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Patient Information (Age 18 & Up)

Legal Name: LAST_____ FIRST_____ MIDDLE_____

Social Security #_____-_____-_____ Date of Birth_____ Age_____ Sex_____

Address: _____ City/State/Zip: _____

Cell Phone: _____ Alternate / Home Phone:_____

Email: _____ Would you like to be updated by text / email? YES or NO

For Patients covered by Insurance

Primary Insurance _____ SS#/Policy # _____

Subscriber/Cardholder Name _____ DOB_____ Address_____

Group Number_____ Eligibility/Benefits Phone # _____

Secondary Insurance _____ SS#/Policy #_____

Subsriber/Cardholder Name_____ DOB_____ Address_____

Group Number_____ Eligibility/Benefits Phone #_____

Have you had an exam, cleaning, fluoride treatment or x-ray in the past 6 months? YES or NO

Have you had dental work including fillings this year? YES or NO

May we know how you heard about our office?_____

Emergency Contact Info: Name_____ Contact Phone Number_____

Physician Information

Primary Care Physician Name:_____ Phone #_____

Address: _____ City/State/Zip:_____ Fax #:_____

Specialty Physician Name:_____ Phone #_____

Address: _____ City/State/Zip:_____ Fax #:_____

Consent for Dental Treatment and Insurance Authorization

I certify that all the above patient information is correct. I request and authorize the dentist to examine, clean and provide dental treatment as may be necessary for proper dental care. I request and authorize necessary dental x-rays to diagnose and/or treat my dental problem. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I also understand that it is my responsibility to give accurate insurance information to the best of my knowledge.

Signature_____ Date:_____

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Tel 919.446.1564 www.HealthySmilesCarolina.com Fax 919.446.1574

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Medical Health History (Age 18 & Up)

Are you Allergic to any medicines or latex? YES or NO

If Yes, Please List: _____

Do you need pre-medication due to artificial heart valve replacement, congenitial heart conditions, total joint replacement and/or a history of infective endocarditis? YES or NO If Yes, Please list:_____

Are you taking any OTC or Prescribed medications, recreational drugs, vitamins, and/or natural remedies? YES or NO

If yes, please list:_____

Have you ever been hospitalized or had a major operation? YES or NO If Yes, Please list_____

WOMEN: Are you currently Pregnant? YES or NO If Yes, how many weeks?_____

Do you have, or have you had any of the following medical problems? Please **CHECK** below

__ Anaphylaxis	__ Cancer/Tumor	__ Heart Disease	__ Seizures / Epilepsy
__ Anemia	__ Chemotherapy	__ Heart Pace Maker	__ Shingles
__ Angina	__ Chest Pains	__ Hepatitis	__ Sinus Trouble
__ Artificial heart valve	__ Cold Sores/Fever Blister	__ HIV / AIDS	__ Stroke
__ Artificial joint	__ Diabetes	__ Jaw Joint Pain	__ Thyroid Problem
__ Asthma	__ Drug Addiction	__ Kidney problem/Dialysis	__ Tobacco Use
__ Attention Deficit Disorder	__ Fainting spells/Dizziness	__ Liver / GI disease	__ Tuberculosis
__ Blood/Bleeding disorder	__ Frequent headaches	__ Rheumatic fever	__ Vision problem

If Yes to any of the above, Please Explain:_____

Have you experienced any other medical problem not listed above? YES or NO

If yes, Please Explain:_____

May we request release of your medical records for our reference? YES or NO

Dental History (Age 18 & Up)

Reason for today's visit:_____

When was your last dental exam?_____ Last Dentist:_____

Reason for leaving_____

How many times per day do you Brush? _____ Floss? _____ Do your gums ever bleed? YES or NO

_____ _____

Signature **Date**

Reviewed by Dentist _____ **Date**_____

Dr. Rickert / Dr. Watson / Dr. Wasson

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Dental Treatment Consent Form
(Age 18 & Up)

Initial Visit: I understand that procedures for a patient's initial visit may include a comprehensive or limited exam, dental cleaning, fluoride application, sealants, intraoral photos and necessary radiographs (x-rays). However, this is subject to change depending on several factors including a patient's behavior, amount of future treatment and time. I understand that all treatment, alternative methods of treatment, and advantages and disadvantages of each will be discussed with me.

