Mint Hill Dentistry

PATIENT REGISTRATION

Patient's Name: _____ Date of Birth: _____ M __ F __

Address: Street: _____ City/State: _____ Zip: _____

Home Phone: _____ Business Phone: _____ Cell Phone: _____

Email Address: _____ Do you want to receive notice by email: Y ___ N ___

Social Security #: _____ Driver's License # _____ Employer _____

Spouse's Name: _____ Employer: _____

Business Phone: _____ Cell Phone: _____

Nearest Relative Not Living with You: _____ Phone #: _____

Who may we thank for referring you?: _____

Person to contact in case of emergency: _____ Phone # _____

DENTAL INSURANCE

Primary Coverage:

Policyholder's Name: _____ DOB: _____

Social Security# _____ Member ID: _____ Relationship to Patient: _____

Employer: _____ Employer's Address: _____

Insurance Company: _____ Address: _____

Group #: _____ Deductible: $ _____ Max Benefit per year: _____

Secondary Coverage:

Policyholder's Name: _____ DOB: _____

Social Security# _____ Member ID: _____ Relationship to Patient: _____

Employer: _____ Employer's Address: _____

Insurance Company: _____ Address: _____

Group #: _____ Deductible: $ _____ Max Benefit per year: _____

I authorize release of necessary information for submission of insurance benefits made on my behalf.

Signed: _____ Date: _____

Mint Hill Dentistry

PATIENT REGISTRATION / CHILD

Patient's Name: _____ Date of Birth: _____ M __ F __

Address: Street: _____ City/State: _____ Zip: _____

Home Phone: _____ School Attending: _____

PARENT/GUARDIAN: _____ Spouse: _____

Nearest relative not living with you: _____

Whom may we thank for referring you? _____

Person Responsible for Account: _____ Relationship to Patient: _____

Address: Street: _____ City/State: _____ Zip: _____

Home Phone: _____ Business Phone: _____ Cell Phone: _____

Employer: _____ Drivers License # : _____

DENTAL INSURANCE

Primary Coverage:

Policyholder's Name: _____ DOB: _____

Social Security# _____ Member ID: _____ Relationship to Patient: _____

Employer: _____ Employer's Address: _____

Insurance Company: _____ Address: _____

Group #: _____ Deductible: $ _____ Max Benefit per year: _____

Secondary Coverage:

Policyholder's Name: _____ DOB: _____

Social Security# _____ Member ID: _____ Relationship to Patient: _____

Employer: _____ Employer's Address: _____

Insurance Company: _____ Address: _____

Group #: _____ Deductible: $ _____ Max Benefit per year: _____

I authorize release of necessary information for submission of insurance benefits made on my behalf.

Signed: _____ Date: _____

MEDICAL HISTORY

FOR

2467--Patient New

Birth Date:

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 may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____

Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____

Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____

Are you on a special diet? ◯ Yes ◯ No _____

Do you use tobacco? ◯ Yes ◯ No

Do you use controlled substances? ◯ Yes ◯ No

Women: Are you

Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics

☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pace Maker ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No	Yellow Jaundice ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No	

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes, please explain: _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

Mint Hill Dentistry
Authorization for Release of Information – Compound Release

Name of Patient _____ Date of Birth _____

Mint Hill Dentistry is authorized to release protected health information about the above named patient in the following manner and to identified persons.

Entity to Receive Information. Check each person/entity that you approve to receive information.	**Description of information to be released.** Check each that can be given to person/entity on the left in the same section.
☐ Voice Mail	☐ Appointment Reminders ☐ Other_____
☐ Other person (s) (provide name and phone number)(i.e. Grandparent, Stepparent, Aunt, Uncle etc)	☐ Financial ☐ Treatment/ Treatment Plans
☐ Email communication-Provide email address* _____	☐ Financial ☐ Treatment Plans ☐ Appointment reminders ☐ Breach notification
☐ Text communication – Provide number * _____ *For text communication to occur, accept the disclosure below:	☐ Appointment reminder ☐ Other: _____
☐ For **text communication** I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive text communication as selected.P	
☐ Photo of patient received by patient or legal guardian ☐ Photo taken by staff (Example: pre/post procedure) ☐ Other	☐ May be posted in office ☐ May be posted on website ☐ Other_____

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization will remain in effect until revoked by the patient.

_____Date _____

Signature of Patient or Personal Representative

*Description of Personal Representative's Authority (attach necessary documentation)

Revised Oct 2014

Mint Hill Dentistry

5833 Phyliss Lane * Mint Hill, NC 28227 * 704-568-8010

FEE AND PAYMENT POLICY

In an effort to keep dental cost down, while maintaining a high level of professional care, we have established the following financial policies:

- **Payment At Time Of Service:** Payment in full is due at the time of service using Cash, Check, Credit Card or Check Card Debit. We accept MasterCard, Visa, American Express and Discover for your convenience.

- **Use of MasterCard/ Visa:** extended payments are available upon request with pre-authorization through your Visa or MasterCard. All account balances are due within 90 days of service.

- **Special Financing:** Through special arrangements with our financial partners, balances over $500.00 may be financed same as case or with low monthly payments with approved credit. Arrangements for special financing must be approved prior to dental services and are based upon the financial partner's criteria.

- **Dental Insurance:** As a courtesy to our patients with dental insurance, our financial department may assist you in determining your dental benefits. A completed dental insurance form or a copy of your current dental insurance card is required. Any benefit estimate given is ***not a guarantee*** of actual insurance payment. Special arrangements for accepting the insurance benefit may be discussed with our financial department. Your insurance policy is a contract between you, your employer and your insurance carrier: our relationship is with you. We will gladly assist you in receiving the maximum benefits provided by your dental carrier: however, you will ultimately be responsible for all fees for services provided regardless of insurance coverage. *Mint Hill Dentistry* will allow 60 days from the date of service for response from your carrier. If payment has not been received within the 60 day period, balances are due by the responsible party within 30 days.

- *Mint Hill Dentistry* / Drs. Sullivan, Burd & Roupas has actively chosen not to participate in Preferred Provider Organizations (PPO/DMO). It is important to us to provide the highest quality of dental care possible based on each individual patient's needs not on coverage allowed by an insurance carrier. We do partner with Delta Preferred and Cigna Discount plans.

- **Returned Checks:** a $35.00 service charge will be accessed on all returned checks.

- **Balances** over 90 days will be accessed and 18% APR and a monthly billing fee. All account balances over 90 days may be subject to referral for collection proceedings allowable by law.

- For all services provided to **minor** patients, we will look to the person who signs this financial agreement for payment.

The Doctors and Staff of *Mint Hill Dentistry* look forward to assisting you in receiving the highest quality dental care. We invite you to discuss your payment options with one of our financial coordinators.

By signing below, I acknowledge reading and understanding the above financial policies of *Mint Hill Dentistry* and it's providers. I understand that my signature acknowledges acceptance and full responsibility of all services including any portion non-covered by my insurance carrier(s). I also understand that I will be responsible for collection costs, attorney's fees and court cost related to unpaid balances brought forth.

Please print Name of Responsible Party: _____ Relationship: _____

Signature _____ Date: _____