DENTISTRY ON CARMEL

Patient Information

Patient Name _____ Date of Birth _____ Today's Date _____

SS # _____ Driver's License # _____ M/F ____ Marital Status _____

Address _____ City _____ State _____ Zip_____

EMAIL _____

Home # _____ Work # _____ Mobile # _____

Employer _____ Emergency Contact _____ Phone # _____

Referral Information

Name of person, office or other source referring you to our practice _____

Responsible Party

☐ **SAME AS PATIENT INFORMATION ABOVE**

Name _____ M/F ____ Date of Birth _____Marital Status _____

SS # _____ Driver's License # _____

Address _____ City _____ State _____ Zip_____

Home # _____ Work # _____ Mobile # _____

Insurance Information

Insured Name _____ SS # _____

Patient Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name _____ Employer _____ Group # _____

Insurance Address _____

City _____ State _____ Zip _____ Phone _____

Appointment Policy: A scheduled appointment is a commitment of our time *just for you.* Therefore, we ask that you make every effort to keep that commitment. While we will always consider that personal emergencies and illness can occur, cancellations without 24-hour notice are subject to a fee. We look forward to serving you and appreciate your understanding in this matter.

Signature_____Date_____

Parent or Guardian if Above Patient is a Minor

Financial Guidelines: We will gladly process any standard dental claims for you. It is important to understand that any treatment rendered is the financial responsibility of the patient or guardian. Payment for the treatment rendered is expected at the time of service. If you have dental insurance, as a courtesy, we will file with the primary insurance carrier only. For any insurance coverage that cannot be verified at time of treatment or for any portion that insurance does not cover, payment is expected at the visit. Account balances over 90 days will be charged interest of 1.5% monthly and 18% annually. Returned checks are subject to a fee. I hereby authorize payment directly to ***M. Katherine Moore DMD*** *of* the group insurance benefits otherwise payable to me.

Signature_____Date_____

Parent or Guardian if Above Patient is a Minor

DENTISTRY ON CARMEL

Medical History

Patient Name _____ Date of Birth _____ Today's Date _____

Primary Care Provider Name _____ Office Telephone _____

1.) Have you been hospitalized, had any major operations or serious illnesses? YES NO
If yes, please describe: _____

2.) Are you allergic to any medications? If ye s list and describe reaction:
_____
Latex Allergy? YES NO
Any other Allergies? YES, NO List: _____

3.) **WOMEN ONLY:** Are you pregnant or think you may be pregnant? YES NO Breastfeeding? YES NO

4.) **Do you currently (or have you ever been told you had) any of the following conditions? (Check all that apply):**

- ☐ Acid Reflux
- ☐ Artificial Heart Valve
- ☐ **Artificial Joints/Prosthesis**
- ☐ Arthritis
- ☐ Asthma
- ☐ Autism/Asperger
- ☐ Bleeding Disorder (Anemia, Hemophilia)
- ☐ Cancer/Tumor
- ☐ Chemical Dependency
- ☐ Depression/Anxiety
- ☐ Diabetes
- ☐ Eating Disorder
- ☐ Fainting/Dizzy
- ☐ Frequent Cold Sores
- ☐ Glaucoma
- ☐ Headaches
- ☐ Hearing Problems
- ☐ Heart Attack
- ☐ **Heart Problems**
- ☐ Hepatitis/Liver Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV/AIDS
- ☐ Joint Replacement
- ☐ Kidney Problems
- ☐ Low Blood Pressure
- ☐ Lung Disease (COPD)
- ☐ Pacemaker
- ☐ Psychiatric Treatment
- ☐ Radiation/Chemo in past
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Seizures
- ☐ Sinus Problems
- ☐ Stomach/intestinal
- ☐ Stroke
- ☐ Thyroid condition
- ☐ Tuberculosis (TB)
- ☐ Ulcers

5.) **Have you ever taken medications (such as bisphosphonates) that affect bone or to prevent bone disease (ie. Fosamax, Zometa, Actonel, Aredia)?** YES NO

6.) **If applicable, are you required to take a premedication prior to your dental appointment (ie. joint replacement, history of infective endocarditis)?** YES NO
If yes, reason: _____

Medication Information

Are you currently taking any Medications? Yes NO **If Yes Please List All Medications Below:**

Drug Name	Dosage	Reason

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status, or if my medication changes, I shall inform the dentist and staff at the next appointment without fail.

