smile forever
FAMILY DENTISTRY
Dr. Dudee & Associates

Personal Information

Name of Patient: _____
Last First Middle Initial

Date of Birth: _____/_____/_____ SSN: _____-_____-_____

Phone: (_____)-_____-_____ ☐ Mobile ☐ Home ☐ Work Alternate: (_____)-_____-_____

Address: _____
Number Street City State Zip

Email Address: _____

Responsible Party (i.e Parent and Legal Guardian), Guarantor, or Insurance Policy Holder

☐ Self – Skip to next section

Name : _____
Last First Middle Initial

Date of Birth: _____/_____/_____ SSN: _____-_____-_____

Phone: (_____)-_____-_____ ☐ Mobile ☐ Home ☐ Work Alternate: (_____)-_____-_____

Address: ☐ Same as Patient ☐ Other – Enter below

_____
Number Street City State Zip

Email Address: _____

Relationship to Patient: _____ **Legal Documentation may be required*

Emergency Contact

Name : _____
Last First Middle Initial

Phone: (_____)-_____-_____ ☐ Mobile ☐ Home ☐ Work Alternate: (_____)-_____-_____

Address: ☐ Same as Patient ☐ Other – Enter below

_____
Number Street City State Zip

Relationship to Patient: _____

6406 McCrimmon Parkway Suite 220 Morrisville, NC 27560
Tel: (919) 460-9061 E-mail: info@smileforeverdental.com Fax (919) 460-9062

Pharmacy Information

Pharmacy Name: _____

Pharmacy Address: _____

Number Street City State Zip

Pharmacy Phone #: (_____) _____-_____

Primary Dental Insurance

Insurance Company: _____

Member/Subscriber ID# _____ Group #: _____

Insurance Company Address: _____

Insurance Company Phone #: (_____) _____-_____

Policy Holder: ☐ Self ☐ Responsible Party (as above) ☐ Other – Enter below

Name : _____

Last First Middle Initial

Date of Birth: _____/_____/_____ SSN: _____-_____-_____

Address: ☐ Same as Patient ☐ Other – Enter below

_____

Number Street City State Zip

Patient's Relation: ☐ Spouse ☐ Dependent/Child ☐ Other: _____

Secondary Dental Insurance - if applicable

Insurance Company: _____

Member/Subscriber ID# _____ Group #: _____

Insurance Company Address: _____

Insurance Company Phone #: (_____) _____-_____

Policy Holder: ☐ Self ☐ Responsible Party (as above) ☐ Other – Enter below

Name : _____

Last First Middle Initial

Date of Birth: _____/_____/_____ SSN: _____-_____-_____

Address: ☐ Same as Patient ☐ Other – Enter below

_____

Number Street City State Zip

Patient's Relation: ☐ Spouse ☐ Dependent/Child ☐ Other: _____

Medical Health History

Existing Patients Only: Please review your health history with our staff, if you are certain there have been no changes you can opt to select the below box and skip to the signature item at the end of this section.

☐ I attest there are no changes from the Health Information already in our system.

Are you in good health? ☐ Yes ☐ No

Has there been a change in your health within the last year? ☐ Yes ☐ No

If yes, please explain: _____

_____

Have you been hospitalized or seriously ill with the last 5 years? ☐ Yes ☐ No

If yes, please explain: _____

_____

Are you being treated by a Physician for any significant health issues? ☐ Yes ☐ No

If yes, please provide details: _____

_____

Are you taking or have you recently taken any medications? ☐ Yes ☐ No

If yes, please list all medications – including vitamins, dietary supplements, and natural or herbal supplements (a scannable list is acceptable): _____

_____

_____

_____

Please list all Allergies (medications, food, items, seasonal, etc.): _____

_____

_____

_____

Have you experienced any of the following:

Chest Pain	☐ Yes	☐ No	Dizzy Spells	☐ Yes	☐ No
Swollen Ankles	☐ Yes	☐ No	Ringing in Ears	☐ Yes	☐ No
Shortness of Breath	☐ Yes	☐ No	Frequent Headaches	☐ Yes	☐ No
Recent Weight loss	☐ Yes	☐ No	Fainting Spells	☐ Yes	☐ No
Persistent or Bloody cough	☐ Yes	☐ No	Blurred Vision	☐ Yes	☐ No
Bleeding or Bruising easily	☐ Yes	☐ No	Seizures	☐ Yes	☐ No
Sinus Problems	☐ Yes	☐ No	Excessive Thirst	☐ Yes	☐ No
Difficulty Swallowing	☐ Yes	☐ No	Frequent Urination	☐ Yes	☐ No
Joint Pain or Stiffness	☐ Yes	☐ No	Dry Mouth	☐ Yes	☐ No
Jaundice	☐ Yes	☐ No	Sleep Apnea/Snoring	☐ Yes	☐ No

Have you ever lived with, or do you currently live with:

