WELCOME TO OUR PRACTICE!

CONFIDENTIAL PATIENT INFORMATION

NAME_____ SEX: □ M □ F _____
FIRST MI LAST PREFERRED NAME

HOME NO_____ WORK NO_____ EXT_____ CELL NO_____

SOCIAL SECURITY #_____ DOB:_____ AGE____ □ MINOR □ S □ M □ W □ SEP □ D

WHICH NUMBER DO YOU WANT US TO USE WHEN WE CONFIRM FUTURE APPTS? □ HOME □ CELL □ WORK □ OTHER_____

PHYSICAL ADDRESS_____APT#_____CITY_____STATE_____ZIP_____

MAILING ADDRESS (IF DIFFERENT THAN ABOVE)_____

EMPLOYED BY_____OCCUPATION_____

BUSINESS ADDRESS_____CITY_____STATE_____ZIP_____

(IF COLLEGE STUDENT) SCHOOL_____CITY_____STATE_____

E-MAIL_____ REFERRED BY_____

EMERGENCY CONTACT: _____ PHONE NUMBER/S: _____ _____

RESPONSIBLE PARTY INFORMATION □ SAME AS ABOVE

NAME_____ □ MALE □ FEMALE
FIRST MI LAST

RELATIONSHIP TO PATIENT: □ SELF □ SPOUSE □ PARENT □ GUARDIAN □ OTHER_____

SOCIAL SECURITY #_____ BIRTHDATE_____ DRIVER'S LICENSE #_____

ADDRESS_____APT#_____ CITY_____STATE_____ ZIP_____

HOME #_____ WORK #_____EXT_____ CELL #_____ OTHER_____

EMPLOYED BY_____EMPLOYER'S ADDRESS_____

PARENT/GUARDIAN CONSENT

I hereby give consent for treatment of my child, _____. I understand the proposed treatment plan may include possible x-rays and the use of local anesthetics, when deemed necessary, for the comfort and well-being of the child. I know that I am responsible for any charges which may occur during his/her dental visit. I understand th that the recommendation s made, may change during treatment.

_____ DATE_____
Signature of Parent/Guardian

**Credit Card # To Keep On File (for use when minors come unattended by parents) MC Visa #_____ DIC#_____ Exp:_____

DENTAL INSURANCE INFORMATION (PLEASE PRESENT YOUR INSURANCE CARD TO BE COPIED) □ See Attached Card

SUBSCRIBER'S NAME_____ INSURANCE COMPANY_____

RELATION TO PATIENT: □ SELF □ SPOUSE □ PARENT □ OTHER CLAIMS ADDRESS _____

SUBSCRIBER'S EMPLOYER_____

_____

SUBSCRIBER'S SSN_____ GROUP #_____

SUBSCRIBER'S DOB_____ ID#_____ NO. TO VERIFY BENEFITS_____

NAME OF OTHER DEPENDENTS COVERED UNDER THIS PLAN

_____ _____ _____ _____

RELEASE OF INFORMATION & ASSIGNMENT OF BENEFITS AUTHORIZATION

I understand it is the policy of this office to require payment in full for all services rendered to me, or to my dependent, at the time of visit unless other arrangements have been made with the business manager.
I authorize payment directly to Dr.Marsha Taylor-Andemichael for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf, or on behalf of my dependents.
I authorize the above doctor and/or provider of services in this office to release any information required to process insurance claims to secure payment of benefits on my behalf, or on behalf of my dependents. I authorize the use of my signature on all insurance claim submissions.

Signature_____ Date _____

Lillington Family Dentistry

Health History

Correct answers to the following questions will allow your dentist to treat you on a more individual basis, providing the care appropriate for your paticular needs.

Name Birth date Age

Why are you seeking dental treatment?

Please answer each question. Check yes or no. If in doubt, leave blank YES NO

1. Are you in good health now…… Y/N
2. Are you now under the care of a physican…….. Y/N
   If so, what is the condition being treated? _____
3. Have you ever been hospitalized or had a serious Y/N
   If yes ,explain _____
4. Have you ever had excessive bleeding following an extraction, or do cuts take longer to heal now than previously to heal now than previously?…….
5. (Women) Are you pregnant? If so, give due date…… Y/N
6. Do you use tobacco in any form? If yes, how much…….. Y/N
7. Do you use alcoholic beverages (more than 2 drinks per day)…… Y/N
8. Do you have or have you ever had any of the following?

GENERAL	**Yes/No**	**HEART/BLOOD VESSELS**	**Yes/No**
Tire easily, weakness	Y/N	Rheumatic fever	Y/N
Marked weight change	Y/N	Heart Murmur	Y/N
Night sweats	Y/N	Chest pain/ discomfort	Y/N
Persistent fever	Y/N	Heart attack/ trouble	Y/N
SKIN		Shortness of breath	Y/N
Eruptions (rash) hives	Y/N	Swelling of ankles	Y/N
Changes in skin color	Y/N	High Blood pressure	Y/N
EYES		Congenital heart disease	Y/N
Visual change	Y/N	Mitral valve prolapse	Y/N
Glaucoma	Y/N	Artifical heart valve	Y/N
EARS		Pacemaker	Y/N
Loss of hearing	Y/N	Heart Surgery	Y/N
Ringing in ears	Y/N	Other	Y/N
NOSE		**BONES/MUSCLES**	
Frequent nosebleeds	Y/N	Arthritis/rheumatism	Y/N
Sinus problems	Y/N	Artifical joint/limbs	Y/N
THROAT	Y/N	**DIGESTIVE SYSTEM**	
Soreness/Hoarseness	Y/N	Hepatitis	Y/N
NERVOUS SYSTEM		Jaundice	Y/N
Stroke	Y/N	Ulcers	Y/N
Headaches	Y/N	Change in appetite	Y/N
Convulsions/epilespy	Y/N	Black, bloody or pale stools	Y/N
Numbness/tingling	Y/N	**URINARY**	
Dizziness/fainting	Y/N	Kidney disease	Y/N
Phychiatric treatment	Y/N	Increase in frequency of urination (night)	Y/N
RESPIRATORY		Burning on urination	Y/N
Tuberculosis	Y/N		
Emphysema	Y/N		

