We would like to welcome you to our practice and strive to make your visit to our office as efficient as possible. Please review the following information regarding your dental care.

Hygiene Policy

Appointments for adults (18 years and older) will consist of a full mouth series of x-rays and a comprehensive exam (full mouth probing, education and examination by the doctor). If you have had x-rays within the past 3 years, please bring them with you. If you cannot obtain your x-rays, new ones will be taken. We cannot guarantee a cleaning on your initial visit because we do not know all patients' particular hygiene needs before their examination. We will be respectful of your time and work to take care of all dental needs in the allotted appointment time. Pediatric patients (under 18) will consist of a panoramic x-ray, bitewing x-rays, a cleaning and a comprehensive exam by the dentist.

Patient Responsibility

We ask that you complete all patient registration and health history forms prior to your schedule dental appointment. You may print and bring these completed forms with you at your first scheduled appointment. If you are unable to print or complete prior to your scheduled dental appointment, please arrive 10 – 15 minutes prior to your scheduled appointment to complete the registration paperwork.

Dental Insurance

We would be happy to file your dental insurance for all dental services as long as you provide the current dental insurance information and a copy of the dental insurance card. Without dental insurance information, payment in full will be required. If you have secondary dental insurance, you will be responsible for filing for reimbursement.

Payment Policy

We expect payment at the time of your appointment for your portion of the services performed, deductibles, and co-insurance.

For routine hygiene visits, our patient's with dental insurance will not have any out of pocket expense. We will accept the insurance payment as payment in full for routine hygiene visits.
For dental appointments other than routine hygiene appointments, we will provide an estimated insurance coverage and patient responsibility. You are responsible to pay this estimated portion at each dental appointment. Patients without dental insurance or filing their own insurance are required to pay balance in full at each appointment and will be provided an itemized statement.
For your convenience, we accept cash, check, Visa, MasterCard, Discover, American Express and Care Credit.

Cancellation/Emergency Policy

Please notify us as early as possible if you are unable to keep your dental appointment. An appointment fee of $55 for a hygiene visit and $100 for a doctor appointment may be charged for any appointments broken with less than 24 hour notice.

Permission for Diagnostic and Treatment Procedures

I authorize North Hills Dentistry to perform diagnostic and treatment procedures, which in their judgement may become necessary while at the office of North Hills Dentistry. If I require specialized and/or emergency care, I will be referred to the appropriate medical facility or professional. I understand that a person listed as my emergency contact will be notified if considered necessary by the professional staff of North Hills Dentistry.

Consent to the Use and Disclosure of Health Information for Treatment, Payment, and Healthcare Operations

I further understand that as part of my healthcare, the office of North Hills Dentistry originates and maintains health records, describing my health history, symptoms, examinations and test results, diagnoses, treatment, and any plans for future care treatment. I understand that information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and information to my bill
- A means by which a third party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

The notice of Health Information and Privacy Practices provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that North Hills Dentistry reserves the right to change this notice and practices and prior to implementation will post a copy of the revised notice. I understand I have the right to request restrictions as to healthcare operations and that North Hills Dentistry is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that North Hills Dentistry has already taken action in reliance thereon.

I fully understand and accept the terms of this consent.

Signature of patient or parent/guardian ____

Date ____________________

Dental Insurance

We have prepared this to help you better understand the complexities of dental insurance; we realize how confusing it can be. Dental insurance is different from medical insurance. Our administrative staff is trained to work with all insurance companies and will be happy to assist you in better understanding your dental benefits. Dental insurance is not designed to pay for all of your dental care. Most contracts have yearly limits, treatment limitations and/or various degrees of "co-payments"

Our fees are based on quality materials, time effort and skill required in providing your treatment needs. All levels of payment by insurance companies, including allowed fees, usual, customary, and reasonable (UCR) are governed by the premiums paid. They have nothing to do with the actual fee for the services rendered but strive to be aware of the usual and customary fees for our area. Our fees are based upon a combination of our costs, our time, and our consistent dedication to providing our patients with the highest quality of care. Thus, there is often a discrepancy between the amount covered under your policy's UCR schedule, and the actual cost of the procedure. The discrepancy is the patient's responsibility.

The treatment recommended by our practice is never based on what your insurance company will pay, as your oral health care and accompanying treatment should not be governed by your insurance company contract. We will submit claims for you electronically the day of the appointment to assist you in receiving the full benefit of your dental policy.

We cannot guarantee any estimated coverage by your dental insurance company. Thus, it should be understood that the dental insurance contract is between the insurance company and the patient. If you are unclear as to whether a particular procedure is covered by your carrier, please request that we submit a pre-estimate for treatment to your dental insurance carrier prior to scheduling.

Please take time to review your insurance policy coverage thoroughly so that we may best serve you. As always, you may feel free to ask any member of our staff for clarification on services, billing and insurance.

