HEALTHY SMILES
FAMILY DENTISTRY

DR. DENNIS CHANG DR. PABLO RAMOS

WWW.HEALTHYSMILESOFNC.COM

(919) 479-1300

Patient Registration

Patient Information:

First Name: _____ Middle Initial: _____ Last Name: _____

Address: _____ Home Phone: (___) ___-____

City: _____ State/Zip: _____ Work Phone: (___) ___-____

Birth Date: _____ Age: _____ Cell Phone: (___) ___-____

Sex: ○Male ○Female Marital Status: _____ Social Security Number (SSN) #:___-___-____

Email Address: _____

EMERGENCY CONTACT: _____ Phone Number: (___) ___-____

How would you prefer to receive appointment reminders? *Please choose one.*
○ Phone Call – If so, which number: (___) ___-____ ○Email ○Text Message

How did you hear about our office? _____

Dental Insurance Information:

Person responsible for account: _____
Last Name First Name Initial

Relationship to patient: _____ Date of Birth: _____ SSN #:___-___-____

Responsible party's employer: _____ Business Phone: _____

Insurance Company: _____ Phone Number: (___) ___-____

Group Number: _____ Patient ID: _____

Responsible Party (If someone other than patient)

Name: _____ Last Name: _____ Date of Birth: _____

Address: _____ Social Security Number (SSN) #:___-___-____

_____

Home #: _____ Work #: _____ Cell #: _____

Regarding HIPPA:

We are required by applicable federal and state laws to maintain the privacy of your health information. We are also required to give you information about our privacy practices. By signing below, you are acknowledging you have reviewed a copy of our HIPPA privacy handout.

Signature: _____

Date: _____

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Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you have or medication that you may be taking could have an important interrelationship with the dentistry you will receive. Thank you for answering questions.

Your Primary Physician's Name & Phone Number: _____

	Conditions		Conditions		Conditions
Y N	Heart Murmur	Y N	Liver Disease	Y N	Artificial Heart Valve
Y N	Venereal Disease/STD's	Y N	Kidney Problems	Y N	Artificial Bones/Joints
Y N	Ulcer	Y N	HIV+/AIDS	Y N	Arthritis
Y N	Tuberculosis	Y N	High Blood Pressure	Y N	Angina Pectoris
Y N	Thyroid Problems	Y N	Hepatitis A	Y N	Anemia
Y N	Stroke	Y N	Hepatitis B	Y N	Allergy
Y N	Sinus Problems	Y N	Hepatitis C	Y N	Sickle Cell Anemia
Y N	Hemophilia	Y N	Abnormal Bleeding	Y N	Cancer-Chemotherapy
Y N	Heart Attack/Date:_____	Y N	Reflux	Y N	Blood Transfusion
Y N	Shingles	Y N	Hay Fever	Y N	Asthma
Y N	Seizures	Y N	Glaucoma	Y N	Fainting Spells
Y N	Rheumatic Fever	Y N	Frequent Headaches	Y N	Drug Abuse
Y N	Radiation Therapy	Y N	Cold Sores/Fever Blisters	Y N	Low Blood Pressure
Y N	Colitis	Y N	Psychiatric Problems	Y N	Diabetes
Y N	Pace Maker	Y N	Emphysema	Y N	Congenital Heart Defect
Y N	Mitral Valve Prolapse	Y N	Difficulty Breathing	Y N	Pre-Med

Do you smoke or use tobacco: Yes O No O

Have you ever used the drug "Fen-Phen"? Yes O No O

*Any other condition(s) not listed, please describe here: _____

_____

	Allergies:				Females ONLY:
Y N	Aspirin	Y N	Jewelry	Y N	Are you taking birth control pills?
Y N	Codeine	Y N	Latex	Y N	Are you nursing?
Y N	Dental Anesthetics	Y N	Metals	Y N	Are you pregnant?
Y N	Erythromycin	Y N	Penicillin		# of weeks_____
Y N	Sulfa	Y N	Tetracycline		

Other:_____

Please list any medications you are currently taking: _____

_____

I request and authorize Dr. Chang and/or Dr. Ramos, and assistants to examine, clean and provide my/ the patient's dental treatment as necessary. I further request and authorize the taking of dental x-rays/photographs as may be considered necessary for diagnostic or educational purposes. **I understand that this office only uses composite (tooth-colors) filling material to restore teeth and amalgam (silver) is not available. I will be responsible for any charges incurred on this account.**

Signature: _____ Date: _____

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Patient Information:

Name – Last, First, MI	Date of Birth:

Information to be disclosed: verbal communication only regarding patient's care – no copies of medical records provided
PLEASE Provide you current telephone numbers

Home Phone #	Cell Phone #
Work Phone #	Other Phone #

We normally contact our patients between 8 a.m. and 5 p.m. Monday through Friday. Please ***check below*** where you would prefer to be contacted during these hours.

