Patient Information and Health History Form

PATIENT INFORMATION

Patient Name _____ Nickname/Preferred Name _____

Birthdate _____ SS#_____ Driver's License #_____

Marital Status: ◊Married ◊Single ◊Widowed ◊Divorced ◊Separated Spouse or Guardian_____

Address _____

City _____ _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

E-Mail Address _____

Referred By _____

Patient's Employer _____ Phone # _____

Emergency Contact_____ Phone #_____Relationship to patient_____

RESPONSIBLE PARTY

Name of person responsible for this account _____ Relationship to patient _____
Address _____ Home Phone _____
Birthdate _____ SS# _____ __ Driver's License # _____
Employer _____ Work Phone _____
Is this person currently a patient in our office? ◊Yes ◊No

INSURANCE INFORMATION

Name of insured _____ Relationship to patient _____
Birth date _____ SS#_____
Name of Employer _____ Work Phone _____
Employer Address_____ City_____ State_____ Zip _____
Insurance Co. _____ Phone # _____
Group # _____ Subscriber ID # _____
Ins. Co. Address _____ City _____ State _____ Zip _____

SECONDARY INSURANCE INFORMATION

Name of insured _____ Relationship to patient _____
Birth date _____ SS#_____
Name of Employer _____ Work Phone _____
Employer Address_____ City_____ State_____ Zip _____
Insurance Co. _____ Phone # _____
Group # _____ Subscriber ID # _____
Ins. Co. Address _____ City _____ State _____ Zip _____

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, you mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◊ Yes ◊ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ◊ Yes ◊ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ◊ Yes ◊ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ◊ Yes ◊ No If yes, please list:_____

_____

Do you take (or have you previously taken) Phen-Fen or Redux? ◊ Yes ◊ No
Have you ever taken Fosamax, Boniva, Actonel, or any medication containing a bisphosphonate? ◊ Yes ◊ No
Are you on a special diet? ◊ Yes ◊ No
Do you use tobacco? ◊ Yes ◊ No If so, what type? _____
Do you use controlled substances? ◊Yes ◊ No
Have you had any joint replacements? ◊Yes ◊ No If yes, explain:_____

Women: Are you…
Pregnant/Trying to get pregnant? ◊ Yes ◊ No Taking oral contraceptives? ◊ Yes ◊ No Nursing? ◊ Yes ◊ No

Are you allergic to any of the following?
◊ Aspirin ◊ Penicillin ◊ Codeine ◊ Acrylic ◊ Metal ◊ Latex ◊ Local Anesthetics
◊ Other If other, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive	◊Yes ◊No	Cortisone Medicine	◊Yes ◊No	Hemophilia	◊Yes ◊No	Recent Weight Loss	◊Yes ◊No
Alzheimer's Disease	◊Yes ◊No	Diabetes	◊Yes ◊No	Hepatitis A	◊Yes ◊No	Renal/Dialysis	◊Yes ◊No
Anaphylaxis	◊Yes ◊No	Drug Addiction	◊Yes ◊No	Hepatitis B or C	◊Yes ◊No	Rheumatic Fever	◊Yes ◊No
Anemia	◊Yes ◊No	Easily Winded	◊Yes ◊No	Herpes	◊Yes ◊No	Rheumatism	◊Yes ◊No
Angina	◊Yes ◊No	Emphysema	◊Yes ◊No	High Blood Pressure	◊Yes ◊No	Scarlet Fever	◊Yes ◊No
Arthritis/Gout	◊Yes ◊No	Epilepsy or Seizures	◊Yes ◊No	Hives or Rash	◊Yes ◊No	Shingles	◊Yes ◊No
Artificial Heart Valve	◊Yes ◊No	Excessive Bleeding	◊Yes ◊No	Hypoglycemia	◊Yes ◊No	Sickle Cell Disease	◊Yes ◊No
Artificial Joint	◊Yes ◊No	Excessive Thirst	◊Yes ◊No	Irregular Heartbeat	◊Yes ◊No	Sinus Trouble	◊Yes ◊No
Asthma	◊Yes ◊No	Fainting/Dizziness	◊Yes ◊No	Joint Replacement	◊Yes ◊No	Spina Bifida	◊Yes ◊No
Blood Disease	◊Yes ◊No	Frequent Cough	◊Yes ◊No	Kidney Problems	◊Yes ◊No	Stomach/Intestinal Disease	◊Yes ◊No
Blood Transfusion	◊Yes ◊No	Frequent Diarrhea	◊Yes ◊No	Leukemia	◊Yes ◊No	Stroke	◊Yes ◊No
Breathing Problem	◊Yes ◊No	Frequent Headaches	◊Yes ◊No	Liver Disease	◊Yes ◊No	Swelling of Limbs	◊Yes ◊No
Bruise Easily	◊Yes ◊No	Genital Herpes	◊Yes ◊No	Low Blood Pressure	◊Yes ◊No	Thyroid Disease	◊Yes ◊No
Cancer	◊Yes ◊No	Glaucoma	◊Yes ◊No	Lung Disease	◊Yes ◊No	Tonsillitis	◊Yes ◊No
Chemotherapy	◊Yes ◊No	Hay Fever	◊Yes ◊No	Mitral Valve Prolapse	◊Yes ◊No	Tuberculosis	◊Yes ◊No
Chest Pains	◊Yes ◊No	Heart Attack/Failure	◊Yes ◊No	Pain in Jaw Joints	◊Yes ◊No	Tumors or Growths	◊Yes ◊No
Cold Sores/Fever Blisters	◊Yes ◊No	Heart Murmur	◊Yes ◊No	Parathyroid Disease	◊Yes ◊No	Ulcers	◊Yes ◊No
Congenital Heart Disorder	◊Yes ◊No	Heart Pacemaker	◊Yes ◊No	Psychiatric Care	◊Yes ◊No	Venereal Disease	◊Yes ◊No
Convulsions	◊Yes ◊No	Heart Trouble/Disease	◊Yes ◊No	Radiation Treatmnt	◊Yes ◊No	Yellow Jaundice	◊Yes ◊No

