st. mary's
FAMILY DENTISTRY

Welcome to St. Mary's Family Dentistry

We would like to thank you for choosing St. Mary's Family Dentistry as your dental care provider. We are pleased to meet any dental needs you or your family have. We will do our best to provide the most professional and up to date care available. The following are some of our office policies and procedures necessary for you to understand.

- As a courtesy St. Mary's Family Dentistry will file your dental claim with your insurance company. Your deductible and co-pay or any portion not covered by your insurance company is due at the time of service. For those patients without insurance coverage, you are responsible for your payment in full on the day of treatment, unless otherwise discussed.
- Broken appointments can be very costly and inconvenient to our practice. Please inform us twenty-four (24) hours in advance if you are unable to keep your appointment. Broken appointments will lead to a $50.00 charge and may lead to you and your family being dismissed from our practice. Any non confirmed appointment may be rescheduled at our discretion.
- If you have Medicaid, you must have your current Medicaid card with you. If you are over the age of twenty-one (21), you are responsible for the $3.00 co-pay. If you do not have a current card we reserve the right to reschedule your appointment.
- If you are more than fifteen (15) minutes late for your appointment, you may be rescheduled for another day. This is also considered to be a broken appointment.
- All patients under the age of eighteen (18) will not be seen or treated, in the absence of a parent or legal guardian, without a signed consent form.
- You are responsible to pay the cost of collecting any debt owed on your account. This includes late fees, and interest to be charged at one percent per month.
- All accounts 90 days past due will be charged 1.5% finance charges regardless of insurance situation.

  By signing below you have read and understood our Notice of Privacy Practice. Your cooperation is greatly appreciated in this matter. If you have any questions, please feel free to ask our staff.

Signature: _____ Date: _____

Medical History Questionnaire

Patient Information

Full Name: _____ Date of Birth: _____
Address: _____
City: _____ State: _____ Zip: _____
Telephone: _____ Work: _____ Cell: _____
Email: _____
Social Security Number: _____ Driver License Number: _____
Employer: _____ Occupation: _____
Sex: _____ Age: _____ Height: _____ Weight: _____
Emergency Contact: _____ Phone: _____

Responsible Party

Full Name: _____ Relationship: _____
Address: _____ Date of Birth: _____
City: _____ State: _____ Zip: _____
Employer: _____ Phone: _____
Social Security Number: _____ Driver License Number: _____
Method of Payment: Cash: _____ Visa/MC: _____ Check: _____ Insurance: _____

Insurance

Name of Insured; _____ Date of Birth: _____
Social Security Number: _____ Employer: _____
Insurance Company: _____ Address: _____
Phone: _____ Group number: _____ Policy Number : _____

If you have additional dental insurance please notify our staff.

We are happy to assist you in understanding and filing your insurance for most dental procedures. Please understand that your insurance is a contract between you, your employer and your insurance company. We will gladly act as your advocate but we cannot be responsible for

settling any disputed claims or coverage. **Please remember that you are ultimately responsible for your bill.**

If we do not receive payment from your insurance carrier within forty-five (45) days we will notify you. Failure of your insurance carrier to reimburse our office within sixty (60) days will result in our billing you directly for the remaining balance.

Signature of Patient or Responsible Party: _____

Date: _____

Patients Medical History

All information provided here is a 100% confidential and any attempt to conceal preexisting conditions or other relevant information could result in serious patient drug interactions or death. The following questions must be answered honestly so that our office can provide you with the best possible care. If we determine that questions have not been answered honestly you will be dismissed from our practice.

Please select the Correct Response

What medications are you taking?

•Nerve pills • Blood Thinners •Pain Killers (including aspirin)
•Tranquilizers •Insulin •Meds for Osteoporosis
•Other(s), (Please List all other Medications you're currently taking)

Name Of Medication	Dosage	Frequency	Reasons

Have you ever taken:

•Bisphosphonates (ex. Aredia/Fosamax) •Phen-fen/Redux

Are you allergic to, or have you had unusual reactions to any of the following?

