Patient's name: _____
First Middle Last

Preferred Name: _____ Today's Date: _____

Street address: _____

City: _____ State: _____ Zip code: _____

Home phone: _____ Cell phone: _____ Work phone: _____

Social Security Number: _____ Date of Birth: _____

Email address: _____ Gender: Female/ male (circle one)

Employer: _____

Marital Status: Married Single Divorced Other

Emergency contact and Relationship: _____Phone: _____

How did you hear about us?

_____

Responsible party (if other than the patient):

Patient's name: _____
First Middle Last

Street address: _____City: _____ State: _____ Zip code: _____

Home phone: _____ Cell phone: _____ Work phone: _____

Social Security Number: _____ Date of Birth: _____

Insurance Policy

Name of Policy holder: _____ Relationship to Patient: _____

Date of Birth: _____ Social security Number: _____

Employer: _____ Insurance company: _____

Member ID #: _____ Group #: _____

We are happy to file insurance claims and assist you in obtaining the maximum benefits specified in your contract. Please keep the following in mind:

1. Your insurance is a contract between you, your employer and your insurance company. We are not a party to that contract. We will do our best to **ESTIMATE** your coverage, and file your insurance on your behalf. Not all dental services are covered under your dental plan. It is essential that you read and understand your coverage and pay special attention to any preauthorization requirements, exclusions and waiting periods.

2. Our office policy states that you are totally responsible for your bill. The **ESTIMATED** patient portion of the fee is due at the time of service. If a balance remains after we receive payment from your insurance carrier we will notify you within 30 days. Failure of your insurance carrier to reimburse our office will result in our billing you directly for the remaining balance.

3. We are committed to providing the highest quality of care. Our treatment recommendations and the dental services we provide are in the best interest of the patient's health. The patient is responsible for payment in full regardless of an insurance company's arbitrary determination of treatment necessity.

4. Our participation is a Preferred Provider Organization (PPO) is a contract between this office and the organization to provide dental services for the negotiated network fee schedule. Individual coverage and benefits will vary within the organization and are dependent on the contract between you, your employer, and the insurance company. While we guarantee our fees will not exceed the network fee schedule, we cannot be responsible for variances in coverage and benefits within the PPO.

5. If your coverage changes for any reason, please notify the office immediately.

By signing this form, you have read and understand our policy. Any denials or insurance payments less than estimated will be your responsibility. Payment will be due upon our billing cycle. All estimated out of pocket fees and deductibles are due the day of treatment. Questions regarding your financial options should be asked **before** your dental appointment.

_____

Signature Date

All information provided is 100% confidential and any attempt to conceal pre-existing 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.

1. Have there been any changes in your general health recently? Yes No

   If yes, please explain: _____

   _____

2. Is a medical doctor currently treating you? Yes No

   If yes, give doctor's name and phone and reason they are treating you: _____

   _____

3. Please list all medication (prescription or over the counter) that you take. _____

   _____

   _____

   _____

   _____

4. Have you ever had a major operation or been hospitalized? Yes No

   If yes, please specify _____

   _____

5. Do you have any artificial joints, heart valves or an organ transplant? Yes No

   If yes, please specify _____

6. Do you have congenital heart condition? Yes No

   If yes, please mark all that may apply:

   - ☐ Unrepaired or incompletely repaired cyanotic congenital heart disease, including a palliative shunt or conduit
   - ☐ Completely repaired congenital heart defect with prosthetic material or device, either placed by surgery or by catheter intervention, during the first six months after the procedure

- Any repaired congenital heart defect with residual defect at the site or adjacent to the site of a prosthetic patch or a prosthetic device

7. Have you had a cardiac transplant that developed a problem in a heart valve? Yes No
8. Do you have chest pains upon exertion? Yes No
9. Are you **allergic** to, or have you had an unusual reaction to any of the following?

***(Circle all that may apply)**

Latex Penicillin Ibuprofen Iodine Codeine Erythromycin

Sulfa drugs Other_____

10. Are you currently taking any recreational drugs? Yes No
    If yes, please specify _____
    _____
11. Have you ever taken the drug fen-phen? Yes No
12. Have you ever taken bisphosphonate such as Fosamax, Actonel, or Boniva? Yes No
13. Have you ever had a blood transfusion? Yes No
14. Have you experienced an unusual reaction to dental anesthetic? Yes No
15. **Please circle if you have ever had or been told you have any of the following:**

Heart Defect	Heart Attack	Learning disabilities
HIV/AIDS	Jaundice	Kidney Disease
Infective Endocarditis	Herpes	Anemia
Rheumatic fever	Asthma	Active Infection
High Blood Pressure	Hives/Skin rash	Arthritis
Hepatitis	Hay fever	Swollen Neck glands
Low Blood Pressure	Epilepsy	Pacemaker
Tuberculosis	Venereal Disease	Osteoporosis
Diabetes	Seizures	Sinus Trouble
Stroke	Cancer	Thyroid Problems

Other: _____

16. Do you use tobacco? Yes No
17. Please list any foods that you are allergic to: _____

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

18. Are you pregnant or suspect that you may be pregnant? Yes No
19. Are you taking oral contraceptives (birth control pills)? Yes No
20. If you use other types of birth control medications that are not pills (such as Depo shot), please list: _____

I have read and understand the above questions. I have answered all of these questions truthfully to the best of my ability and knowledge. I consent to the diagnostic procedures and dentistry necessary for proper dental care.

