CARING MODERN DENTISTRY

JOE ADAMS, DDS & ASSOCIATES

PATIENT REGISTRATION

Patient Name: _____
Last First MI

Preferred Name: _____ Title: _____

Gender : ❑ Male ❑ Female Family Status: ❑ Married ❑ Single ❑ Child

Birth Date: _____ SSN: _____

Home Phone: _____ Mobile Phone: _____

Work Phone: _____ EXT: _____

Email Address: _____

Mailing Address: _____
City State Zip

If patient is under 18, please complete information for person responsible for payment:

Name: _____
Last First

Mailing Address: _____
City State Zip

Relationship to patient: _____ Best Phone Number: _____

Birth Date: _____ SSN: _____

Whom may we thank for referring you to our practice? _____

Please flip over and continue

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DENTAL INSURANCE INFORMATION

Please provide the front desk with a copy of your dental insurance card.

Name of Policy Holder: _____
Last First

Policy Holder's Birth Date: _____ Policy Holder's SSN: _____

Policy Holder's Address: _____
City State Zip

Home Phone Number: _____ Work Phone Number: _____ Mobile Number: _____

Relationship to Patient: ❑ Self ❑ Spouse ❑ Child

Policy Holder's Employer: _____

Name of Insurance Company: _____

If patient is a student, at what school are they currently enrolled? _____

INSURANCE AUTHORIZATION

By checking this box: ❑

I authorize my insurance company to pay the dentist all insurance benefits rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether paid or not by insurance.

_____ _____
Signature of Policy Holder Today's Date

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MEDICAL INFORMATION

Patient Name: _____
Birth Date: _____

Indicate which of the following conditions you have or have had in the past. By checking the box, it will indicate a "YES" response, leaving the box blank will indicate a "NO" response.

- ❑ *Pre-Med – Amox
- ❑ Allergy – Codeine
- ❑ Allergy – Penicillin
- ❑ Anemia
- ❑ Artificial Joint
- ❑ Chemotherapy
- ❑ Emphysema
- ❑ Frequent Headaches
- ❑ Heart Murmur
- ❑ High Cholesterol
- ❑ Leukemia
- ❑ Mental Disorders
- ❑ Other
- ❑ Respiratory Problems
- ❑ Sleep Disorder
- ❑ Tobacco User
- ❑ *Pre-Med – Clind
- ❑ Allergy – Erythro
- ❑ Allergy – Sulfa
- ❑ Angina
- ❑ Asthma
- ❑ Con. Heart Disorder
- ❑ Epilepsy
- ❑ Glaucoma
- ❑ Hemophilia
- ❑ Hypoglycemia
- ❑ Limb swelling
- ❑ Nervous Disorders
- ❑ Pacemaker
- ❑ Rheumatic Fever
- ❑ Stomach Problems
- ❑ Tuberculosis
- ❑ AIDS/HIV
- ❑ Allergy – Latex
- ❑ Alzheimer's
- ❑ Art. Heart Valve
- ❑ Blood Disease
- ❑ Diabetes
- ❑ Excessive Bleeding
- ❑ Head Injuries
- ❑ Hepatitis
- ❑ Jaw Pain
- ❑ Liver Disease
- ❑ Osteoporosis
- ❑ Pregnancy
- ❑ Sickle Cell Anemia
- ❑ Stroke
- ❑ Tumors
- ❑ Allergy – Aspirin
- ❑ Allergy – Metal
- ❑ Anaphylaxis
- ❑ Arthritis
- ❑ Cancer
- ❑ Dizziness/Fainting
- ❑ Frequent Cough
- ❑ Heart Disease
- ❑ High Blood Pressure
- ❑ Kidney Disease
- ❑ Lung Disease
- ❑ Other Allergies
- ❑ Radiation Treatment
- ❑ Sinus Problems
- ❑ Thyroid Disease
- ❑ Ulcers

Do you take antibiotic premedication for your dental visits? If yes, please explain:

Please flip over and continue checking boxes

- ❑ Hospitalized within last 2 years (illness or injury)
- ❑ Presently being treated for any other disease
- ❑ Taking medication for weight control (i.e. fen-phen)
- ❑ Taking dietary supplements
- ❑ Subject to frequent headaches
- ❑ A smoker or smoked previously
- ❑ History of snoring/sleep apnea
- ❑ FEMALES: Taking birth control pills
- ❑ FEMALES: Hormone Replacement Therapy
- ❑ FEMALES: Pregnant/Nursing

If any conditions or alerts selected above need further clarification, please describe below:

What is your estimate of your general health?