Heart Disease	☐ Yes	☐ No	HIV/AIDS	☐ Yes	☐ No
Heart Attack/Defect	☐ Yes	☐ No	Cancer	☐ Yes	☐ No
Heart Murmur/Afib	☐ Yes	☐ No	OsteoAthritis	☐ Yes	☐ No
Rheumatic Fever	☐ Yes	☐ No	Rheumatoid Arthritis	☐ Yes	☐ No
Stroke	☐ Yes	☐ No	Eye Disease	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No	Skin Diseas	☐ Yes	☐ No
Lung Disease	☐ Yes	☐ No	Anemia	☐ Yes	☐ No
Hepatitis ☐A ☐B ☐C	☐ Yes	☐ No	STD/STI	☐ Yes	☐ No
Stomach Issues/Ulcers	☐ Yes	☐ No	Herpes	☐ Yes	☐ No
Diabetes ☐Type1 ☐Type2	☐ Yes	☐ No	Kidney/Bladder Disease	☐ Yes	☐ No
Mitral Valve Prolapse	☐ Yes	☐ No	Thyroid Disease	☐ Yes	☐ No

Have you ever had, are currently actively involved in, or soon to be going through:

Surgery	☐ Yes	☐ No	Chemotherapy	☐ Yes	☐ No
Blood Transfusion	☐ Yes	☐ No	Radiation Treatment	☐ Yes	☐ No
Joint Replacement	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No
Psychiatric Care	☐ Yes	☐ No	Birth Control	☐ Yes	☐ No
Contact Lenses	☐ Yes	☐ No	Valve Replacement	☐ Yes	☐ No
Pregnancy/Nursing	☐ Yes	☐ No			

Do you currently consume, or have you consumed:

Recreational Drugs	☐ Yes	☐ No	Alcohol	☐ Yes	☐ No
Tobacco (any form)	☐ Yes	☐ No	Bisphonates	☐ Yes	☐ No

Tell us about your Smile and your Dental History

When was your last Dental Visit? ☐ 6 months or less ☐ 1-2 years ☐ 3+ years

How often do you brush?

☐ Not every day ☐ Once a day ☐ Twice a Day ☐ Three + a Day

How often do you floss?

☐ Not sure ☐ Once a week ☐ Once every few days ☐ Once a day

What are primary concerns for your current or upcoming dental visit?

☐ Cleaning/Hygiene ☐ Tooth/Smile Appearance ☐ Orthodontics

☐ Tooth Pain ☐ Tooth Sensitivity ☐ Cavities

☐ Sensitive/Bleeding Gums ☐ Loose Tooth ☐ Tooth Replacement

☐ Other: _____

Do you feel you have good dental health and do you like your smile? ☐ Yes ☐ No

If no, please tell us what you would like to change to feel more confident and healthy:

_____

_____

Are you nervous or afraid of Dental Treatment? ☐ Yes ☐ No

Do you have, or have you had any diseases or medical issues not listed previously on this form? ☐ Yes ☐ No

If yes, please explain: _____

_____

Have ever been told by a physician/dentist to pre-medicate prior to any dental treatment? ☐ Yes ☐ No

If yes, please explain: _____

_____

Have you ever experienced:

Bleeding Gums	☐ Yes	☐ No	Hot/Cold Sensitivity	☐ Yes	☐ No
Chronic Bad Breath	☐ Yes	☐ No	Snoring	☐ Yes	☐ No
Sour Taste in mouth	☐ Yes	☐ No	Food sticking in teeth		
Burning sensation in mouth	☐ Yes	☐ No	Face or Eye soreness	☐ Yes	☐ No
Jaw Soreness	☐ Yes	☐ No	Clenching Jaw muscles	☐ Yes	☐ No
Difficulty opening jaw	☐ Yes	☐ No	Grinding of Teeth	☐ Yes	☐ No
Clicking/popping in jaw	☐ Yes	☐ No	Stiff Neck	☐ Yes	☐ No
Wearing braces	☐ Yes	☐ No	Oral Surgery	☐ Yes	☐ No

Do you grind or clench your teeth?	☐ Yes	☐ No
Do you wear a bite appliance (i.e. a mouth or tooth guard)	☐ Yes	☐ No
Have you been diagnosed with sleep apnea or other sleep issues?	☐ Yes	☐ No
Have you have had periodontal treatment (deep cleaning, gum graft)	☐ Yes	☐ No
Have you ever had braces or other orthodontic treatment?	☐ Yes	☐ No
Do you have any of your wisdom teeth?	☐ Yes	☐ No
Do you experience any pain or bleeding when brushing/flossing?	☐ Yes	☐ No
Are you concerned about bad breath (halitosis)?	☐ Yes	☐ No
Any issues getting numb or reactions to anesthesia?	☐ Yes	☐ No
Will you allow us to administer Dental X-Rays as needed to assist in accurately diagnosing your oral health or to assess any issues you may have?	☐ Yes	☐ No

Medical and Personal Information Attestation

I certify that I have reviewed and provided, as accurately as possible, all information provided to this point on this form as related to my current and past personal, health, dental status and history. I also assert that I am legally entitled to verify this information with my signature for myself or my ward and have provided legal documentation as needed.

