



DAD & DOC DENTAL

high tech, common sense dentistry

Jamie Peterson, DDS | Greg Swartz, DDS

PATIENT INFORMATION

Date _____ Social Security # _____

Patient Name _____
Last Name First Name Middle Initial

Address _____

City _____ State _____ Zip _____

Sex M F Age _____ Birthday _____
 Married Widowed Single Minor Separated Divorced

Patient Employer/School _____ Occupation _____

Employer/School Address _____

Employer/School Phone () _____ Employer Email _____

How did you hear about us? Website Phonebook Current Patient _____ Other _____

Home Phone () _____ Cell Phone () _____ Text Yes No

Work Phone _____ Ext. _____ Email _____

Best # to reach you between 5:30pm – 7:30pm _____ Confirm appointments by email? Yes No

In case of Emergency, Contact: Name _____ Relationship _____ Phone _____

PRIMARY INSURANCE

Person Responsible for Account _____
Last Name First Name Middle Initial

Relation to Patient _____ Birthdate _____ SS# _____

Address (if different than patient) _____

City _____ State _____ Zip _____

Primary Insurance Employer _____ Dental Insurance Company _____

Group/Plan # _____ Member/Subscriber ID# _____

Insurance Company Customer Service Phone _____

ADDITIONAL INSURANCE

Is patient covered by additional dental insurance? Yes No

Subscriber Name _____ Relation to Patient _____ Birthdate _____

Address(if different than patient) _____

City _____ State _____ Zip _____

Secondary Insurance Employer _____ Secondary Dental Insurance Co. _____

Group/Plan # _____ Member/Subscriber ID# _____

Insurance Company Customer Service Phone _____

PATIENT NAME: _____

BIRTH DATE: _____

DATE: _____



DAD & DOC DENTAL

high tech, common sense dentistry

Jamie Peterson, DDS | Greg Swartz, DDS

Name of Your Physician: _____ Office Telephone: _____

Address of Your Physician: _____

1. Have you ever been hospitalized, had any major operations or had any serious illnesses? Yes No

If yes, explain:

2. Have you been under a physician's care in the last 2 years? Yes No

If yes, explain:

3. With regard to cigarette smoking, how would you classify yourself? Current smoker Ex-smoker Never smoker

4. Do you currently use smokeless tobacco (e.g. snuff, plug)? Yes No
If yes, about how many times do you use smokeless tobacco per day? Less than 1 1-5 6-10 11-20 more than 20

5. Do you have (or have you ever been told you had) any of the following conditions? (circle all that apply)

- a. Congenital heart problems
- b. Infective endocarditis or other heart infection
- c. Artificial heart valves
- d. Heart Transplant
- e. Artificial joints or prostheses

6. Have you ever had an allergic reaction, or any other unusual reaction, to any of the following medications or substances?
If yes, what reaction(s) did you have to this substance? (circle all that apply)

- | | | | | | | | |
|---|-------|----|------|----------|---------------|----------|-------------------------------|
| a. Penicillin | Yes | No | Rash | Swelling | Upset Stomach | Vomiting | Other reaction (explain)_____ |
| b. Sulfa or other antibiotics | Yes | No | Rash | Swelling | Upset Stomach | Vomiting | Other reaction (explain)_____ |
| c. Aspirin | Yes | No | Rash | Swelling | Upset Stomach | Vomiting | Other reaction (explain)_____ |
| d. Codeine or morphine | Yes | No | Rash | Swelling | Upset Stomach | Vomiting | Other reaction (explain)_____ |
| e. Dental anesthetic (e.g. Novocain or lidocaine) | Yes | No | Rash | Swelling | Upset Stomach | Vomiting | Other reaction (explain)_____ |
| f. Latex | Yes | No | Rash | Swelling | Upset Stomach | Vomiting | Other reaction (explain)_____ |
| g. Airborne substances (e.g. pollen, perfume) | Yes | No | Rash | Swelling | Upset Stomach | Vomiting | Other reaction (explain)_____ |
| h. Other medications or substances (explain) | _____ | | | | | | |