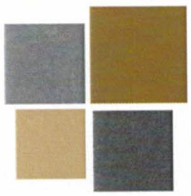
❑ Excellent ❑ Good ❑ Fair ❑ Poor

Name of your physician, phone number and your most recent physical exam:

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment:

List all medication (prescription and over the counter), including regular dosages of aspirin:

❑ By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes.



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DENTAL INFORMATION

Patient Name: _____
Birth Date: _____

How would you rate the condition of your mouth?

❑ Excellent ❑ Good ❑ Fair ❑ Poor

What is your immediate concern?

Personal History. Check all that apply:

- ❑ Had an unfavorable dental experience
- ❑ Had trouble getting numb
- ❑ Had/Have braces, orthodontic treatment
- ❑ Had any teeth removed
- ❑ Had complications from past dental work
- ❑ Had any reactions to local anesthetic
- ❑ Had your bite adjusted

Smile Characteristics. Check all that apply:

- ❑ Is there anything about the appearance of your teeth you would like to change?
- ❑ Have you ever whitened your teeth?
- ❑ Have you felt uncomfortable or self-conscious about the appearance of your teeth?
- ❑ Have you been disappointed with the appearance of previous dental work?

Bite and Jaw Joint. Check all that apply:

- ❑ You have problems with your jaw joint.
- ❑ You have problems chewing.
- ❑ Your teeth changed in the last 5 years, become shorter, thinner, or worn.
- ❑ Your teeth are crowding or developing spaces.
- ❑ You chew ice, bite your nails, use your teeth to hold objects, or have other oral habits.
- ❑ You clench your teeth in the daytime or make them sore.
- ❑ You have problems with sleep or wake up with an awareness of your teeth.
- ❑ You wear or have worn a bite appliance.

Please flip over and continue checking boxes

Tooth structure. Check all that apply:

- ❑ The amount of saliva in your mouth seems too little or you have difficulty swallowing.
- ❑ Any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth.
- ❑ Grooves or notches on your teeth, chipped teeth, or had a toothache or cracked filling.
- ❑ Food gets caught between any teeth.

Gum and Bone. Check all that apply:

- ❑ Gums bleed when brushing or flossing.
- ❑ Treated for gum disease or were told you have lost bone around your teeth.
- ❑ Noticed an unpleasant taste or odor in your mouth.
- ❑ History of periodontal disease in your family.
- ❑ Experienced gum recession.
- ❑ Had any teeth become loose on their own (without injury) or have difficulty chewing.
- ❑ Experienced a burning sensation in your mouth.

If any of the checked boxes need further explanation, please describe:

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Financial Policy

As validated by my signature on the bottom of this form, I understand and agree that:

All patient balances are due immediately after treatment is rendered. Please ask us if you are interested in learning about third party financing, which may allow you to finance your treatment in low monthly payments.

Should a balance accrue on the account a statement will be sent and payment is to be made, in full, by the date on the statement. If payment is not paid within 30 days interest may be applied to the entire account balance. A revised statement with the new account balance, payable immediately, will be sent.

A returned check fee may also be applied and must be payable from you for each check payment returned to us by your bank.

Dental insurance is a contract between the patient, their employer (if applicable) and the insurance provider. Submitting claims for payment to the insurance provider is a courtesy provided by the dentist, not an obligation. Ultimately, I am responsible for any treatment that is unpaid by the insurance provider.

If there is dental insurance on the account, I understand that the clinic has established the patient balance based on the information I have provided. Final treatment payment is subject to the terms and conditions of my insurance provider on the date of service. As such, until payment is received from my insurance provider, no patient payment is final.

