PINEVILLE
FAMILY DENTISTRY

Welcome to Pineville Family Dentistry. We will do our best to make your appointment as convenient and pleasant as possible. If at any time you have any questions regarding your treatment, your appointments or fees, please feel free to ask. This acquaintance form will help us serve you better. All information is confidential.

PATIENT REGISTRATION Today's Date:________________

Patient Information

○ Mr
○ Mrs. Last Name:__________________________ First Name:__________________________ Middle in.:_____
○ Ms. Preferred Name:________________________Email Addresss:________________________________
Home Address:_________________________________City:____________________ State:______ Zip:_____
Home phone:____________________________Cell Phone:_________________________________
Birth Date: _____/______/______ Age: _______ Social Security #: _________-________-_________
Employer:_______________________________________ Job Title:____________________________________
Work phone:__________________________ Ext. ________
Spouse Name:___________________________________ Spouse phone:______________________________
Spouse Employer:______________________________Job Title:_______________________________________
Patient is: ____Primary Policy holder ____Secondary Policy holder _____Self pay
Who may we thank for referring you? ____

Responsible Party (if someone other than the patient)

○ Mr
○ Mrs. Last Name:__________________________ First Name:__________________________ Middle in.:_____
○ Ms. Preferred Name:________________________Email Addresss:________________________________
Home Address:_________________________________City:____________________ State:______ Zip:_____
Home phone:____________________________Cell Phone:_________________________________
Birth Date: _____/______/______ Age: _______ Social Security #: _________-________-_________
Responsible Party is: ____Primary Policy holder ____Secondary Policy holder _____Self pay

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Primary Insurance Information

Name of insured:____________________________________Relationship to insured: ____________________
Insured S.S.#:______-______-______ Insured Birth Date: ______/______/_____
Member #:______________________ Group #:______________________
Remaining Benefits:______________________ Remaining Deductible:________________________
Employer:_________________________Address:____
City, State, Zip:____
Ins. Company:_____________________Address:____
City, State, Zip:____
Telephone: ____

Secondary Insurance Information

Name of insured:____________________________________Relationship to insured: ____________________
Insured S.S.#:______-______-______ Insured Birth Date: ______/______/_____
Member #:______________________ Group #:______________________
Remaining Benefits:______________________ Remaining Deductible:________________________
Employer:_________________________Address:____
City, State, Zip:____
Ins. Company:_____________________Address:____
City, State, Zip:____
Telephone: ____

______I have filled out this form to the best of my ability and knowledge.
Patient/Guardian Signature:____ Date:___________________

MEDICAL HEALTH HISTORY:
Please fill out yes/no for the following:

Heart
_____High/Low Blood Pressure
_____Heart Valve Problem
_____Stroke(s)
_____Pacemaker
_____Artificial Heart Valve
_____Mitral Valve Prolapse

Blood
_____Abnormal Bleeding
_____Anemia

Intestinal
_____Ulcers
_____Weight gain or loss
_____Special Diet

Bone/Joint
_____Arthritis
_____Back or neck pain
_____Joint Replacement
Type & Year:_____________

_____Diabetes Type:_________________
_____Cancer/Tumor Type:_________________
_____Asthma
_____Seizures/Epilepsy
_____Dizziness/Convulsions
_____Diabetes Type:_______________
_____Cancer/Tumor Type:_______________
_____ Tuberculosis
_____Hepatitis or Liver problems
_____Herpes, HPV,HIV or AIDS
_____Organ Transplant

Women
_____Pregnant ______Months
_____Nursing

Allergies
_____Latex _____Local Anesthetics
_____Penicillin _____Sulfa Drugs
_____Barbituates,sedatives or sleeping pills
_____Aspirin, Acetominophen or Ibuprofen
_____Codeine, Demerol or other narcotics
Other allergies:_______________________

Do you smoke? _____
History of alcohol or drug abuse? _____
Please list all current medications that you are taking.
____
____

Dental Health History:

How long has it been since your last dental visit?__________________________
Were x-rays taken at your last visit?__________
What is your current dental problem?
____

Patient/Guardian signature:_________________________________ Date:__________

Pineville Family Dentistry
Financial Policy

Assignment and Release
I the undersigned, have insurance with ______________________________, and assign directly Pineville Family Dentistry. All benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits.

