (If yes, please list below)

4. YES NO Are you allergic to any medicine or materials? (Including Penicillin, Codeine, Latex, etc…)

5. YES NO Have you ever had an implant or replacement of any joint, heart valve or body part? (If yes please specify below)

6. YES NO Do you have any diseases, traits or conditions not listed above?

7. YES NO Have you ever been told you were NOT eligible to donate blood?

8. YES NO Do you use any form of tobacco? (If yes, please circle and give frequency)
SMOKE: Cigarettes Cigars Pipe SMOKELESS: Chewing Tobacco Snuff or "Dip" FREQUENCY: _____

9. YES NO Do you use dental floss? If yes, how often? _____

10. YES NO Do your gums bleed when you brush or floss?

11. YES NO Do you favor one side of your mouth when chewing?

12. YES NO Do you have a fear of having dental work done?

13. YES NO Are you having any discomfort at this time?

14. (Circle one) Do you use an **ELECTRIC** or **MANUAL** toothbrush?

15. YES NO FEMALES: Are you pregnant? (If yes, please circle trimester) 1 2 3

16. YES NO FEMALES: Are you currently taking birth control pills?

PATIENT SIGNATURE: _____ DATE: _____

(Legal guardian if patient is a minor)

Provider's Comments: (Please date each entry)

☐ Continued on Back

Date							
BP							
Pulse							
Initials							

Medicaid & NC Health Choice Ins.

Welcome to Fayetteville Family Dentistry. We thank you for allowing us the opportunity to meet your dental needs and expectations. Please carefully review this information as it important to you as a new or existing patient.

Please initial or sign below that you are aware and agree to the office terms, procedures, and policies.

Initial _____ Date _____

A 48 hour notice is requested to cancel or reschedule an appointment. A 24 hour notice is required. Failure to give a notice or not showing up for the scheduled appointment, will result in dismissal from the practice.

Initial _____ Date _____

A copy of your insurance card and picture ID must be brought to every appointment. We are happy to file all insurance as a courtesy to our patients. Dental benefits are based on allowed procedures and plan policies provided by your insurance company. Any balance due to uncovered or un-allowed procedures, loss of insurance coverage, insurance participation that does not cover dental services, or any services not covered by the insurance plan, will be due to the responsible party at 100% of our current dental fee(s).

Initial _____ Date _____

If you are 21 years of age or older, a $3.00 co-pay is due at each visit. Payment is collected at the date and time of service. We accept Cash, Checks, Visa, MasterCard, and Care Credit. We do not offer in-house financing.

Signature _____

Date _____

I have read the above policies and understand I am financially responsible for _____(patient name), including any balance, whether paid by insurance or not. I authorize the use of my signature in order to submit any and all information required to process benefit claims or verification to the insurance company or companies I have provided by any form of transmission or communication.

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Financial & Appointment Policy

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Please initial or sign below that you are aware and agree to the office terms, procedures, and policies.

Initial _____ Date _____

A 48 hour notice is requested to cancel or reschedule an appointment. A 24 hour notice is required. Failure to give a notice will result in a $50.00 broken appt fee. We reserve the right to terminate our relationship as a result of repeated missed appointments. We do offer a courtesy call prior to your appointment as a reminder only.

Initial _____ Date _____

We are participating providers with United Concordia, Delta Dental Premier, Delta-Federal Retiree Program, Medicaid, and NC Health Choice.

Note: We are happy to file all insurance as a courtesy to our patients. Dental benefits are based on a negotiated contract between your employer and the insurance company, not our office. Any claim(s) denied, or procedure(s) changed, downgraded, combined, or fees reduced to comply with the plan policy provisions will be due within 90 days of the treatment date by the responsible party signing. Failure to comply within the allowed timed, will result in collections processing or legal suit, including any legal or processing fees.

Initial _____ Date _____

An estimated patient portion is presented to you prior to treatment. Payment is collected at the date and time of service. We accept Cash, Checks, Visa, MasterCard, and Care Credit. We do not offer in-house financing.

Signature _____

Date _____

I have read the above policies and understand I am financially responsible for _____(patient name), including any balance, whether paid by insurance or not. I authorize the use of my signature in order to submit any and all information required to process benefit claims or verification to the insurance company or companies I have provided by any form of transmission or communication.

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