Select all that apply: •Latex •Aspirin •Penicillin/Amoxicillin
•Sulfa Drugs •Codeine •Erythromycin

•Dental Anesthetics •Tetracycline
Foods: _____
Other: _____

Do you use tobacco?•No •Yes/ How used? _____
How Much? _____
How long? _____

Have there been any changes in your general health recently? Yes• No•
Are you currently being treated by a medical Doctor? Yes• No•
If yes, what is the Doctors Name? _____
Phone Number? _____
Have you ever been seriously ill? Yes• No•
Have you ever been hospitalized? Yes• No•
Why? _____
Have you ever had a major operation? Yes• No•
Have you had a physical exam in the last year? Yes• No•
Have you ever had to take antibiotics before having dental work? Yes• No•
Do you have artificial joints or heart valves? Yes• No•
Do you have chest pains upon exertion? Yes• No•
Have you ever had x-rays for a tumor, growth or any other condition? Yes• No•
Have you ever been exposed to the AIDS virus (HIV)? Yes• No•
Would you consent to a blood test (at our expense) if the Doctor or Staff member suffers a needle stick or puncture wound? Yes• No•
Are you currently using any recreational drugs such as cocaine? Yes• No•
Have you ever had a blood transfusion? Yes• No•
Have you ever experienced an unusual reaction to dental anesthetic? Yes• No•

Have you ever been told that any of the following pertain to you?

Mitral Valve Prolapse	Yes• No•	Heart Murmur	Yes• No•
High/Low Blood Pressure	Yes• No•	Diabetes/ Hypoglycemia	Yes• No•
Heart Attack /Stroke	Yes• No•	Herpes	Yes• No•
Heart Disease	Yes• No•	Congenital Heart Defect	Yes• No•
Chest Pains	Yes• No•	Scarlet Fever	Yes• No•
Nervousness	Yes• No•	Cancer/ Tumors	Yes• No•
Shingles	Yes• No•	Artificial Bones/ Joints	Yes• No•
Emphysema	Yes• No•	Headaches	Yes• No•
Frequent Neck Pain	Yes• No•	Back Problems	Yes• No•
Thyroid Problems	Yes• No•	Kidney Problems	Yes• No•
Liver Problems	Yes• No•	Respiratory Problems	Yes• No•
Sinus Problems	Yes• No•	Stomach Problems/ Ulcers	Yes• No•
Psychiatric Problems	Yes• No•	Alcohol/ Drug Abuse	Yes• No•

Tuberculosis TB	Yes• No•	Jaw Problems TMJ/TMD	Yes• No•
Cosmetic Surgery	Yes• No•	X-ray or Cobalt Treatment	Yes• No•
Chemotherapy	Yes• No•	Difficulty Breathing	Yes• No•
Leukemia	Yes• No•	Bleeding Problems	Yes• No•
Hives/Skin Rash	Yes• No•	Epilepsy	Yes• No•
Seizures/ Fainting	Yes• No•	Anemia	Yes• No•
HIV+/AIDS/ARC	Yes• No•	Rheumatic Fever	Yes• No•
Hepatitis	Yes• No•	Tuberculosis	Yes• No•
Stroke	Yes• No•	Jaundice	Yes• No•
Heart Surgery	Yes• No•	Artificial Valves	Yes• No•
Asthma	Yes• No•	Hay fever	Yes• No•
Venereal Disease	Yes• No•	Kidney Disease	Yes• No•
Arthritis/ Rheumatism	Yes• No•	Glaucoma	Yes• No•

Other: _____

Do you bleed for a long time when you cut yourself?	Yes• No•
Do you have frequent or severe headaches?	Yes• No•
Do you have sinus trouble?	Yes• No•
Do you have painful or swollen joints?	Yes• No•
Do you have frequent cold sores or canker sores?	Yes• No•
Do you have complaints about your ears/hearing?	Yes• No•
Do you have frequent colds?	Yes• No•
Are you nervous?	Yes• No•
Have you lost or gained weight in the last few months?	Yes• No•
Has your appetite changed recently?	Yes• No•
Are there any foods that you cannot eat?	Yes• No•

For Women Only

Are you pregnant?	Yes• No•
Are you nursing?	Yes• No•
Are you taking oral contraceptives (birth control pills)?	Yes• No•

Women who take oral contraceptives (birth control pills) should take extra Precautions when taking antibiotics. Antibiotics can cause failure of birth control pills which could result in pregnancy.

