ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

WESTERN WAKE FAMILY DENTISTRY
Dr. Daniel Moore, DDS, PLLC

As required by the Privacy Regulations, I hereby acknowledge that I have received a current copy of Western Wake Family Dentistry's "NOTICE OF PRIVACY PRACTICES", revision date June 1, 2012.

As required by the Privacy Regulations, _______________ from Western Wake Family Dentistry has explained the "NOTICE OF PRIVACY PRACTICES" to my satisfaction.

As required by the Privacy Regulations, I am aware that Western Wake Family Dentistry has included a provision that it reserves the right to change the terms of its notice and to make the new notice provisions effective for all protected health information that it

Requests

___ I wish to file an additional form requesting restrictions or objecting to one or multiple of the above policies regarding my Protected Health Information.

Emergency Contacts

1. ____
   First and Last Name   Contact Phone #

   Yes ___ **No** ___ This person can also receive information regarding my personal health and account information.

2. ____
   First and Last Name   Contact Phone #

   Yes ___ **No** ___ This person can also receive information regarding my personal health and account information.

I understand that this office is not required to honor any changes to the "Notice of Privacy Practices".
I have read "NOTICE OF PRIVACY PRACTICES" and understand my rights contained in the notice. By way of my signature, I provide Western Wake Family Dentistry with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

______________________________ ______________________________

Patient's Name (Printed)   Patient Signature   Date

____

Authorized Facility Signature or Parent/Guardian if Minor   Date

(FOR OFFICE USE ONLY)

Signed form received by: ______________________________ Date: ______________

The following effort was made to obtain receipt: (Describe)______________________________

____

Attendance Policy

Welcome to Western Wake Family Dentistry. We are glad you have chosen us to provide your dental care. As our new patient, we would like to provide you with our attendance policy, so that we are on the same page, and can provide you with better care. We ask that you respect our attendance policy, as it helps us to better treat you and all of our other patients who are in need of care.

Please arrive **5 minutes before** your scheduled appointment.

We **require 48 hours notice** before changing or cancelling an appointment, **otherwise we cannot continue to see you as a patient**.

Your co-pay, if it applies, is *always due at the time of your appointment.*

We respect your time by setting aside time on the schedule for you, and we ask that you do the same for us. If you miss an appointment or cancel within that 48 hours, we cannot reschedule you, and will refer you to other dentist offices in the area.

By Signing below, you acknowledge that you understand these rules and will adhere to them.

____
Patient Name, Printed

________________________________ ______________
Patient Signature Date

Welcome to WESTERN WAKE FAMILY DENTISTRY

PERSONAL INFORMATION

Name____
Last First MI (Preferred)

Birthdate______________ SS#___________________ Gender: [ ] M [ ] F Married: [ ] Y [ ] N

Work Phone________________ Wireless Phone__________________ Home Phone___________________

Email____

Preferred contact method [ ] HmPhone [ ] WkPhone [ ] WirelessPh [ ] Email

Preferred contact method for confirmations [ ] HmPhone [ ] WkPhone [ ] WirelessPh [ ] Email

Preferred contact method for recall [ ] HmPhone [ ] WkPhone [ ] WirelessPh [ ] Email

Student status if dependent over 19 (for ins) [ ] Nonstudent [ ] Fulltime [ ] Parttime0

How did you hear about us?____
(If someone referred you here, please write down their name so we can thank them.)

PATIENT ADDRESS

Check box if same for entire family [ ]

Address____

Address 2____

City___________________________ State_______Zip___________________

INSURANCE POLICY 1 - Please present insurance card to receptionist.

Your relationship to subscriber: [ ] Self [ ] Spouse [ ] Child Subscriber Birthdate__________________

Subscriber Name___________________________________Subscriber ID # ______________________

Insurance Company _____________________________________Phone__________________________

Employer_________________________Group Name____________________Group #________________

INSURANCE POLICY 2

Your relationship to subscriber: [ ] Self [ ] Spouse [ ] Child Subscriber Birthdate__________________

Subscriber Name___________________________________Subscriber ID # ______________________

Insurance Company _____________________________________Phone__________________________

Employer_________________________Group Name____________________Group #________________

Dental History

Patient Name ______________________________________

Today's Date__________________

Birthdate_____________________

Reason for Today's Visit______________________________________

Date of Last Dental Care ____________________

Former Dentist____

Date of Last Dental X-Rays _________________

Check if you have any of the following:

- [ ] Bad breath
- [ ] Bleeding gums
- [ ] Clicking or popping in jaw
- [ ] Food gets stuck in teeth
- [ ] Grinding teeth
- [ ] Loose teeth or broken fillings
- [ ] Periodontal treatment
- [ ] Sensitivity to cold or hot
- [ ] Sensitivity to sweets
- [ ] Sores in your mouth
- [ ] Oral surgery in the past
- [ ] Denture or partials

Are you interested in teeth whitening? _________________

What other concerns do you have about your teeth? ____

Medical History

Physician's Name________________________________

Date of Last Visit______________________________

Have you ever had any serious illness or operations? _____

If yes, please describe:___________________________

Women: Are you pregnant? Or could become pregnant? _______ Nursing?______ Taking Birth Control Pills?_______

Check if you have any of the following:

- [ ] Anemia
- [ ] Arthritis, Rheumatism
- [ ] Artificial Heart Valves
- [ ] Artificial Joints
- [ ] Asthma
- [ ] Back Problems
- [ ] Blood Disease
- [ ] Chemotherapy
- [ ] Circulatory Problems
- [ ] Radiation Treatment
- [ ] Respiratory Disease
- [ ] Rheumatic Fever
- [ ] Cortisone Treatments
- [ ] Cough, Persistent
- [ ] Diabetes
- [ ] Epilepsy
- [ ] Fainting
- [ ] Glaucoma
- [ ] Headaches
- [ ] Heart Murmur
- [ ] Heart Palpatations
- [ ] Tuberculosis
- [ ] Shortness of Breath
- [ ] Stroke
- [ ] Hemophilia
- [ ] Hepatitis
- [ ] High Blood Pressure
- [ ] HIV/AIDS
- [ ] Jaw Pain
- [ ] Kidney Disease
- [ ] Liver Disease
- [ ] Mitral Valve Prolapse
- [ ] Pacemaker
- [ ] Ulcer
- [ ] Thyroid Problems
- [ ] Tobacco Habit

Medications:

List medications you are taking:

____

____

____

Allergies:

- [ ] Aspirin
- [ ] Codeine
- [ ] Local Anesthetics
- [ ] Sulfa
- [ ] Latex
- [ ] Other:___________________

____

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any of his staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature____ Date__________________________