LEESVILLE Dental Care

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Today's Date: _____

Last Name: _____ First (Legal) Name: _____ Middle Initial: _____

Preferred Name: _____ Preferred Method of Contact: ○ Email ○ Phone ○ Text

Address (NO PO BOX): _____

City: _____ State: _____ Zip: _____

Mailing Address (if different from above): _____

Date of Birth: _____ Age: _____ Social Security #: _____

Email Address: _____

Home Phone #: _____ Cell #: _____

How did you hear about us? _____ Referred By: _____

Sex: ○ Male ○ Female Driver's License #: _____ State Issued: _____

Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Employer Name: _____ Work Phone #: _____ Ext: _____

Employer (Work) Address: _____

RESPONSIBLE PARTY INFORMATION

Relationship to Patient: ○ Parent ○ Spouse ○ Self ○ Other Sex: ○ Male ○ Female

Last Name: _____ First (Legal) Name: _____ Middle Initial: _____

Address (NO PO BOX): _____

City: _____ State: _____ Zip: _____

Best Contact Phone #: _____ Social Security #: _____

Date of Birth: _____ Email Address: _____

PRIMARY INSURANCE INFORMATION

Name of Insured (Policy Holder): _____ Insured's Date of Birth: _____

Insured's Social Security #: _____ Employer Name: _____

Patient's Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Insurance Company: _____ Phone #: _____

Claims Mailing Address: _____

Subscriber/Member/ID #: _____ Group #: _____

Time 11:25 AM

Justin M. Russo, DDS, PLLC

Date 12/30/2015

Eaglesoft Medical History

Patient Name: Birth Date: Date Created:

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
Have you ever been hospitalized or had a major operation?	○ Yes ○ No	If yes
Have you ever had a serious head or neck injury?	○ Yes ○ No	If yes
Are you taking any medications, pills, or drugs?	○ Yes ○ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	○ Yes ○ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	○ Yes ○ No	If yes
Are you on a special diet?	○ Yes ○ No	
Do you use tobacco?	○ Yes ○ No	

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other? ☐ If yes

Do you use controlled substances? ○ Yes ○ No If yes

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

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

Have you ever had any serious illness not listed ○ Yes ○ No If yes

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 patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X

Date:_____

Justin M. Russo, DDS, PLLC

Patient Dental History

What is the main reason for your visit today?

Cleaning _____ Tooth Pain _____ Sensitivity _____ Whitening _____

Fresher Breath _____ Implants _____ Dentures _____

Other/Comments:

_____

_____

When was your last dental cleaning? _____

Do you like the appearance of your smile? Yes _____ No _____

What changes (if any) would you like to make about your teeth?

_____

How often do you brush your teeth? _____

Do you floss your teeth? Yes _____ No _____ How often? _____

Do you have bleeding gums? Yes _____ No _____

Do you find yourself clenching or grinding your teeth? Yes _____ No _____

Have you ever had gum treatments, deep cleanings or scaling and root planing? Yes ___ No ___

What is your main concern with dental treatment?

Cost _____ Location _____ Comfort _____ Quality of Treatment _____

Practice Staff _____ Office Cleanliness _____ Other: _____

Revised 8/5/2015

JUSTIN M. RUSSO DDS, PLLC
13220 STRICKLAND ROAD, SUITE 166
RALEIGH, NC 27613
(919) 890-5147

I, _____, consent to be a patient at the above named office and agree to a radiographic and clinical examination. **I also understand and consent to the following:**

1. During the course of treatment, I may undergo procedures in all phases of dentistry including periodontics (gum treatment and surgery), oral surgery, endodontics (root canals), fixed and removable prosthodontics (crowns, bridges, and dentures), implant dentistry, restorative dentistry, temporomandibular disorder treatment, sleep apnea treatment, oral pathology, pediatric dentistry, and radiography.

2. I will provide a thorough and complete medical history, supply a full list of my medications with dosages, and consent to my dentist communicating with my other medical practitioners to inquire about any aspect of my health history.

3. No guarantees can be made about treatment outcomes, restoration longevity, or prognoses. I understand that any branch of medicine, including dentistry, can involve unanticipated results.

4. I will pay in full any cost of treatment or insurance copayments according to the office's financial policy. I understand that even if an insurance preestimate is given or a procedure has been preapproved, I am responsible for *any* costs that my insurance does not cover.

5. My treatment plan may change at any time and I will do my best to approach my dental care with optimism and open communication with my dentist, hygienist, and dental office staff.

6. I am welcome to ask questions about any aspects of my dental care and will request information if I am confused or need more information. I am responsible for clarifying any aspects of my treatment that I am unsure about.

_____ _____

Patient or Guardian Name Date

Justin M. Russo, DDS, PLLC Financial Policy

In our practice, our foremost concern is patient care. We strongly believe that financial concerns should not be an obstacle to obtaining dental services necessary to restoring and/or preserving good oral health. We are sensitive to the fact that our patients have different needs in fulfilling their financial obligations.