Estimates and treatment plans are based upon information gained from the examination. As with any dental treatment, there may be unforeseen treatment adjustments and/or complications. This is a preliminary estimate only and lab charges (if applicable) have been estimated and included total.

Estimates do not take into consideration any money that was billed toward my financial maximum or treatment limits that may have been used at other dental clinics.

A submission to my insurance provider will be sent to determine an approximate final investment. However, it is an estimate only. Final insurance splits may be adjusted upon receiving the predeterminations. Predeterminations from my insurance provider(s) are NOT a guarantee of payment.

As with any dental treatment, there may be unforeseen treatment adjustments and/or complications. The clinic will make an effort to anticipate any changes in the treatment plan and advise me at that time. However, such events are unpredictable. Likewise, the timing or spacing of appointments may need to be modified as needed to accomplish the best result possible.

The clinic will make every effort to accommodate my scheduling needs.

I have read, understand and agree to the above financial policy for payment of professional fees. I understand that I am ultimately responsible for all fees for services rendered to me and/or my family.

Signature of Responsible Party: _____ Date: _____

CARING MODERN DENTISTRY

JOE ADAMS, DDS & ASSOCIATES

Office Policies

Our goal is to provide high quality care to our patients and respect their schedule as well. In fairness to other patients, and the office staff, we require advanced notice when changing or cancelling an appointment.

When you schedule an appointment, we reserve that time and prepare in anticipation of serving you. If you should need to reschedule, we kindly request that you contact us with advanced notice. We understand that conflicts arise; however failing your appointment or canceling without adequate notice more than once may result in a charge.

Patients who continue to no-show and/or cancel without notice may be dismissed from the practice and asked to find another dentist.

Any patient who is late may be considered a "no show" for their appointment and may need to be rescheduled.

As with any dental treatment, there may be unforeseen treatment adjustments and/or complications. The clinic will make an effort to anticipate any changes in the treatment plan and advise me at that time. However, such events are unpredictable. Likewise, the timing or spacing of appointments may need to be modified as needed to accomplish the best result possible.

I have read, understand and agree to the above appointment policy.

Patient/Responsible Party Signature: _____ Date: _____

Please flip over and continue

CARING MODERN DENTISTRY
JOE ADAMS, DDS & ASSOCIATES

Authorizations

Patient Name: _____

Caring Modern Dentistry is authorized to release health information about the above named patient in the following manner and to the selected person (s).

Send emails to address: _____

About my: (check all that apply) ☐ Medical Information ☐ Financial Information ☐ Appointment Reminders

Send texts to number: _____

About my: (check all that apply) ☐ Medical Information ☐ Financial Information ☐ Appointment Reminders

Leave voicemails at number: _____

About my: (check all that apply) ☐ Medical Information ☐ Financial Information ☐ Appointment Reminders

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You may discuss information about me with: _____

Relationship: _____

About my: (check all that apply) ☐ Medical Information ☐ Financial Information ☐ Appointment Reminders

You may discuss information about me with: _____

Relationship: _____

About my: (check all that apply) ☐ Medical Information ☐ Financial Information ☐ Appointment Reminders

For email and/or text communications, I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communications as selected above.

☐ I agree

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 disclosed as a result of this authorization may be subject to re-disclosure 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 my treatment will not be conditioned on signing.

THIS AUTHORIZATION WILL REMAIN IN EFFECT UNTIL REVOKED BY THE PATIENT.

Patient Signature (Please click SIGN HERE) _____

Date: _____

JOE ADAMS, DDS
CARING MODERN DENTISTRY
1109 SOUTH PARK DRIVE • REIDSVILLE, NC 27320
(336) 342-0889 • WWW.DRJOEADAMS.COM

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED BY CARING MODERN DENTISTRY AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

YOUR RIGHTS: When it comes to your health information you have certain rights. This section explains your rights.

