PATIENT REGISTRATION FORM

Date: _____

Patient Information

Name: (first) _____ (last) _____ (m.i.) _____ Preferred name: _____

Birth date: _____ SS#: _____ Driver license: _____ E-mail: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone- Home: _____ Work: _____ Cell: _____

Sex: ___ *M* ___ *F* Marital Status: ___ *Single* ___ *Married* ___ *Separated* ___ *Divorced* ___ *Widowed*

Employer: _____ Occupation:_____

Emergency contact: _____ Phone: _____ Relationship to patient:_____

Preferred method of contact: ___ *home phone* ___ *cell phone* ___ *work phone* ___ *e-mail* ___ *text message*

Best time to call: ___ *morning* ___ *afternoon*

How did you hear about us? ___ *insurance* ___ *newspaper ad* ___ *internet search* ___ *direct mail*

___ *family/friend (name)* _____

___ *other* _____

Responsible Party/Primary Insurance Information

Name of responsible party/policy holder: (first) _____ (last) _____ (m.i.) _____

Birth date: _____ SS#: _____ Driver license: _____ Relationship to patient:_____

Address: _____ City: _____ State: _____ Zip: _____

Phone- Home: _____ Work: _____ Cell: _____

Employer: _____ Occupation:_____

Insurance: _____ Member ID #: _____ Group ID #: _____

Secondary Insurance Information (if applicable)

Name of responsible party/policy holder: (first) _____ (last) _____ (m.i.) _____

Birth date: _____ SS#: _____ Driver license: _____ Relationship to patient:_____

Address: _____ City: _____ State: _____ Zip: _____

Phone- Home: _____ Work: _____ Cell: _____

Employer: _____ Occupation:_____

Insurance: _____ Member ID #: _____ Group ID #: _____

HEALTH HISTORY

Patient Name:_____ Patient Identification Number:_____

Birth Date:_____

I. CIRCLE APPROPRIATE ANSWER (leave Blank if you do not understand question):

1. Yes No Is your general health good?
2. Yes No Has there been a change in your health within the last year?
3. Yes No Have you been hospitalized or had a serious illness in the last three years?
   If YES, why?_____
4. Yes No Are you being treated by a physician now? For what? _____
   Date of last medical exam?_____ Date of last Dental exam_____
5. Yes No Have you had problems with prior dental treatment?
6. Yes No Are you in pain now?

II. HAVE YOU EXPERIENCED:

7.	Yes	No	Chest pain (angina)?	18.	Yes	No	Dizziness?
8.	Yes	No	Swollen ankles?	19.	Yes	No	Ringing in ears?
9.	Yes	No	Shortness of breath?	20.	Yes	No	Headaches?
10.	Yes	No	Recent weight loss, fever, night sweats?	21.	Yes	No	Fainting spells?
11.	Yes	No	Persistent cough, coughing up blood?	22.	Yes	No	Blurred vision?
12.	Yes	No	Bleeding problems, bruising easily?	23.	Yes	No	Seizures?
13.	Yes	No	Sinus problems?	24.	Yes	No	Excessive thirst?
14.	Yes	No	Difficulty swallowing?	25.	Yes	No	Frequent urination?
15.	Yes	No	Diarrhea, constipation, blood in stools?	26.	Yes	No	Dry mouth?
16.	Yes	No	Frequent vomiting, nausea?	27.	Yes	No	Jaundice?
17.	Yes	No	Difficulty urinating, blood in urine?	28.	Yes	No	Joint pain, stiffness?

III. DO YOU HAVE OR HAVE YOU HAD:

29.	Yes	No	Heart disease?	40.	Yes	No	AIDS
30.	Yes	No	Heart attack, heart defects?	41.	Yes	No	Tumors, cancer?
31.	Yes	No	Heart murmurs?	42.	Yes	No	Arthritis, rheumatism?
32.	Yes	No	Rheumatic fever?	43.	Yes	No	Eye diseases?
33.	Yes	No	Stroke, hardening of arteries?	44.	Yes	No	Skin diseases?
34.	Yes	No	High blood pressure?	45.	Yes	No	Anemia?
35.	Yes	No	Asthma, TB, emphysema, other lung diseases?	46.	Yes	No	VD (syphilis or gonorrhea)?
36.	Yes	No	Hepatitis, other liver disease?	47.	Yes	No	Herpes?
37.	Yes	No	Stomach problems, ulcers?	48.	Yes	No	Kidney, bladder disease?
38.	Yes	No	Allergies to: drugs, foods, medications, latex?	49.	Yes	No	Thyroid, adrenal disease?
39.	Yes	No	Family history of diabetes, heart problems, tumors?	50.	Yes	No	Diabetes?