Printed Name: _____

SIGNATURE: _____ **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 4/14/03 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 providing 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 and 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 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 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 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 judgement in 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, 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 official's 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 emails).

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 practically 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 per page and for staff time per hour to locate and 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 a satisfactory explanation of 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 use 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.

Privacy Officer Narender S Dudee

Address: 6406 McCrimmon Parkway | Suite 220
Morrisville, NC 27560

Telephone: (919) 460-9061

Fax: (919) 460-9062

Email: info@smileforeverdental.com

TO OUR PATIENTS

What is HIPAA? The Health Insurance Portability and Accountability Act

Why? 1. HIPAA protects you and the privacy of your health information. • This permits us to file your electronic insurance claims which protects the privacy of your information and allows for faster reimbursement.

- This is required by law.

Attached:

- Notice of Privacy Practices - at your leisure please read the complete explanation of HIPAA.
- Acknowledgement of Receipt of Notice of Privacy Practices – please complete & give to a staff member.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Your signature states that you have received this Notice of Privacy Practices.
You May Refuse to Sign This Acknowledgement

By signing below I certify that I have received and reviewed a copy of this office's Notice of Privacy Practices.

Printed Name: _____

SIGNATURE: _____ **DATE:** _____

FOR OFFICE PERSONEL TO ANSWER ONLY IF PATIENT DID NOT SIGN THIS FORM

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

☐ The individual refused to sign.

☐ Communications barriers prohibited obtaining the acknowledgement.

☐ An emergency prevented us from obtaining acknowledgement.

☐ Other (Please Specify) _____

Staff Person's Name: Signature:

smile forever FAMILY DENTISTRY Dr. Dudee & Associates
6406 McCrimmon Parkway Suite 220 Morrisville, NC 27560
Tel: (919) 460-9061 E-mail: info@smileforeverdental.com Fax (919) 460-9062

PATIENT FINANCIAL POLICY

Your dental health is important to us, and we want to ensure that you receive the gentle, compassionate care necessary. We realize that every person's financial situation is different. For this reason, we offer the following payment options from which you may choose.

Cash or Check
☐ MasterCard, Visa, Discover or American Express
☐ Care Credit

INSURANCE FILING

We may accept assignment of your insurance benefits; however, we require that your estimated portion and deductible be paid at the time of service. Since your insurance policy is an agreement between you and your insurance company, please realize that it is your responsibility to follow up on claims and payments. We will send a statement to you each month your account has an outstanding balance. Payment in full is appreciated on all statements.

Our staff will file your claims with your insurance provider on your behalf. If we are in-network with your insurance company, you are entitled to and we will accept the negotiated rate.

I have read, understand, and agree to the payment terms of this financial policy. I agree to allow Smile Forever Family Dentistry to file my insurance on my behalf and be paid directly by the insurance company.

Relation to Patient: ☐ Self ☐ Parent of a minor ☐ Other: _____

SIGNATURE: _____ DATE: _____

NOTE: A 1.5% finance charge per month will be assessed on all balances over 60 days old. All accounts over 120 days past due will be forwarded to our collection service. All fees and costs associated with the collections process (including charges of 30% of the amount submitted to collections as well as all legal fees) will be the responsibility of the patient.

PATIENT CONSENT FOR ELECTRONIC COMMUNICATION

There is some risk that any individually identifiable health information and other confidential information that may be contained in such an e-mail or text message may be misdirected, disclosed to, or intercepted by unauthorized third parties. Agreeing to receive electronic communication from our office indicates that you understand and accept that risk.

Some of the information that we may transmit electronically includes:

- Appointment reminders/changes
- Treatment Plan
- Account Payments/Cost Estimates
- Insurance Information and Coverage

We do our best to communicate in a manner that best suits your needs. You can customize some of our phone and electronic communications. However, certain situations may require us to override those preferences and you retain the responsibility for attendance, payment, and updating your information as needed.

☐ I consent and accept the risk in receiving and sending information via e-mail and/or text messaging. I understand I can withdraw my consent at any time.

☐ I **do not** consent to receive any information via e-mail and/or text messaging. I agree to the following information to be communicated electronically

I further agree that I am responsible for providing updates to my e-mail address and mobile phone number. Please talk to our office if you have any questions

SIGNATURE: _____ DATE: _____

smile forever FAMILY DENTISTRY Dr. Dudee & Associates
6406 McCrimmon Parkway Suite 220 Morrisville, NC 27560
Tel: (919) 460-9061 E-mail: info@smileforeverdental.com Fax (919) 460-9062