Patient Dental History

Reason for today's Visit: •Exam •Emergency •Consultation

Are you in Pain? •No •Yes/ How long? _____

Please indicate any of the following problems:

•Discomfort, clicking or Popping of jaw •Broken/chipped tooth
•Red, swollen or bleeding gums •Sensitive tooth, teeth or gums
•Blisters/ sores in or around the mouth •Locking jaw
•Lost/broken filling(s) •Bad breath
•Teeth grinding Other(s): _____

When was the last time you visited the dentist? _____ Where? _____
When was the last time you had your teeth cleaned? _____

Do you usually see a dentist every six (6) months Yes• No•
May we take dental x-rays if they are needed? Yes• No•
Do you have fluoride in your drinking water? Yes• No•
Do you take a fluoride supplement? Yes• No•
Have you ever had periodontal (gum) treatment? Yes• No•
Have you ever had orthodontic treatment (braces)? Yes• No•
Do you floss regularly? Yes• No•
Do your gums bleed when you floss? Yes• No•
What kind of toothbrush do you use? • Hard • Medium • Soft

I have read and understand the questions. I have answered all of these questions truthfully to the best of my ability and knowledge.

Signature: _____ Date: _____

St. Mary's Family Dentistry
817 Brooklyn St.
Raleigh, NC 27605
Telephone: (919) 896-7117

Authorization for Release of Information

Name of Patient _____ Date of Birth _____
_____ 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	□ Results of lab tests/x-rays Other_____

□ Spouse (provide name and phone number) _____	□ Financial □ Medical
□ Parent (provide name and phone number) _____	□ Financial □ Medical
□ Email communication-Provide email address* _____ *In order for email communication to occur, please accept the disclosure below:	□ Financial □ Medical □ Breach notification
□ For email communication I understand that if email is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email communication,	
□ Communication about treatment alternatives even if this office is being compensated for making the communication.	

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.

The information is released at the patient's request and 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)

St. Mary's Family Dentistry

817 Brooklyn St.
Raleigh, NC 27605

(919) 896-7117

To: Our New Patient,

In order to keep our schedule running smoothly and for us to be able to be on time for your appointment the following policy has been put in place:

1. Our team will make every effort to confirm your appointment 24 (twenty-four) hours in advance. However, if we are unable to contact you, and we do not receive a call back to confirm by 12 noon of the day prior to your appointment, we will cancel your appointment.
2. If your appointment is confirmed but you do not show for any reason, our office will

charge your account $50.00/ hour to cover the cost of the office and staff that was reserved for you. You will not be given a new appointment until the “no-show” fee is paid. Exceptions are given on individual basis and circumstances.

Please keep in mind we offer several ways to confirm your appointment: phone calls, leave a message, email, and Text messaging. If you would like to sign up for email and/or text messaging please let our front desk staff know.

We value your time at our office and we’re trying to do everything possible to make your experience as pleasant and efficient as possible.

Thank you,

St. Mary’s Family Dentistry

Signature: _____

Date: _____

St. Mary’s Family Dentistry
817 Brooklyn St.
Raleigh, NC 27605

Telephone: (919) 896-7117
Fax: (919)896-7565

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name & Address: _____
_____

I have received a copy of the Notice of Privacy practices for the above named practice.

_____ _____

Signature Date

For Office Use only

We were unable to obtain a written acknowledgment of receipt of the Notice of Privacy practices because:

- An emergency existed & a signature was not possible at the time.
- The individual refused to sign
- A copy was mailed with a request for a signature by return mail
- Unable to communicate with the patient for the following reasons: _____
- Other: _____

Prepared By:_____

Signature: _____

Date:_____

st. mary's
FAMILY DENTISTRY

Patient Name: __ Date:

Last, First MI (Preferred Name)

E-Mail Address: __ Family Status: _

Consent for Internet Communications

I grant my permission to St. Mary's Family Dentistry to upload and store confidential patient information — including account information, appointment information and clinical information — to the secured web site for St. Mary's Family Dentistry. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand St. Mary's Family Dentistry and myself are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that St. Mary's Family Dentistry is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand St. Mary's Family Dentistry is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the St. Mary's Family Dentistry web site with my ID and password. I also agree to immediately notify St. Mary's Family Dentistry of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns. I also understand State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand St. Mary's Family Dentistry will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my patient information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that St. Mary's Family Dentistry has the right to monitor, retrieve, store, upload and use my patient information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand St. Mary's Family Dentistry will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand St. Mary's Family Dentistry **CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.**

I have read the information above regarding the secured uploading of patient information to the web site for St. Mary's Family Dentistry, and grant St. Mary's Family Dentistry permission to securely upload my patient information to the web site.

_____ Date: _____

Signature of patient, parent or guardian

Relationship to Patient:_____