7. Do you have (or have you ever been told you had) any of the following conditions?

a. High blood pressure (hypertension)	Yes	No	Don't Know
b. High cholesterol	Yes	No	Don't Know
c. Heart disease (e.g., angina, coronary artery disease, congestive heart failure)	Yes	No	Don't Know
d. Diabetes (sugar diabetes, blood sugar problems)	Yes	No	Don't Know
e. Cancer or tumors	Yes	No	Don't Know
f. Inflammatory diseases (e.g., arthritis, rheumatism, lupus, fibromyalgia)	Yes	No	Don't Know
g. Frequent Headaches	Yes	No	Don't Know
h. Asthma, emphysema, or other lung disease	Yes	No	Don't Know
i. Thyroid problems	Yes	No	Don't Know
j. Epilepsy or seizure disorders	Yes	No	Don't Know
k. Fainting or dizzy spells	Yes	No	Don't Know
l. Hepatitis or other liver disease	Yes	No	Don't Know
m. Tuberculosis (TB)	Yes	No	Don't Know
n. HIV+ or AIDS	Yes	No	Don't Know
o. Blood disorders (e.g., anemia, hemophilia)	Yes	No	Don't Know
p. Kidney problems	Yes	No	Don't Know
q. Stomach or intestinal problems	Yes	No	Don't Know
r. Phobias, severe anxieties, depression, or other psychological problems	Yes	No	Don't Know
s. Radiation, surgery, or chemotherapy to treat cancer	Yes	No	Don't Know
t. Bleed excessively after being cut or receiving dental care	Yes	No	Don't Know
u. Heart attack, stroke, or coronary bypass operation	Yes	No	Don't Know
v. Shortness of breath after climbing 1 flight of stairs	Yes	No	Don't Know
w. Pacemaker	Yes	No	
x. Pregnant or think you may be pregnant	Yes	No	
y. Breastfeeding	Yes	No	
z. Are there any other problems or issues about your health that you know of?	Yes	No	

If yes, explain _____

8. Have you ever taken medications (such as bisphosphonates) that affect the bone or to prevent bone disease (e.g., Fosamax, Zometa, Actonel, Aredia)?

Yes No

9. Are you currently taking any medications or substances, including over-the-counter, prescription, vitamin, or herbal products, for any reason?

Please list below

Yes No

Medications or substances (with dosage)

I understand the need for these questions to be answered truthfully. To the best of my knowledge, the answers I have given are accurate. I also understand it is very important to report any changes in my medical and dental status to the dentist at the earliest possible time, and I agree to do so. I give permission to the dentist to obtain from my physician any additional information regarding my medical history needed to provide me the best dental treatment possible.

PERSON COMPLETING FORM: Signature: _____ Date: _____

If other than patient, indicate relationship to patient: _____

DAD & DOC Dental Practice

APPOINTMENT AGREEMENT

At DAD & DOC Dental Practice, we understand that your time is very valuable. We are constantly striving to make your experience here more pleasant than any other place you have previously been. Trying to accommodate every patient's individual needs and work schedule can be challenging. We make every effort to stay on time so that our patients will not have to wait unnecessarily.

Your appointment is a commitment of time between you and our office. We ask that you make every effort to keep that commitment. We do provide a courtesy reminder call one to two days prior to your appointment.

If you find that you cannot keep your appointment, we do require a minimum notice of 24 hours so we are able to assist other patients with their dental needs. If our office is not notified within the 24 hours, you will be subject to a \$50 late cancellation charge.

By signing below, I agree to fulfill my obligation as a patient at DAD & DOC Dental Practice and agree to the "broken appointment" fee should I not give proper notification.

Signature of patient or responsible party

Date

DAD & DOC Dental Practice

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAYBE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes:

- *Treatment* means providing, coordinating, or managing health care and related services by one or more health care providers. Examples would be teeth cleaning services, extraction letters, and periodontal or endodontic referrals.
- *Payment* means such activities as obtaining reimbursement for services, confirming coverage, and obtaining specific benefit information such as benefit maximums and deductibles met, etc., billing or collection activities, and utilization review.
- *Health care operations* include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individual identifiable information. We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relative, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain – a paper copy of this notice from us at your first delivery of services date.
- The right to provide – and we are obligated to receive – a written acknowledgement that you have received a copy of our Notice of Privacy Protection Practices.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health.