_____

Signature Date

Acknowledgement of Receipt of Notice of Privacy Practices

I have received a copy or have access to the Notice of Privacy Practices for Lincolnton Family Dentistry.

_____ _____

Signature Date

For Office Use Only

We were unable to obtain a written acknowledgement 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 requested for a signature by return mail.
- ☐ Unable to communicate with the patient for the following reason: _____
- ☐ Other: _____

Staff member signature & Date: _____

My Dental goals are (Please circle all that may apply):

Whiter teeth	Full Dentures	Partials
Pain free	Cavity Free	Better Chewing
Straighter teeth	Better breath	Sedation dentistry
Healthier gums	Less Bleeding	Stop snoring
Replacing missing teeth		Decrease sensitivity

21. Have you ever had a bad dental experience? Yes No

    If yes, please explain: _____

22. When is the last time you were seen by a dentist? _____
23. Do you take fluoride supplements? Yes No
24. Have you ever had periodontal treatment (Gum treatment)? Yes No
25. Do you floss regularly? Yes No
26. Do your gums bleed when you brush or floss? Yes No

If you could change anything about your smile, what would it be?

_____

_____

_____

Signature Date

Thank you for taking the time to complete these new patients' forms. We personalize your dental care based on the answers you've provided.

Lincolnton
FAMILY DENTISTRY
DR. ANTUAN L. HERRIOTT, DMD, PA

Financial Policy

It is our goal for patients to clearly understand their treatment needs, as well as their financial responsibility, before treatment begins. Payment of estimated patient portion is due at the time of treatment. We desire to make dental treatment affordable to all of our patients. Therefore, we offer the following payment options:

CareCredit, cash, check, Visa, and Mastercard.

If a check is returned for insufficient funds there will be a **$35 fee added to your balance** to cover any incurred bank cost.

As a courtesy to you we will gladly process your insurance claim forms. Our responsibility is to provide you with the treatment that best meets your needs, not to try to match your care to insurance plan limitations. Dental insurance plans do no correspond to individual patient needs, and as such, some routine and necessary dental services are not covered even though you may need those services. Please remember your insurance policy is a contract between you and your insurance company. As a courtesy to you our office does do pre-treatment estimate, which we send to the insurance company to better estimate your cost, but it is impossible for us to have knowledge of every aspect of your insurance plan. It is your responsibility to have all financial questions answered prior to treatment to minimize any confusion on your behalf. **Any balance unpaid by the insurance company is your responsibility.**

By signing this form, you are agreeing that you read and understand the terms and conditions of this financial agreement for the Lincolnton Family Dentistry.

Signature: _____ Date: _____

Lincolnton FAMILY DENTISTRY
DR. ANTUAN L. HERRIOTT, DMD, PA

Broken Appointment Policy

We understand that things happen, and schedules do change, if this happens we ask that provide us with **at least two (2) business days' notice** for any appointment changes. Please understand that we do value you as a patient **however** if you have multiple missed appointments (2 or more) we will no longer schedule you in advance. On the day that you know that you can keep your appointment give our office a call and we will do our best to work you in to the schedule for that day.

1- You must be on time for your appointment. If you arrive more than 10 minutes late without prior notice you **may** still be seen but you will have to wait.

2- We will attempt to call you the day before your appointment to confirm. If a message is left on your machine/voicemail and we do not receive a call back, we will assume that you know and understand your appointment time. **The reminder calls are only courtesy calls**. We do attempt to call everyone but ultimately the appointment made by you is your responsibility.

I have read and fully understand the above policy

_____ _____

Signature Date

____Patient ____Parent ____Guardian

Authorization for release of information (HIPAA)

Patient Name_____ **Date of Birth** _____**,** gives **Lincolnton Family Dentistry** authorization to release protected health information in the following manner and to the identified persons. (Please **check all** that may apply)

May we:

- ☐ Leave voice mail
- ☐ Leave message with someone? If so who _____

Messages about:

- ☐ Lab results
- ☐ Financial
- ☐ Medical
- ☐ Treatment plans
- ☐ Other: _____

Would you like emails? If so, what is your email address? _____

Emails about:

- ☐ Financial
- ☐ Treatment plans
- ☐ Medical
- ☐ Appointment Reminders
- ☐ Breach information

Would you like text messages? If so, what is your phone number? _____

Text messages about:

- ☐ Appointment reminder

Email and text message communications are not sent in an encrypted manner and there may be a risk of it being accessed inappropriately. Would you still like to receive information in this manner?

- ☐ Yes
- ☐ No

Lincolnton Family Dentistry may take photos and post them in our office, on our website and on Facebook. If you would like for your photos to be used please check the following boxes to let us know which you agree to, if any.

- ☐ Photos taken by staff as before and after procedure
- ☐ May be posted on Facebook
- ☐ May be posted on office website
- ☐ May be posted in office

Patient Rights:

Please be aware that you as a patient :

- Has the right to revoke this authorization at any time.
- 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 coditioned on signing.

This authorization will remain in effect until revoked by the patient.

_____ _____

Signature of Patient Date