Upon written request:

- Ask to see or get an electronic or a paper copy of your health record or other information we have about you. We will also provide a summary of your health information if requested. We will charge a reasonable, cost based fee. We will provide this information as soon as possible but no later than 30 working days of the request.
- Ask us to correct your health information you think is incorrect or incomplete. We may say "no" but will tell you why in writing within 60 days.
- You can ask us to communicate with you in a certain way (for example, home or office phone) or to send mail to a different address. We will accommodate all reasonable requests.
- Ask us not to use or share certain health information for treatment, payment or our operations. We are not required to agree with your request and may say "no" if it would affect your care.
- If you pay for a service or health care item out of pocket in full and you ask us not to share that information for payment or our operations with your health insurer we will agree unless we are required by law to share that information.
- Ask us for a list or an accounting of the times we have shared your health information for reasons other than treatment, payment, healthcare operations, and when you have asked us to share information. We will provide a list for the past six years for the request. One request per year will be provided free of charge. For additional requests we will charge a reasonable, cost based fee.
- Revoke an authorization to use or disclose PHI at any time except where action has already been taken.

You may also:

- Choose someone to act on your behalf. If you have given someone medical power of attorney or they are your legal guardian, that person can exercise your rights and make choices about your health information. We will ask for proof of this relationship before we take any action.
- Ask for a paper copy of this document even if you have agreed to receive the notice electronically. We will provide that copy promptly.
- File a complaint. If you feel your rights have been violated you may contact the designated Privacy Officer, [Practice officer, address, phone number and email address]
- File a complaint with the US Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Ave, S.W., Washington, D.C. 20201, calling 1.877.696.6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints.
- We will not retaliate for filing a complaint.

OUR RESPONSIBILITIES: The law requires us to:

- Maintain the privacy and security of your protected health information.
- Notify you promptly if a breach occurs that may compromise the privacy or security of your information.
- Follow the duties and privacy practices described in this notice and give you a copy of it.
- Not to use or share you information other what is described in this notice unless you tell us we can in writing. If you tell us we can and then change your mind, just let us know in writing you have changed your mind.

YOUR CHOICES - For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in situations described below, talk to us.

- In these cases you have both the right and the choice to tell us to: share information with your family, close friends, or others involved in your care and share information in a disaster relief situation.

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

- In these cases we never share your information unless you give us written permission:
  - Marketing purposes
  - Sale of your information
  - Most sharing of psychotherapy notes
  - In the case of fundraising, we may contact you for fundraising efforts, but you can tell us not to contact you again.

OUR USES AND DISCLOSURE – We typically use or share your health information in the following ways:

Treatment: We can use your health information and share it with other professionals who are treating you. Example: we may share your health information to an outside doctor for referral. We will also provide your health care providers with copies of various reports to assist them in your treatment.

Payment: We can use or share your health information to bill and get payment from health plans or other entities. Example: we give information about you to your health insurance plan so it will pay for your healthcare.

Health Care Operations: We can use and share your health information to run our practice, improve your care, and contact you when necessary. Example: we use health information about you to manage your treatment and services.

Other ways we can use or share your health information – We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

- **Help with public health and safety issues:** We can share health information about you for certain situations such as: preventing disease, helping with product recalls, reporting adverse reactions to medication, reporting suspected abuse, neglect, or domestic violence, and preventing or reducing a serious threat to anyone's health and safety.
- **Comply with the law**: We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see if we are complying with federal privacy law.
- **Respond to organ and tissue donation requests:** We will share health information about you with organ procurement organizations.
- **Work with a medical examiner or funeral director:** We can share health information with a coroner, medical examiner, or funeral director when you die.
- **Address workers' compensation, law enforcement, and other government requests:**
  - For workers' compensation claims
  - For law enforcement purposes or with a law enforcement official
  - With health oversight agencies for activities authorized by law
  - For special government functions such as military, national security, and presidential protective services
- **Respond to lawsuits and legal actions:** We can share your health information to respond to a court or administrative order, or in response to a subpoena.
- **Research:** We can use or share your information for health research.

CHANGES TO THIS NOTICE - We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office and on our website.

Patient/Responsible Party Signature: _____

Patient Name: _____ Date: _____

Privacy Officer: Brittany Knight
Email Address: brittany@caringmoderndentistry.com
Phone Number: (336) 342-0889

Effective date: 4/14/2003

Revision Date: 3/30/2022