Home Phone#_____ Cell Phone#_____ Work Phone#_____ Other Phone#_____

If we need to reach you after hours, please ***check below*** where you prefer to be called:

Home Phone#_____ Cell Phone#_____ Work Phone#_____ Other Phone#_____

Your protected Health Information Designees:

If you are not available at the time that we call, please list below those individuals (designees) with whom we can leave a message or briefly discuss your medical information (e.g. lab or test results, prescription information).
This person (designee) will also be able to call the office on your behalf.
Please print the name and relationship to you/patient of each designee below:

Designee Name:	Relationship to Patient:
Designee Name:	Relationship to Patient:
Designee Name:	Relationship to Patient:

_____ Check here if you ***DO NOT want*** your health care information discussed with anyone other than yourself.

Confidential Voice Mail:

Please ***check below*** where we have your permission to leave a confidential voice mail (e.g. lab or test results, prescription information). Leave the space(s) blank if you ***DO NOT wish*** to receive voice mails.

Home Phone#_____ Cell Phone#_____ Work Phone#_____ Other Phone#_____

Information for Fellow My Health Patient Portal:

Please ***write below*** an email address that we can send you an invite to participate in our new patient portal. The portal allows you the ability to communicate with Arbor Family in regards to: appointment requests, medication refill requests, allows bidirectional communication between you and your provider and allows them to personally inform you regarding labs and other test results.

Email Address:

Your signature ***below*** confirms your approval of these updated HIPPA communication preferences. You may change your selections at any time, but do so in writing by completing an updated form.

_____ _____

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY **DATE SIGNED**

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Our Financial Policy

Thank you for choosing **Healthy Smiles Family Dentistry** for your dental care, where we are committed to the success of your treatment. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we request you read and sign.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE.

WE ACCEPT CASH OR VISA/MC. NO PERSONAL CHECKS WILL BE ACCEPTED.

WE OFFER CARE CREDIT, AN AFFORDABLE FINANCING OPTION FOR TREATMENT.

Regarding Insurance:
Our practice participates with the following insurance plans: Aetna, ameritas, BCBS, Cigna, Delta Dental, Guardian, MetLife, United Concordia, United Healthcare and many more. If you have any questions whether or not our practice participates with your particular plan, please contact the patient coordinator. If your plan is one with which we participate, we will bill and collect according to your plan. All deductible, co-payments and disallowed charges will be due at the time of service.

If we do not participate with your insurance plan, we will submit your dental claim form as a courtesy to you. Although your insurance company may pay at a higher rate, a payment of 60% is required at the time of service for all treatment other than routine cleaning appointment. For cleaning appointments, a payment of 30% is required.

We will do all that we can to get the most benefits possible reimbursed for you, however we cannot bill your carrier for your reimbursement unless you provide us with current insurance information. Please be aware that some of the services provided may not be covered or may be considered above the "usual and customary procedures." Our practice is committed to providing the best treatment for our patients, while charging what is reasonable and customary for our area. You are responsible for payment of your account, regardless of any insurance company's arbitrary determination of usual and customary fees. If insurance has not responded to a claim within 60 days of submittal, the full account balance becomes the account holder's responsibility.

(Past due balances are subject to a finance charge of 15% minimum. In the event that your account is placed in the hands of a collection agency, the costs involved (including any attorney's fees), will be at the expense of the patient.)

Regarding Missed Appointment
We do not "double book" appointments. When we schedule an appointment, the time is reserved just for you. If you must change an appointment, please give us at least 24 hour notice. There is a fee of $75 for missed appointments or for appointments that are canceled without a 24 hour notice. In some cases, we reserve the right to charge the full value of the missed time. Please help us serve you better by keeping scheduled appointments.
Thank you for reading and understanding our Financial Policy. Please let us know if you have any questions or concerns.

X_____ _____

Signature of patient or responsible party **Date**

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HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provide safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is a "friendly" version. A more complete text is posted in the office.
What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov
We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, email, US mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

Signature: _____ **Date:** _____