Lillington Family Dentistry
Health History

9. Are you ALLERGIC or have you ever experienced any reaction to the following?

	Yes/No		Yes/No
Local anesthetics (e.g. novocaine)	Y/N	Aspirin or codeine	Y/N
Barbiturates/sedatives/sleeping pills	Y/N	Sulfa drugs	Y/N
Penicillin/ other antibiotics	Y/N	Other allergies	Y/N

10. Are you taking any of the following?

Antibiotics/sulfa drugs	Y/N	Tranquilizers	Y/N
Blood thinners	Y/N	Insulin/other diabetes drugs	Y/N
Blood pressure medication	Y/N	Recreational drugs	Y/N
Thyroid medicine	Y/N	Digitalis/other heart medications	Y/N
Cortisone/steroids	Y/N	Nitroglycerin	Y/N
Antihistamines/allergy drugs	Y/N	Aspirin	Y/N
Cold remedies	Y/N		

Other medications please list

1……..

2……

3……

4……

11. Is there any disease, condition or problem not listed above that you think we should know about, or is there any activity your doctor says you cannot do? If so explain.

……..

……..

12.Physician's Name……Phone……..

13. Have you ever had serious trouble associated with previous dental treatment?……..

……..

14. Does dental treatment make you nervous?

No…….Slightly……..Moderately…… Extremely…….

Date of last dental visit…….

15. Have you ever been treated for periodontal disease (gum disease,pyorrhea,trench mouth)? Y/N

16. Do you have or have you ever had any of the following?

	Yes/No		
Bleeding,sore gums	Y/N	Loose teeth	Y/N
Unpleasant taste/bad breath	Y/N	Sensitive to hot	Y/N
Burning tongue	Y/N	Sensitive to cold	Y/N
Frequent blisters, lips/mouth	Y/N	Sensitive to sweets	Y/N
Swelling/lumps in mouth	Y/N	Sensitive to biting	Y/N
Ortho treatment	Y/N	Food impaction	Y/N
Biting cheeks/lips	Y/N	Clenching/grinding	Y/N
Clicking/popping jaw	Y/N	Shifting of teeth	Y/N
Difficulty opening/closing jaw	Y/N	Change in bite	Y/N

17. Do you use the following?

Brush	Y/N
Dental floss	Y/N
Fluoride rinse	Y/N
Mouth rinse (Act,Listerine,Scope, etc)	Y/N

Signature……Date……

Lillington Family Dentistry
205 West Front St.
Lillington, NC 27546
910- 984-1556 office
910-984-1557 fax

Lillington Family Dentistry

Dr. Taylor-Andemichael, DDS

Please read our financial policy carefully and sign. We are committed to providing you with the best possible care with courtesy and compassion. In order to achieve these goals, we need your assistance and your understanding of our cancellation and payment policy.

Cancellations/Late Arrivals:

Late cancellations (failure to provide 24 hours notice) will be considered as a "no show". Appointments are in high demand, and your early cancellation will give another patient the opportunity to have access to timely dental care. We make every effort to seat you at the time of your appointment. Late arrivals are very disruptive to the schedule. If you arrive for your scheduled appointment 10 minutes or more late, we reserve the right to ask you to reschedule your appointment. If we are unable to see you on the day of the scheduled appointment, you will be considered a "no show". Failure to present at the time of a scheduled appointment will be recorded in the patient's chart. After 3 missed appointments, patient will be dismissed from the practice.

Payments/Insurance:

Co-payment and payment for services are due at the time services are rendered. We do not accept personal checks at initial, new patient visit. We accept cash, credit card (Visa, Mastercard, Discover, American Express) and Care Credit (financing program). A treatment plan for all dental work will be established prior to making an appointment. As a courtesy, we will file claims on your behalf and ask that you pay your estimated co-payment at time of service. However, estimated copayments are only an estimate and we cannot guarantee insurance payment until claim is received. Your insurance is a contract between you and your insurance company.

Past Due Accounts:

If a patient is unable to make mutually agreeable payment arrangements, we will be glad to reschedule that appointment. Account balances older than 30 days will be subject to additional collection fees and interest charges of 1.5% per month. Accounts older than 90 days will be sent to an outside collection agency.

Returned Checks:

Checks returned due to insufficient funds or closed accounts will be charged a $30 non-sufficient fund fee and any future checks will not be accepted. If you have any questions about our financial policy or have any uncertainty regarding insurance coverage, please don't hesitate to ask. We are here for you!

I hereby authorize Drs. Negash Andemichael & Associates, PA to submit claim and assign benefits on my behalf to my insurance company. I have read and understand the above office policies and I agree to comply with its guidelines.

Signature of Patient/Guardian: _____

Date:_____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect **5/31/2009**, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider proviing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0._____ for each page, $_____ per hour for staff time to copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.)We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer Dr. Marsha Taylor-Andemichael

Telephone (910) 984-1556 **Fax**

Email Address dra@lillingtonfamilydentistry.com

Mailing Address 205 W Front Street
Lillington, NC 27546

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____ , have received a copy of this office's Notice of Privacy Practices.

_____

Please Print Name

_____

Signature

_____

Date

If this Acknowledgement is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's name _____

Relationship to Patient _____

For Program Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify) _____

_____