____ ____________________
Signature of patient/parent/legal guardian Date

Patient Agreement and Financial Policy
I hereby agree to be responsible for the costs of care provided by Pineville Family Dentistry and/or the dental team for myself or my dependent(s). These include any deductibles and amounts not covered by insurance. **I also understand that it is my responsibility to be aware of any limitations, and benefits of my insurance policy. Payment to this office is my responsibility and I am aware that if the insurance company does not reimburse the doctor, I am responsible for the total amount(s).** I am aware that fees quoted are valid for 90 days only.

I understand that if I pay by check and the check is returned, I will be charged a fee of $30 to cover the bank charge.

I understand that because appointments are not double-booked, I must provide a notice of cancellation at least 48 hours prior to my scheduled appointment time. **For appointments scheduled for 90 minutes or longer, I will be required to make a reservation fee of $100 prior to scheduling the appointment, which will be applied to my out-of-pocket expense for the appointment.** This reservation fee is non-refundable. If I fail to make it to my appointment time or I do not give adequate notice of 48 hours if I am unable to keep my appointment, the reservation fee will be forfeited.

For any appointment, a cancellation or failed appointment fee of $25 will be charged to the patient, parent or legal guardian if a notice of cancellation at least 48 hours prior to the scheduled appointment time is not given. The $25 fee will be donated to a non-profit organization of Pineville Family Dentistry's choice.

We make every effort to schedule appointments that are most convenient for you and that fit your personal schedule. Because we do not schedule several patients at the same time, all appointments are reserved exclusively for you. In return, we ask that you make every effort not to change your reserved dental appointment.

I understand that for any treatment less than $250 payment in full is due at the time of service. I understand that after 60 days, any unpaid balance will incur a $10 billing fee. I understand that failure to pay amounts due to this office within 60 days will result in my account being placed with a collection agency. In the event that my account is further referred to an attorney, I agree to pay all collection and attorney fees.

____ __________________
Signature of patient/parent/legal guardian Date

Minor/Child Consent
I, being the parent or legal guardian of _____________________________, do here, by request and authorize the dental staff to perform necessary services for my child, including but not limited to radiographs (x-rays) and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered. I also understand that the parent or guardian who brings my child in for treatment will be responsible for payment. A receipt will be provided so I may seek reimbursement.

____ ___________________
Signature of patient/parent/legal guardian Date

Pineville Family Dentistry

Your Privacy Is Important to Us

Acknowledgement of Receipt of Notice of Privacy Policies

I have received a copy of the Notice of Privacy Practices of Pineville Family Dentistry. I hereby authorize, as indicated by my signature below, Pineville Family Dentistry to use and to disclose my protected health information for any necessary clinical, financial, and insurance purpose, as authorized in the Patient Consent form.

________________________________ ________________________________
Print Name Address

________________________________ ___________
Signature Date

Please check your preferred means of communication:

- ☐ You may contact me at my home telephone number ____________________________
- ☐ You may contact me on my mobile telephone number ____________________________
- ☐ You may contact me on my work telephone number ____________________________
- ☐ You may send me an unencrypted email/text message at: ________________________
- ☐ Other ____

Please list authorized persons with whom we may discuss your Protected Health Information (PHI) in addition to custodial parents and legal guardians:

1. ____ Date Added / Removed:__________

2. ____ Date Added / Removed: __________

3. ____ Date Added / Removed: __________

4.____ Date Added / Removed: _________

* * *

For Office 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
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining the acknowledgement
- ☐ Other (Please Specify) ____

Staff Person Initials ___________