Signature ____

Date ________________________

Financial Agreement

As a condition of your dental treatment in our office, financial arrangements must be made in advance. We request that each patient consider their financial obligation prior to their visit.

All dental services including emergency services must be paid at the time services are rendered.

Patients who carry dental insurance must understand that this practice will do our best in preparing your insurance forms or assist each patient in making collections from insurance companies on their behalf. However, the dental practice cannot render services on the assumption that our charges will be paid at 100% by your insurance company.

A service charge of 1.5% per month may be applied to an account with an unpaid balance over 90 days. Any unpaid accounts with balances past 90 days may so reported to a collection agency and/or an attorney in an attempt to collect the remaining payment. All late charges are the sole responsibility of the patient.

Patient must understand that the fee estimated listed is just an estimate. Treatment plans developed in this practice are subject to change depending on the specific dental condition.

- In consideration for the services rendered to me by the doctor, I agree to pay in full my estimated portion at the time of service. I also agree that I shall be responsible if the remaining balance exists once insurance has paid.
- I grant permission to you and your staff, to telephone me to discuss matter related to this form.
- If my account is turned over to collection agency/attorney, I agree to pay all collection costs and attorney fees for any suit instituted.
- I have read and fully understand the above conditions of treatment and agree to its content.

Signature ____

Date _________________________

Patient Demographics

Patient Name ____ Date __________________

Date of birth: _______________________ Home Ph # __________________ Cell # __________________

Address ____

City _______________________ State ____________ Zip __________________

E-mail _____________________________ Male Female SS # ___________________

I would like my reminders via: E-mail ☐ Text ☐ Both ☐ Patient is a minor: Yes No

Patient's or Parent's Employer: _______________________________ Work Phone _________________

Business Address: __________________________ City __________________ State ______ Zip _______

Spouse or Parent's Name/s: ____

Person to contact in case of emergency: _____________________________ Relationship: __________

Responsible Party

Name of person responsible for account: _____________________________ Relationship: __________

Address: ___________________________ City __________________ State ____________ Zip ________

Social Security # __________________________ Birthdate ___________________

Employer: ______________________________ Is this person currently a patient of our practice? _____

For your convenience, we offer the following methods of payment: Cash, Check, Visa, MasterCard, American Express, Discover and Care Credit.

Insurance Information

Name of Insured: ____ Relationship ________________

Social Security # __________________________ Birthdate ___________________

Name of Employer: ____________________________________ Work number ______________________

Insurance Company: _____________________________ Group # _______________ ID# _____________

Ins Co Address: _____________________________ City _____________ State ______ Zip ________

Today's Date: ____________________

North Hills Dentistry

B.P. ____________

Medical History

Patient Name: ____ Birth Date: ____________________

Although dental personnel primarily treat the area in and around your mouth, your 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 below**
Do you take or have you taken, Phen-Fen or Redux? ❍ Yes ❍ No ____________________
Are you on a special diet? ❍ Yes ❍ No ____________________
Do you use tobacco? ❍ Yes ❍ No ____________________
Do you use controlled substances? ❍ Yes ❍ No ____________________

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 yes, please explain: ____________________

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

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

Have you ever had any serious illness not listed above? ❍ Yes ❍ No If yes, please explain: ____________________

If you have checked "yes" for artificial joint, which joint/date of surgery: ____________________

Have you ever used smokeless tobacco products? ____________________

Are you/have you ever taken fosamax/boniva (bisphosponate meds) for bone health? ____________________

Do you suffer from dry mouth? ____________________

Are there any recent sores or growths in your mouth? ____________________

Medications List - Please include prescribed and over the counter

____

____

____

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 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: ____________________

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for North Hills Dentistry to use and disclose protected health information (PHI) about me and to carry out treatment, and payment operations. North Hills Dentistry Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have the right to review and receive the Notice of Privacy Practices prior to signing this consent. North Hills Dentistry reserves the right to revise its Notice of Privacy Practices anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to North Hills Dentistry, Attention: Privacy Officer at 3803 Computer Drive, Ste 101, Raleigh NC 27609.

With this consent, North Hills Dentistry may call my home or other alternative locations and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO (Treatment, Payment and Healthcare Operations) such as appointment reminders, insurance items and any calls pertaining to my clinical care.

With this consent, North Hills Dentistry may mail to my home or other alternative location any items that assist the practice in carrying out TPO.

However, the practice is not required to agree to my requested restrictions, but, if it does, it is bound by this agreement.

By signing this form, I am consenting to North Hills Dentistry's use and disclosure of my PHI to carry out TPO.

I may revoke by consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, North Hills Dentistry may decline to provide treatment to me.

____

Printed Patient's Name or Legal Guardian

____ ________________________

Signature of Patient or Legal Guardian Date