RTP DENTAL CARE

5318 NC HWY 55. Suite 204
Durham, NC 27713
(919) 806 8218

Patient Information

WELCOME!!

We are pleased to welcome you to our practice.

Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Date: _____ Home phone: (_____) _____ Cell phone: (_____) _____

Last name: _____ First name: _____

Address: _____ City: _____

State: _____ ZIP: _____ Email: _____

☐ Minor ☐ Single ☐ Married

Sex ☐ M ☐ F Birthdate: _____ Marital Status: ☐ Widowed ☐ Separated

Occupation: _____ Employer/School: _____

Address: _____ City: _____ State: _____ ZIP: _____

Whom may we thank for referring you? _____

In case of emergency who should we be notified? _____ Phone: _____

Reason for today's visit _____

GUARDIAN OR RESPONSIBLE PARTY

☐ Myself ☐ Other: Last name: _____ First name: _____

Relation to patient: _____ Birthdate: _____ Phone_____

Address: ☐ same as above ☐ Other _____

Insurance Information: Subscriber

☐ Myself ☐ Other: Last name: _____ First name: _____

Relation to patient: _____ Birthdate: _____ SSN# _____

Insurance company _____ Subscriber ID# _____ Group# _____

By HIPAA Privacy, your information is secured unless we receive a signed consent from you to share with the person or entity designated by you. But we may disclose your health information to your family, friends, representative, or any other individual identified by you when they are involved in your care or in the payment for your care. Please check below who can receive information about your personal and health information:

☐ Anyone in my family
☐ Nobody
☐ Others: _____

Medical History

Do you smoke or use tobacco? ☐ Y ☐ N
Do you take medication for osteoporosis? ☐ Y ☐ N

Check (✓) if you have or have had any of the followings:

- ☐ Abnormal bleeding
- ☐ Alcohol abuse
- ☐ Allergies
  - ☐ Aspirin
  - ☐ Codeine
  - ☐ Dental Anesthetics
  - ☐ Erythromicin
  - ☐ Jewelry
  - ☐ Latex
  - ☐ Metals
  - ☐ Penicilin
  - ☐ Tetracycline
  - ☐ Other_____
- ☐ Anemia
- ☐ Angina Pectoris
- ☐ Arthritis
- ☐ Artificial Bones
- ☐ Artificial Heart Valve
- ☐ Asthma
- ☐ Blood Transfusion
- ☐ Cancer/Chemotherapy
- ☐ Colitis
- ☐ Congenital Heart Defect
- ☐ Cosmetic Surgery
- ☐ Diabetes
- ☐ Difficulty Breathing
- ☐ Drug Abuse
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting Spells
- ☐ Fever Blisters
- ☐ Frequent Headaches
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Heart Attack
- ☐ Heart Surgery
- ☐ Hemophilia
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ High Blood Pressure
- ☐ HIV + AIDS
- ☐ Kidney Problems
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Pace Maker
- ☐ Pneumocystitis
- ☐ Psychiatric Problems
- ☐ Radiation Therapy
- ☐ Rheumatic Fever
- ☐ Seizures
- ☐ Shingles
- ☐ Sickle Cell Disease
- ☐ Sinus Problems
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Yellow Jaundice

If you are woman:
✓ Are you pregnant? ☐ Y ☐ N ✓ Nursing? ☐ Y ☐ N ✓ Taking birth control pills? ☐ Y ☐ N

Medications: _____

_____

Is there any disease, condition, or problem that you think this office should know about that is not covered above?_____

 Signature: _____ Date: _____

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Patient name: _____

OFFICE POLICY

Children & Minors:
An adult must accompany any minors under the age of 18 during the entire visit in the office. Children under the age of 10 cannot be left unattended in the waiting area. Please arrange childcare if necessary.

Appointment:
In order to provide quality and effective dental care, please be on time for your appointment. If you are more than 15 minutes late, we may need to reschedule you to allow enough time for your treatment.

Cancellation Policy::
To cancel or reschedule an appointment, please notify us at least 48hs in advance of your scheduled time. We reserve the right to charge a fee of **$50.00** per hour for no shows, changes, and cancellations made less than 48 hours in advance.

Financial Agreement:
We accept cash, check, and most credit cards. A fee of $25.00 will be applied for returned checks.
For non-insured patients, the fee for the treatment rendered must be paid in full on the day of service.
For insured patients, the estimated patient copay and deductible for the treatment rendered must be paid in full on the day of service. Please understand that we are not responsible for how your insurance company handles its claims or for what benefits they will pay on a claim. We can only assist you in estimating your portion of the cost of treatment. After all payments and adjustments, **you will be responsible for any balance in your account** and a billing statement will be sent to you.
I HAVE READ, UNDERSTAND, AND AGREE TO THE STATEMENTS OUTLINED ABOVE.

Signature: _____

HIPAA POLICY

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 received 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 treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Signature: _____ Relationship to Patient: _____ Date: _____

For Office Use Only

We attempt 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 _____

Staff signature: _____