

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) _____

Patient Agreement

Thank you for choosing Western Wake Family Dentistry. Our primary mission is to deliver the best and most comprehensive dental care available.

Attendance Policy:

A **fee of \$35** is charged for patients who miss or cancel without **48-hour notice**. If your appointment is scheduled for a Monday, we will need to know by Thursday before if we need to reschedule for you. This aids us in scheduling your treatment, and your fellow neighbors' treatment, as quickly as possible, and as conveniently as possible.

Payment Options:

You can choose from:

- Cash, Check, Visa, MasterCard, American Express, CareCredit or Discover Card
- Convenient Monthly Payment Options¹ from our in house payment plan.

We offer a 5% courtesy accounting adjustment to patients who pay for their treatment with cash or check (excluding cleanings and emergency visits) upon scheduling it.

Please note:

Western Wake Family Dentistry requires payment at the beginning of your treatment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.²

Western Wake Family Dentistry charges \$25 for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

By signing below, you understand and agree to honor our attendance and payment policies.

Patient, Parent or Guardian Signature Date

Patient Name (Please Print)

¹Subject to credit approval

²However, if we do not receive payment from your insurance carrier within 90 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.

Welcome to WESTERN WAKE FAMILY DENTISTRY

PERSONAL INFORMATION

Name _____
 Birthdate _____ Last SS# _____ First MI (Preferred) 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:

<input type="checkbox"/> Bad breath	<input type="checkbox"/> Grinding teeth	<input type="checkbox"/> Sensitivity to sweets
<input type="checkbox"/> Bleeding gums	<input type="checkbox"/> Loose teeth or broken fillings	<input type="checkbox"/> Sores in your mouth
<input type="checkbox"/> Clicking or popping in jaw	<input type="checkbox"/> Periodontal treatment	<input type="checkbox"/> Oral surgery in the past
<input type="checkbox"/> Food gets stuck in teeth	<input type="checkbox"/> Sensitivity to cold or hot	<input type="checkbox"/> 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:

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

Medications:

Allergies:

List medications you are taking:

<input type="checkbox"/> Aspirin	<input type="checkbox"/> Sulfa
<input type="checkbox"/> Codeine	<input type="checkbox"/> Latex
<input type="checkbox"/> Local Anesthetics	<input type="checkbox"/> 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 _____