Have you ever had any serious illness not listed above? ◊Yes ◊ No If yes, please explain_____

_____

If I could change anything about my smile, it would be: _____

_____

Comments:_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or the patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN_____DATE_____

FINANCIAL POLICY AND AGREEMENT

Welcome to Dr. Thurmond's office! We are excited to have you as a patient, and look forward to getting to know you. Dr. Thurmond, our providers and staff are committed to providing you with the best treatment possible, and are dedicated to ensuring that your overall experience with us is successful and pleasant. To enable us to serve you, please review the following policies.

FINANCIAL POLICY

Initial _____ You are responsible for payment for all services performed in our practice, and payment is due at the time service is provided. Our office accepts cash, personal checks, MasterCard, Visa, Discover and CareCredit. Financing is available upon request and approval, but must be arranged prior to treatment.

Initial _____ We charge a $25.00 fee for all checks returned, and we will require a different form of payment in the future. If your account is not paid as agreed and is turned over to collections, additional fees will also be added to cover these costs.

Initial _____ Minor children 15 and under are required to have a responsible adult accompanying them to their appointments. We recognize that families are very busy, and if you wish to have someone other than a parent or legal guardian accompany your child to an appointment, we must have a Proxy Consent Form on file assigning responsibility to that person. Please ask us for a copy of this form. The parent (or legal guardian), or the assigned adult accompanying a minor is responsible for full payment at the time of service. For unaccompanied minors over age 16, non-emergency treatment will be denied unless charges have been pre-authorized to be approved by Visa/MasterCard, Discover, Care Credit, or payment by cash or check at time of service. Please call us ahead of time to make these arrangements for your child's appointment.

INSURANCE POLICY

Initial _____ Many of our patients have dental insurance benefits. While our office will gladly work with you to help get the maximum benefit available to you, it is important to understand that most dental insurance plans do not cover 100% of your cost of treatment. We are happy to provide an ***estimate*** of your out-of-pocket costs for each appointment, and you will be expected to pay any estimated out-of-pocket charges *on the day services are rendered.*

To accomplish this, we must have accurate information regarding your policy. It is your responsibility to keep us informed of any changes in your policy or benefits. Please contact our office prior to any scheduled appointments if you have cost concerns regarding your treatment.