IV. DO YOU HAVE OR HAVE YOU HAD:

51.	Yes	No	Psychiatric care?	56.	Yes	No	Hospitalization?
52.	Yes	No	Radiation treatments?	57.	Yes	No	Blood transfusions?
53.	Yes	No	Chemotherapy?	58.	Yes	No	Surgeries?
54.	Yes	No	Prosthetic heart valve?	59.	Yes	No	Pacemaker?
55.	Yes	No	Artificial joint?	60.	Yes	No	Contact lenses?

V. ARE YOU TAKING:

61.	Yes	No	Recreational drugs?	63.	Yes	No	Tobacco in any form?
62.	Yes	No	Drugs, medications, over-the-counter medicines (including Aspirin), natural remedies?	64.	Yes	No	Alcohol?

Please list:_____

_____

VI. WOMEN ONLY:

65.	Yes	No	Are you or could you be pregnant or nursing?	66.	Yes	No	Taking birth control pills?

VII. ALL PATIENTS:

67. Yes No Do you have or have you had any other diseases or medical problems NOT listed on this form?

If so, please explain:_____

_____

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication.

Patient's signature:_____ Date:_____

HIPAA NOTICE OF PRIVACY PRACTICES

Albemarle Road Family Dentistry complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Albemarle Road Family Dentistry protects confidential health care information, known as "Protected Health Information" (PHI). Below is a list of your privacy rights under HIPAA. Albemarle Road Family Dentistry legal duties and privacy practices regarding your PHI are also included in this Notice.

1. Albemarle Road Family Dentistry may use and give your health information to:
   - Provide treatment
   - Receive payment for services
   - Operate health care services
2. Albemarle Road Family Dentistry may use and give your health information for:
   - Law enforcement requests
   - Judicial and administrative proceedings related to legal actions
   - Healthcare fraud and abuse detection or compliance with the law
   - Use by another healthcare provider treating you
   - Government health oversight activities
   - Reports required by law related to births, deaths or diseases
   - Reports required by law related to neglect and abuse, or domestic violence
   - Notifying a party about exposure to a possible communicable disease
   - Use by another healthcare provider for payment to that provider
   - Military, national defense and security or other governmental functions
   - Workers' compensation purposes and in compliance with related laws
   - Averting a serious threat to public health and safety
3. You have the right to:
   - Inspect or get a copy of your dental record
   - Change information on your dental record if you think it is incorrect
   - Get a list of persons whom Albemarle Road Family Dentistry shared your PHI
   - Ask Albemarle Road Family Dentistry to limit the information it shares
   - Ask for a copy of your privacy notice
   - Write a letter of complaint to Albemarle Road Family Dentistry or the federal government

If you have any questions or if you wish to file a complaint, or exercise any rights listed in this Notice, please contact:

Patient Care Coordinator
Albemarle Road Family Dentistry
6404 Albemarle Road, #C
Charlotte, NC 28212
(704) 910-4720

Initials: _____

GENERAL CONSENT FOR TREATMENT

I understand that dentistry is not an exact science and that therefore, reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized.

I hereby authorize any of the doctors or dental auxiliaries to proceed with and perform the dental exams and treatments as explained to me. I understand that this is only an estimate and subject to modification depending on unforseen or undiagnosable circumstances may arise during the course of treatment. I understand that regardless of any dental insurance coverage I may have, I am responsible for payment of the dental fees. I agree to pay any attorney fees, or court costs, that may be incurred to satisfy this obligation.

PHOTOGRAPHS, SLIDES & VIDEOS CONSENT

I authorize Albemarle Road Family Dentistry to take photographs, slides, and/or videos of my face, jaws, and teeth.

I understand that the photographs, slides, and/or videos will be used as a record of my care, and may be used for educational purposes in lectures, demonstrations, and professional publications.

I further understand that if the photographs, slides, and/or videos are used in any publication, or as part of a demonstration, all reasonable attempts will be made to conceal my identity.

VIDEO SURVEILLANCE CONSENT

I understand that this office is monitored 24 hours a day by video surveillance cameras. The video monitoring is conducted in all public areas, including business areas, waiting areas, hallways, and treatment rooms. There are no cameras in private areas such as the restrooms. The use of video surveillance is for ensuring the safety and security of patients and staff members, and for protecting office properties. The video content is stored in a safe place. When recorded images from the cameras must be viewed for law enforcement, investigative reasons, or other purposes, it is only undertaken by authorized personnel, in a private area that is not accessible to other staff and/or visitors.

I understand that I may ask more questions about the video surveillance system. I will be given a copy of this Consent for my records if requested.

Initials: _____

APPOINTMENT POLICY

Missed appointments, late shows or late cancellations result in lost time which could be used for other patients waiting to receive treatments. We make every effort to provide quality dental care to our patients in a timely manner, so we ask that our patients to keep their appointments and be on time. Please take a moment to familiarize yourself with our Appointment Policy. Thank you!

