Welcome to

Triangle Park Dental

2003 E NC- 54 Suite A, Durham NC 27713

(919) 321-0222

PATIENT LAST NAME:_____ FIRST:_____ INITIAL:___

How do you wish to be addressed?_____ Date of Birth _____

Address_____ City_____ State_____ Zip _____

Telephone (Mobile)_____ (Work)_____ (Home) _____

Email_____

How did you hear about our practice? _____

INSURANCE INFORMATION

Primary Insurance	**Secondary Insurance**
Subscriber Name_____	Subscriber Name_____
Subscriber ID _____	Subscriber ID _____
Date of Birth _____	Date of Birth _____
Relationship to Subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other	Relationship to Subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other
Employer Name _____	Employer Name _____
Employer Phone _____	Employer Phone _____
Insurance Company _____	Insurance Company _____
Insurance Group _____	Insurance Group _____
Insurance Phone _____	Insurance Phone _____

Please present your insurance card to be photocopied for our records.

RESPONSIBLE PARTY (If minor)

Last Name:_____ First:_____ Initial:____

Address *(If different)*_____ Date of Birth _____ City_____ State_____ Zip _____

Telephone (Home)____ (Work)_____ (Mobile) _____ Email _____

EMERGENCY CONTACT

Last Name:_____ First:____ Initial:___ Telephone (☐ Mobile ☐ Work ☐ Home) _____

AUTHORIZATION

I consent to the diagnostic procedures and dental treatment performed by my dentist, and to the release of information concerning my (or my child's) health care, advice, and treatment to another dentist, or for evaluating and administering any claims for insurance benefits. I consent to the direct payment of my insurance benefits to dentist or dental group and understand that my insurance benefits may pay less than the actual bill for services and that I am responsible for any services not paid or covered by my insurance benefits and any account balance.

I attest to the accuracy of the information on this page.

Signature_____ Date _____

(Responsible Party, if under 18)

PATIENT REGISTRATION
DENTAL & MEDICAL HEALTH HISTORY

TRIANGLE PARK DENTAL

PLEASE COMPLETE ALL INFORMATION – THANK YOU

DENTAL HISTORY

Reason for today's visit _____ Date of last dental visit _____

Former dentist _____ Date of last dental x-rays _____

Please check if you have/had:	Yes	No
Bad breath	☐	☐
Blisters on lips or mouth	☐	☐
Burning sensation on tongue	☐	☐
Chew on one side of mouth	☐	☐
Cigarette, pipe, or cigar smoking	☐	☐
Smokeless tobacco	☐	☐
Dry mouth	☐	☐
Food collection between teeth	☐	☐
Clench or grind teeth	☐	☐
Growths or sore spots in your mouth	☐	☐
Gums swollen, tender or bleeding	☐	☐

	Yes	No
Head, neck, jaw pain, or aches	☐	☐
Lip or cheek biting	☐	☐
Loose teeth or broken fillings	☐	☐
Mouth breathing	☐	
Orthodontic treatment	☐	☐
Nitrous Oxid	☐	☐
Periodontal treatment	☐	☐
Sensitivity to pressure or irritants (cold, heat, sweets)	☐	☐
How often do you floss? _____		
How often do you brush? _____		

Have you ever had an allergic reaction to Novocaine, local, or general anesthetics? Yes No

If Yes, please explain _____

Have you ever had trouble from previous dental care?

Yes No If Yes, please explain _____

MEDICAL HISTORY

Physician's name _____ Date of last visit _____

Physician's address _____

Blood Pressure _____ Have you had any serious illnesses or operations ☐ Yes ☐ No If yes, please describe _____

Have you ever had a blood transfusion ☐ Yes ☐ No If yes, give approximate dates _____

(Women) Are you pregnant? ☐ Yes ☐ No Due date _____ Nursing? ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ No

Please check if you have/had:	Yes	No
Allergies, hay fever, sinusitis	☐	☐
Anemia	☐	☐
Arthritis, Rheumatism	☐	☐
Artificial heart valves	☐	☐
Artificial joints	☐	☐
Asthma	☐	☐
Required Hospitalization	☐	☐
Have you used steroids	☐	☐
Date of last episode_	☐	☐
Bleeding abnormally with operations or surgery	☐	☐
Blood disease, clotting disorders	☐	☐
Cancer	☐	☐
Chemical dependency	☐	☐
Chemotherapy	☐	☐
Circulatory problems	☐	☐
Cortisone treatments	☐	☐
Cough, persistent or bloody	☐	☐
Diabetes	☐	☐
Emphysema	☐	☐
Epilepsy	☐	☐
Fainting	☐	☐
Glaucoma	☐	☐

	Yes	No
Headaches		
Heart murmur	☐	☐
Heart problems	☐	☐
Hepatitis type_____		
Herpes	☐	☐
High blood pressure	☐	☐
Any immune deficiency	☐	☐
Jaundice	☐	☐
Kidney disease	☐	☐
Low blood pressure	☐	☐
Mitral valve prolapse	☐	☐
Osteoporosis	☐	☐
Osteopenia	☐	☐
Pacemaker	☐	☐
Radiation treatments	☐	☐
Respiratory disease	☐	☐
Rheumatic fever	☐	☐
Scarlet fever	☐	☐
Shortness of breath	☐	☐
Sinus trouble	☐	☐
Sickle cell anemia	☐	☐
Skin rash	☐	☐