We will gladly file your insurance claims, and will do everything possible to see that you receive the full benefits from your insurance company; however, many variables exist from policy to policy (i.e. deductibles, annual maximums, allowable fee limitations, non-covered procedures and other restrictions), therefore we cannot guarantee any estimated charges. Because your insurance is an agreement between you and the insurance company, ultimately you are responsible for all charges.

Insurance payments are ordinarily received within 30-60 days from the time of filing a claim. If for some reason your insurance company has not paid their estimated portion within 60 days from the start of treatment, you are responsible for payment in full at that time.

Dr. Thurmond is committed to providing the best possible treatment for our patients at a reasonable cost. We are in-network providers with Blue Cross of North Carolina, and are a Premier provider through Delta Dental of North Carolina. This helps us ensure that we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

(Over please)

Beverly Thurmond D.D.S., PLLC

APPOINTMENT POLICY

Late Arrivals

Initial _____

When we establish an appointment for you, we are reserving your provider's time exclusively for you to receive the best quality of care and treatment that you need. Having ALL patients arrive on time enables us to serve each of you in a timely and thorough manner. Patients presenting late may be reappointed at the sole discretion of your provider; chronic lateness may be grounds for dismissal from our practice.

Rescheduling

Initial _____

We understand that life is busy, and unforeseen circumstances may arise which require you to reschedule an appointment. Our expectation is that you will contact us at least 48 business hours prior to your scheduled time. Patients who cancel their appointments with less than 48 hours of notice, or who simply do not attend, will incur a $50.00 broken appointment fee. Three missed appointments are grounds for dismissal from our practice.

AUTHORIZATION AND RELEASE

I have read, understand and agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to Dr. Thurmond's office. I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered. I have also had a chance to have any concerns regarding these policies addressed by Dr. Thurmond or a member of her staff.

Patient Name: _____ Date: _____

Signature: _____

Relationship to patient: _____

ELECTRONIC APPOINTMENT REMINDER CONSENT

The office of Dr. Beverly Thurmond offers you the opportunity to confirm your appointment via email and/or text message. We know how busy you are and are excited to offer this convenient and free service to our patients. This is how it works:

1. You can receive an email or text or both. You decide!
2. A confirmation email/text message will be sent 30 days prior to your appointment, and again 5 days prior to your appointment. You confirm by following the instructions. If multiple family members have same-day appointments, only one message will be sent that lists each person's name and appointment time.
3. A reminder email/text message will be sent two days prior to your appointment and again two hours prior to your appointment. If you have already confirmed, this communication is just a friendly reminder.
4. A patient who confirms WILL NOT receive a reminder phone call.

Please Initial

____ 5. If you cannot keep your appointment, please contact us **at least 48 business hours** prior to your appointment so that we may offer that time to another patient. Remember that our business hours are Monday – Thursday.

____ 6. If you cancel an appointment with less than 48 hours of notice or miss a confirmed appointment, a $50.00 missed appointment fee may be charged.

Any texting fees charged by your cellular company are your responsibility. There is no charge from us for this service.

Patient Consent for Use of Electronic Mail & Text Messaging

Printed Name _____ Date _____

Select which option(s) by placing an X in the box:

You ☐ **Spouse/Partner** ☐ **Child(ren)** ☐

☐ E-mail address (Please print very clearly) _____

☐ Cell Phone number for text messages _____

☐ Opt Out – Please call me to confirm my appointments

Signature _____

Beverly Thurmond D.D.S., PLLC

HIPAA PRIVACY FORM

Acknowledgement of Receipt of Notice of Privacy Practices

Purpose: This form is to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

****You may refuse to sign this acknowledgement****

I, _____, have received a copy/explanation of this office's Notice of Privacy Practices.

_____ _____

Signature of Patient/ or Guardian **Date**

Relationship to Patient: Self or Other:_____

Authorization Release:

Please print the name of ANY individual (spouse, family member, step-parent, etc.) that you authorize Beverly Thurmond, D.D.S., PLLC to share your health information with. If you prefer we discuss your treatment details with you only, it is NOT necessary to list an additional party.

Print name of authorized person:_____

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.**
- **Communications barriers (such as language barrier) prohibited obtaining the acknowledgement**
- **An emergency situation prevented us from obtaining acknowledgement at time of service.**
- **Other (please specify) _____**