This notice is effective as of April 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that our privacy protections have been violated. You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, about violations of their provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

By signing this form, I agree to allow the use and disclosure of my medical record information for the purposes described above. A copy of this authorization (consent) form will be give to me.

Signature: _____

Date: _____

Please contact us for more information:
DAD & DOC Dental Practice
10479 N. NC Hwy 109. Ste. 107B
Winston Salem, NC 27103
(336) 283-8244
www.dadanddoc.com

For more information about HIPAA or to file a complaint:
The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, SW
Washington, DC 20201
(202) 619-0257 or Toll Free 1-877-696-6775

DAD & DOC Dental Practice

FINANCIAL POLICY

As a condition of the treatment performed by the providers of the office, financial arrangements must be made in advance for the full cost of proposed treatment. The practice's vitality depends upon payment for services as rendered and it is the responsibility of the patient or patient's parent/guardian to satisfy the costs incurred in dental care. Financial arrangements on the part of each individual must be determined prior to treatment completion.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are rendered. Additionally, a discount can be extended, at the management's discretion, for payments in full with cash or check. (Inquire for more details.)

Individuals who carry dental insurance understand that all dental services furnished are charged directly to the patient and that said patient is personally responsible for payment of all dental services provided, regardless of dental insurance reimbursement. As a customer courtesy, this office will help prepare and submit patients' insurance forms as well as assist in making collections from insurance companies. We will credit any such collections to the appropriate account. However, this dental office cannot render services on the assumption that our charges will be paid in part or in full by an insurance company. (Please understand that the amount to be paid by your particular policy is pre-determined and agreed to by your employer and the insurance company. If you have any questions about the amount the plan will pay or the treatments your plan will cover, you should refer these questions to your employer.) Additionally, there may be a deductible, a co-insurance factor, and a yearly maximum to be considered. Most policies cover what they consider a "usual and customary fee." However, the insurance company sets these fees, and they are not always the same as the fees that may be charged in this or any office. All these factors may combine to reduce the benefits you will ultimately receive. We will do our best to see that you receive your full benefits within the structure of your particular dental plan but any balance that remains on your account, whether your insurance company covered the procedure in question or not, is ultimately your responsibility to pay.

A service charge of 2% per month (24% per annum) on any unpaid balance will be charged on all accounts exceeding 60 days from date of service, unless previously written financial arrangements are agreed upon and satisfied. I understand that the fee estimate listed for any proposed dental care can only be extended for a period of six months from the date of diagnosis and/or examination. I further acknowledge that the proposed treatment plan can shift and/or change from the diagnosed treatment plan once treatment is begun due to unforeseen circumstances beyond the doctors' control.

In consideration for the professional services rendered to me by the doctor, at the provider's recommendation, or at my own request, I agree to pay the reasonable value of said services to said doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time allotted for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition, and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to DAD & DOC Dental Practice and/or DAD & DOC Dental Practice's financial coordinator to telephone me at home or at my place of business to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent or guardian

Date

Relationship to patient

Signature of guarantor of payment/responsible party

Date

Relationship to patient

Vital Information About Your Dental Insurance

As a service for you, we will be happy to help you file your insurance. Your dental insurance is a contract between you and your employer. Dental benefit plans can vary from company to company with different procedures covered or not covered.

Your insurance plan will pay only what it allows for each service, regardless of what the actual fee might be.

Your Employee Benefits Director can usually help you become familiar with your plan and its restrictions, and our office will assist you in maximizing your benefits.

Our Responsibilities:

1. Complete your insurance claim forms and submit them to your carrier for you within 24 hours of treatment.
2. Follow-up with your insurance regarding claim questions.
3. Accept direct payment from your carrier and keep track of balances.
4. If necessary, re-file your insurance a second time within a 60 day period.

Your Responsibilities:

1. To pay fees not covered by your insurance at the time of treatment.
2. To pay any account balance not paid by your insurance.
3. To provide our office with current insurance coverage and notify us with any changes in coverage to allow correct filing of claims.

Signature of Patient or Insured

I hereby authorize payment directly to the dental office of the insurance benefits otherwise payable to me. I understand that I am ultimately responsible for all costs of dental treatment. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payers.

Patient or Insured

Date