	Yes	No
Slow healing wounds		
Stroke	☐	☐
Swelling of feet or ankles	☐	☐
Thyroid problems	☐	☐
Tonsilitis	☐	☐
Tuberculosis	☐	☐
Tumor or growth on head/neck	☐	☐
Ulcer	☐	☐
Venereal disease	☐	☐
Weight loss, unexplained	☐	☐
Do you wear contact lenses?	☐	☐
Do you consume alcoholic beverages?	☐	☐
Are you currently under the care of a Physician?	☐	☐
Are you allergic/sensitive to Latex?	☐	☐
Allergic to Penicillin, Aspirin, or other drugs?	☐	☐
If Yes, please specify _____	☐	☐

List any medications that you are taking:

_____

_____

_____

AUTHORIZATION AND RELEASE

I have read and answered the above questions to the best of my knowledge.

Patient/Guardian Signature _____ Date _____

Reviewed by: _____ Date _____

Patient last name: _____ Patient first name: _____

TRIANGLE PARK DENTAL

PRIVACY PRACTICES RECEIPT / CONSENT FORM

SECTION A: PATIENT GIVING CONSENT

Patient Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient Number: _____ Social Security Number: _____

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read the Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting front office.

Telephone: 919-321-0222
Address: 2003 E NC HWY 54 Suite A, Durham, NC 27713

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation.

SECTION C: SIGNATURE

I, _____ have had full opportunity to read and consider the contents of this Consent form and the Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and heath care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative (parent/guardian) on behalf of the patient, complete the following:

Personal Representative's Name:

SECTION D: 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 acknowledgement
- ☐ Other (please specify) _____

Signature: _____ Date: _____

You are entitled to a copy of this consent after you sign it.

SECTION E: REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will *not* affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature:_____ Date: _____

If this Revocation of Consent is signed by a personal representative (parent/guardian) on behalf of the patient, complete the following:

Personal Representative's Name: _____

SECTION F: PATIENT/RELATIVE HIPAA CONSENT

I,_____, understand that by signing this Consent form, I am giving my consent to Triangle Park Dental to disclose and discuss my protected health information to carry out treatment, payment activities and health care operations with the following family member:

Name:_____

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the front Desk listed on Section B.

_____

Patient's Signature (Legal Guardian, if Patient is a minor) Date:

OFFICE POLICY

Financial and Insurance Information

Payment is due at the time services are rendered unless arrangements have been approved in advance. We will collect estimated co-payments and deductibles on the day services are rendered. Patients are expected to pay in full by cash, debit card or major credit card the day services are rendered. Financial responsibility for patients that are minors lies with the parent who accompanies the child to the appointment. Minors should be accompanied by a parent to answer any questions with regards to treatment or patient care.
Quality dental care is a financial investment. If you have insurance benefits, we will work with you to help you understand and maximize your coverage. Insurance companies and coverage can vary. You must realize however; Your contract for insurance benefits exists between you and your insurance carrier. The insurance coverage you will receive depends upon the quality of the plan purchased by the employer. Plans vary greatly and insurance companies do not give us the exact reimbursement amounts. These reimbursements are ESTIMATES, please contact your insurance company if you need an exact reimbursement amount. It is ultimately your responsibility to be aware of your own or your dependents dental coverage and provide us with as much information as possible in order to better assist you.

Please remember that you are ultimately responsible for your account with our office.

1. We accept payment for services by cash, check, Mastercard, Visa, and American Express.
2. If you have dental insurance, we will be happy to file your claim(s) for you as a courtesy. Ultimately, what insurance does not cover is the responsibility of the patient.
3. If your insurance does not cover 100 percent of the charges, you may be billed any additional amount. You will receive an estimate of your liability prior to any appointments so that you will be financially prepared. Please remember that, regardless of insurance coverage, you are responsible for your account with our office.
4. When treatment is rendered, our staff will fully brief you on the costs and ask that your estimated co-payment and deductible be paid at the time of service. We will file insurance claims and accept assignment of benefits. After receiving payment from your insurance, we will send a statement with any balances due or credits. We ask that payment be made within 14 days of the statement. In the event of a credit, we will promptly issue you a refund. In the event that your insurance does not pay within 45 days, we ask that you makepayment in full and contact your insurance company regarding reimbursement to you.
5. If you do not have insurance, your insurance pays you, or you are over your insurance limit, payment in full is expected at the time of service.
6. In the event of default of payment or after 90 days, a service charge of 1.5 percent per month or 18 percent annually will be added to any outstanding balances not paid within 30 days of the current monthly billing statement. All accounts in which effort to pay is not made will be subject to collection proceedings.
7. Your appointment is scheduled specifically for you. Therefore, we require cancellation or reschedule notice of 48 business hours. If such a notice is not given, or failed to show up for your appointment, a $50 fee (the minimum cost of your appointment) will be charged to your account. If you have any question about the above information or any uncertainty regarding insurance coverage, please do not hesitate to ask. We are here to assist you.

Thank you for reviewing our financial and insurance policy. We will make every effort to explain your costs to you before treatment so we can avoid misunderstandings and focus on your dental health. We strongly recommend for you to contact your insurance company to verify coverage benefits for the treatment plan we have provided. If you have any questions, please ask-we are here to serve you.

I have read, understand, and agree to abide by this policy. I have been given the opportunity to receive a copy of this document.

Signature Patient/ Parent Guardian: _____ Date: _____