Signature: _____ Date: _____

6219 Carmel Rd Charlotte, NC 28226 (704) 900 5045

DENTISTRY ON CARMEL

Relationship to Patient: ☐ Adult Patient ☐ Parent ☐ Guardian ☐ Other

Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I acknowledge that I have read your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out my treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

Office Use Only

I attempted to obtain the patient's signature in acknowledgement of this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date	Initials	Reason

DENTISTRY ON CARMEL

Assignment of Insurance Benefits Agreement

M. Katherine Moore DMD/ Dentistry on Carmel will accept an assignment of benefits from your insurance company with the following provisions. It is important to understand that the contract regarding your dental benefits is between you, your employer and your insurance company. The following provisions identify our policies governing insurance claims.

By checking each statement below, I am agreeing to the terms and conditions set forth in this agreement.

- ☐ Although we are willing to complete insurance information forms and submit a claim on your behalf, we do not accept responsibility for the outcome of the transaction. Completing insurance forms is a courtesy we extend to you in an effort to maximize your insurance reimbursement. By having our office process your insurance forms, it is important to understand that this does not eliminate your financial obligation for your treatment.

- ☐ We require you to sign this form and any other necessary assignment documents that may be required by your insurance company. This instructs your insurance company to make payments directly to our office.

- ☐ We require you to pay the co-insurance amount, (which is the amount not covered by your insurance company) at the time we provide service to you.

- ☐ Insurance payments ordinarily are received within thirty (30) to sixty (60) days from the time of filing. If your insurance company has not made payment to our office within sixty (60) days, we will ask you to pay the balance due at that time. You will then be responsible for seeking reimbursement from your insurance company.

- ☐ Our office does not guarantee that your insurance company will pay for treatment that you receive from our office. We perform routine insurance billing procedures upon verification of coverage. However, if your claim is denied, you will be responsible for paying in full at that time.

- ☐ Our office will not enter into a dispute with your insurance company over any claim. We will provide any necessary documentation your insurance company requests to sort out any confusion or questions that may arise. We will cooperate fully with regulations and requests of your insurance company. It is ultimately your responsibility to resolve any type of dispute over payments made or not made by your insurance company.

I have read and understand the above conditions. I hereby authorize my insurance company to pay my dental benefits directly to the doctor.

Signature of Patient or Responsible Party_____ Date _____

DENTISTRY ON CARMEL

Authorization for Release of Medical Information

Name of Patient _____ Date of Birth _____

I hereby authorize the release of protected health information about the above-named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Entity to Receive Information. Check all entities authorized to receive your personal information.	**Information to be Released.** For each section, check the information that you authorize released.
❑ Voicemail (provide name & phone number) _____	❑ Appointments / Scheduling Reminders
❑ Email (provide name & email address) _____	❑ Appointments / Scheduling reminders
❑ Parent (provide name & phone number) _____ _____	❑ Appointments / Scheduling reminders ❑ Financial ❑ Medical (including but not limited to lab results, x-rays, records, progress notes)
❑ Spouse (provide name & phone number) _____ _____	❑ Appointments / Scheduling reminders ❑ Financial ❑ Medical (including but not limited to lab results, x-rays, records, progress notes)
❑ Other (provide name & phone number) _____ _____	❑ Appointments / Scheduling reminders ❑ Financial ❑ Medical (including but not limited to lab results, x-rays, records, progress notes)

❑ I do NOT AUTHORIZE the release of any of my personal information to the entities described above.

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward. I understand that information used or disclosed because of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

Signature of Patient or Personal Representative _____ Date _____