In general terms the procedures that you may need include:

- Teeth cleaning
- Application of sealants
- Restoration of broken teeth or fillings
- Treatment of infected teeth or gums
- Extractions of 1 or more teeth
- Use of nitrous oxide to help reduce anxiety as needed
- Use of local anesthetics as needed

*I hereby authorize treatment and the use of local anesthetics, nitrous oxide and/or other medications necessary for dental treatment

Treatment: We will advise you that although the best results are expected, there is no way within reason, of anticipating complications. Therefore, it is not possible to guarantee the results of the treatment. I understand that during the course of the patient's dental treatment, something unexpected may arise that may necessitate procedures in addition to or different from those listed on the patient's treatment plan, and that I will be consulted prior to initiation of treatment procedures that are not listed. Although the occurrence is remote, it is known that some risks are associated with dental procedures. I understand that potential complications and problems may include but are not limited to: the possibility of pain or discomfort during treatment, bleeding, swelling, temporary or permanent numbness, discoloration, injury to adjacent teeth and surrounding tissue, development of temporomandibular joint disorder, nausea, vomiting and allergic reactions that may require hospitalization. I authorize the dentists and designated staff members to perform all recommended treatment mutually agreed upon.

Informed Consent and Authorization: I have read and understand what has been reviewed in this consent form, and that all questions about the procedure or procedures have been answered in a satisfactory manner. I also understand that I have the right to be provided with answers to questions which may arise during the course of treatment. I have had sufficient opportunity to discuss the patient's dental condition/problems, the planned procedures and treatment, alternative approaches and/or no treatment. Recognizing the potential problems and risks of dental treatment, authorization is given for dental treatment to be rendered by the dentist and office staff.

Payment: I agree to be responsible for any services rendered. I understand that payment above and beyond the estimated insurance coverage amount is payable at the time treatment is provided. I authorize payment directly to the Dental Office Healthy Smiles of any insurance benefits. I authorize release of any information relating to dental insurance claims.

Print Name _____

_____ _____
Signature Date

_____ _____
Dentist Signature Date

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Financial Policy (Age 18 & Up)

The office of Healthy Smiles is a General Dentistry Practice dedicated to the dental care of children and young adults. Our office provides dental care as determined by the American Dental Association. Treatment decisions by the dentists at Healthy Smiles are not made based on your insurance company, but rather the patient's best interest and standard of care. Insurance companies may have limits or exclusions for the recommended treatment. It is up to you to know your insurance policy and any possible limitations or exclusions. Please advise us before treatment if you do not want certain types of dental care.

Payment is due at the time treatment is provided. We accept most insurance plans and file dental insurance as a courtesy to our patients if you have provided all required insurance information. There is no guarantee that services will be covered. If you have insurance, we collect the estimated amount or percentage not covered at each visit. In the event of insurance delays or disputed claims beyond 30 days, you are responsible for any balance on your account, whether insurance has paid us or not. We will be glad to send a refund to you once insurance has paid us. Our goal is to help you in maximizing your benefits. Please remember that insurance only assists in payment and rarely covers your full costs. We can only assist you in estimating your portion of the cost of treatment, we at no time guarantee what your insurance will or will not do with each claim. We cannot be responsible for any errors in filing your insurance, once again we file claims as a courtesy to you. Please keep us informed of any insurance changes such as policy name, insurance company address, or a change of employment. There may be additional charges to cover the cost of lab fees, depending on the treatment provided and type of insurance coverage. Patients receiving major work such as crowns or space maintainers must have their portions completely paid off before the work can be delivered or cemented. Treatment that is delayed could complicate matters as problems may worsen if not treated in a timely manner.

For accounts past due, you will become responsible for the entire balance, regardless of the reason. If a bill becomes outstanding in our office, this office is not obligated to render further treatment until the total amount due has been paid in full. Outstanding balances sent to collections are subject to court costs and administrative fees. Patients needing emergency care who have dental insurance will be required to pay for any needed treatment, including but not limited to exam and radiographs prior to treatment being rendered. Patients needing emergency care on weekends or after normal office hours are required to pay for services rendered in cash, regardless of insurance coverage.

Appointment Policy

We offer courtesy phone calls prior to your visit. Please indicate below if you would like an email and/or text reminder.

Personal E-mail: _____ Text (Mobile phone #):_____

Our Office requires 2 business days notice of cancellation. In the event of an illness, call the office as soon as possible.
We charge a fee of $25 for 'no show' appointments and appointments cancelled without 2 business days notice.
If a patient is more than 10 minutes late for an appointment, we will reschedule the appointment.
Reminder phone calls are a courtesy and are not required.
Patients are responsible to remember and keep appointments and should not depend on reminder phone calls/emails/texts.