Confirmation

As a courtesy, we will attempt to confirm your upcoming appointment by text message and/or phone call. Please confirm your appointment! If we do not receive your confirmation by 9 AM one working day prior to your appointment, it will be canceled and you will need to reschedule.

Cancellation

If you need to change your appointment, please notify our office by 9 AM one working day in advance so your appointment can be made available for another patient. An appointment canceled after this time will be considered a failed appointment.

When unexpected circumstances make it necessary to cancel an appointment within a short notice, please contact our office as soon as possible and we will do our best to accommodate your situations.

Failed/Canceled Appointments

If you fail your appointment, you will need to reschedule. When you fail and/or cancel your appointment, we reserve the right not to schedule your subsequent appointment. You may be seen on a walk-in or same-day basis only. At the doctor's discretion, patients with many failed or cancelled appointments will be dismissed from our practice.

Late Arrivals

Please plan to arrive before your appointment time. If you arrive more than 10 minutes late for your appointment, you may be worked into our schedule only when time allows or asked to reschedule for the next available appointment.

After-hours Appointments

After-hours appointments are available for special procedures or when requested by patient. We require a non-refundable deposit up to the cost of the treatment. A nominal "after-hours fee" may be applied in addition to the regular cost of the treatment.

Appointment Delays

We respect your time and make every effort to remain on schedule. However, some visits are more complicated than initially anticipated, and emergencies may arise that could possibly delay us. In such a case, every effort will be made to notify you beforehand. Please accept our apology should this occur during your appointment.

Children Under 18

We are happy to see children as patients, but a parent or guardian must accompany them to the office. The law states that we may not treat them without permission of a responsible adult (18 years or older). Children under 18 who come without a parent or guardian will not be seen on that day.

Child Care Arrangements

Due to safety concerns, we cannot have unsupervised children at the office. Please make arrangements for supervision of your children during dental visits.

Initials: _____

FINANCIAL POLICY

At Albemarle Road Family Dentistry we are dedicated to providing you with the best possible dental care and we are pleased to discuss our professional fees with you at any time. Your understanding of our financial policy is important to our professional relationship. If you have any questions regarding these financial policies, please do not hesitate to speak to our office personnel. We are here to help you in every possible way!

Available Payment Options

You can choose from: Cash, Debit Cards, Visa, and Master Card. No check accepted. Ask us for payment plan options.

Patients with Insurance Coverage

- Patient/Responsible Party authorizes payment to Albemarle Road Family Dentistry by the insurance carrier.
- As a courtesy, we will accept most insurance, and will gladly process your claims at no charge. We will estimate your insurance coverage and your portion for treatment, which is due in full at the time of service. As this is an estimate only, you may have an additional balance due or we may issue you a refund after we have received payment from your insurance carrier.
- It is important to note that the balance on your account is your responsibility regardless of your insurance coverage. In the event that your insurance carrier has not paid in sixty (60) days from the date of service, you will be responsible to pay your account.
- If you have any questions regarding your insurance coverage, please contact your insurance carrier. Due to the variety and complexity of insurance policies, we cannot adequately advise you on these matters.

Patients without Insurance

For patients without dental insurance, payment is due in full at the time of service.

Deposits

- For treatments that include laboratory fees or requiring multiple visits, we request a deposit of 50% of the total treatment fee.
- A deposit will be required for an appointment scheduled outside regular office hours. If the appointment is not kept or is cancelled with less than 24 hours advance notice, the deposit will be forfeited.

Refunds for Unfinished Treatment

If a patient decides to discontinue treatment after it has been started, a full refund will not be given. Individual circumstances may be discussed with the office manager and/or dentist.

Finance Charge/Collections

All accounts overdue more than 90 days are subject to a finance charge at a percentage rate in accordance with North Carolina state law. If collection action becomes necessary for non-payment, you will be responsible to pay all costs of collecting, or attempt to collect any debt owed on your account, including collection cost, legal fee, and finance charge.

Patient Records/X-rays

Request for a duplicate copy of your records/x-rays is subject to a $20 fee. Please allow one day for processing your request.

Initials: _____

AUTHORIZATION AND CONSENT

1. I received a copy of this office's **HIPAA Notice of Privacy Practices**. I understand that I may ask any questions I might have regarding this Notice.
2. I understand and agree to the **General Consent for Treatment.**
3. I understand and agree to the **Photographs, Slides & Videos Consent.**
4. I understand and agree to the **Video Surveillance Consent.**
5. I understand and agree to the **Appointment Policy.**
6. I understand and agree to the **Financial Policy.**

_____	_____	_____
Patient/Guardian, Relationship to Patient	Signature	Date