There is a $100 fee for after-hours emergency dental visits, to be paid at the time of service.

I acknowledge I have read this financial policy and I am responsible for all charges whether or not paid by insurance.

I hereby authorize payment of the dental benefits, otherwise payable to me, directly to Healthy Smiles.

I understand the financial and appointment policies of the dental office of Healthy Smiles.

_____ _____

Signature Date

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Dentist Credentials

Healthy Smiles employs several dentists that have dedicated their careers to providing excellent dental treatment to children and young adults. Dr. Rickert, Dr. Watson, and Dr. Wasson are general dentists and members of the American Dental Association and the North Carolina Dental Society. Our doctors share a genuine interest in making all of our patients feel right at home. We strive to make your visits as comfortable and enjoyable as possible.

Shelly Rickert, DDS – General Dentist

University of North Carolina – Chapel Hill School of Dentistry 1994

Crystal Watson, DDS – General Dentist

University of North Carolina – Chapel Hill School of Dentistry 2006

Harpreet Wasson DDS – General Dentist

University of North Carolina – Chapel Hill School of Dentistry 2006

_____ Initial here for Acknowledgement of Credentials

Notice of Privacy Practices Acknowledgement

The Health Insurance Portability and Accountability Act (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 provides safeguards to protect your privacy. A more complete text is available in the office at your request. I understand that as a part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a means by which a third-party payer can verify that services billed were actually provided
- a means of communication among the many health professionals who contribute to my care
- a source of information for applying my diagnosis and treatment information to my bill
- a tool for routine healthcare operations such as assessing quality and review of the competence of healthcare professionals.

I acknowledge that I have access to your Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices from time to time, and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices. I understand that I have the right to request restrictions as to how my health information may be used or disclosed by providing a written request to the Privacy Officer within this practice. I understand that the organization is not obligated to agree to the request. 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 may have already taken actions relying on your authorization.

Print Your Name_____

Signature_____ Date _____

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DENTAL RADIOGRAPHS / X-RAY INFORMATION & POLICY

DO I NEED DENTAL RADIOGRAPHS (X-RAYS)?

Yes, dental x-rays show us the condition of your teeth, teeth roots, jaw placement, and the overall health of the facial bones. Dental x-rays reveal abscesses, abnormal growths, impacted teeth and pinpoint the location of cavities that are in between the teeth. These cavities would otherwise be impossible to see in the mouth. With x-rays we can catch that cavity well before it causes pain and infection.

HOW OFTEN DO I NEED DENTAL X-RAYS?

We only take x-rays that are necessary to provide the best clinical care and this is decided on a case-by-case basis in accordance with the American Dental Association Guidelines. For example, those who have had cavities will need dental x-rays more often than people with no cavities. These intervals usually range from 6 - 12 months and are based on the individual needs of the patient.

CAN I RECEIVE DENTAL TREATMENT IF I REFUSE DENTAL X-RAYS?

No. Treatment without necessary x-rays is considered substandard. If a patient refuses to have necessary x-rays, then the dentist may refuse to provide dental care to the patient.

HOW MUCH RADIATION WILL I BE EXPOSED TO FROM DENTAL X-RAYS?

We understand your concern with being exposed to x-rays. Our state of the art digital x-ray equipment allows us to obtain the best diagnostic images while using the smallest amount of radiation possible. Digital radiography has decreased the amount of radiation exposure by 90% compared to standard x-ray films of the past. The daily radiation we receive from the sun or from travel in an airplane are much higher than that of being exposed to a dental x-ray.

Type of Exposure	Estimated Exposure
Dental radiographs – Bitewings (4 images)	0.038
Dental radiographs – Full Mouth series (18 images)	0.150
Medical Chest X-ray	0.080
Medical Upper GI X-ray series	2.440
Average radiation in the U.S. from natural sources (per year)	3.000

http://www.ada.org/en/member-center/oral-health-topics/x-rays

NOTE: During your visit, if x-rays are needed for records or to make decisions regarding the patient's dental treatment, we will inform you prior to taking the necessary x-rays. If your feeling about dental x-rays conflicts with what we feel is necessary for your dental examination, we will stop treatment and refer you to another dental provider.

Patient Name_____

_____ _____

Signature Date

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