PAYMENT & FEES

- **WE ACCEPT: Cash, Cashier's Checks, Money Orders, Visa, M/C, Discover & American Express.** If you do not have dental insurance, or if you choose to file claims for treatment yourself, you must pay 100% of the charges at the time services are rendered.

- **PAYMENT PLANS**: If you should need a payment plan, our practice accepts **Care Credit,** which offers monthly payment plans, often at 0% interest, upon application approval. We will be happy to assist you with the application process and answer any questions you may have.

- **APPOINTMENTS:** Appointment times are **reserved for you**. Please arrive on time so that we may provide the attentive service you deserve. *If you are more than 10 minutes late, we may have to reschedule in order to have enough time for your treatment.*

- **BROKEN APPOINTMENTS:** Appointments that are cancelled or rescheduled without 48 hour notice or scheduled appointments that you do not keep ('no show') will be charged a fee of $50.00. *This fee is subject to change at the practice's discretion.*

- **DELINQUENT ACCOUNTS:** Accounts over 90 days are subject to interest at 3% per month.

- **RETURNED CHECKS:** Will be assessed a $50.00 fee plus any other fees incurred by our financial institution.

***Patient/Guardian Initial here** _____

Revised 7/22/2015

FINANCIAL OBLIGATIONS RELATED TO PATIENTS WITH INSURANCE

Dental insurance is designed to pay ***a portion of the costs*** associated with dental care. If you have dental benefits, you are fortunate that a portion of the costs associated with dental care MAY be covered. We file insurance claims as a courtesy to our patients. While we do our best to verify coverage for all services rendered, **YOU AS THE POLICY HOLDER ARE ULTIMATELY FINANCIALLY RESPONSIBLE FOR UNDERSTANDING THE BENEFITS AND LIMITATIONS OF YOUR COVERAGE.**

Because plans differ in coverage, **please check with your employer and/or the insurance company regarding the specifics of YOUR benefits**. Most insurance companies have strict limitations related to the timing and frequency of covered procedures, so we encourage you to educate yourself as much as possible on this subject.

****YOU ARE RESPONSIBLE FOR ANY/ALL SERVICES NOT COVERED BY YOUR INSURANCE,** including but not limited to co-payments, deductibles, and non-covered services. In cases where non-covered services are rendered, you are responsible to pay 100% of these charges at the time services are rendered. Any treatment fees quoted to you during a visit are **ONLY AN ESTIMATE** of what is reported to us by your dental carrier, which is **NOT A GUARANTEE OF PAYMENT ON THE SERVICE/PROCEDURE**. You will receive a statement for any remaining amount owed once the claim is processed. *If your insurance has not paid the balance due after 60 days from the date of service, you are responsible for that amount.* After 90 days, a finance charge may be added or the account may be turned over to a collection agency.

We are considered ***OUT OF NETWORK*** for all insurance companies **EXCEPT Aetna, Ameritas, Blue Cross/Blue Shield of NC, Cigna (Total Cigna DPPO), Delta Dental Premier, Guardian & MetLife Dental.**

***Patient/Guardian Initial here** _____

ACKNOWLEDGEMENT

I hereby acknowledge that I have read, understand, and agree to adhere to the practice's Financial Policy as outlined above. **Please note that whichever parent accompanies the minor patient to their appointment and signs the financial agreement will be considered the responsible party for the minor's account.*

Patient's signature _____

Guardian's signature (if patient is <18 yo) _____

Date _____

If you are representing a minor patient or are the parent, please complete the following:

Patient's Name _____

Relationship to Patient _____

Print Guardian's name _____

Revised 7/22/2015

Leesville Dental Care is proud of the quality of patient care we provide. We try our best to respect each patient's time and we ask the same in return. Because we will not compromise the service and quality of patient care, please read our policy below carefully.

CANCELLATION OF AN APPOINTMENT

In order to be respectful of other patient's needs, please be courteous and call our office promptly if you are unable to attend an appointment. This time will be given to someone who is in urgent need of treatment. **Any appointment(s) not cancelled 2 business days in advance is subject to a $50.00 cancellation fee.**

NO SHOW POLICY

A no show is an appointment that was not cancelled in advance. No shows inconvenience other patients who need dental care. **Therefore, if you no show for a scheduled appointment you will be charged a fee of $50.00 for every half hour of the scheduled appointment time.**

DEPOSITS REQUIRED FOR SCHEDULED SERVICES

Please be advised that a deposit is required for the procedures below. The deposit will be applied towards your out-of-pocket expense and reserves the date and time for your treatment.

Restoration appointments will require a $50.00 deposit
Services < $500.00 will require a $50.00 deposit
Services ranging $500.00 - $1000.00 will require a $100.00 deposit
Services > $1000 will require a $200.00 deposit

I have read and agree to this policy.

Patient Name_____

Patient/Guardian Signature _____ Date_____

Revised 8/4/2015

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

LEESVILLE DENTAL CARE

13220 Strickland Road, Suite 166 / Raleigh, NC 27613

Acknowledgement

- I, _____, hereby acknowledge that I have received and/or reviewed a copy of **Leesville Dental Care**'s *HIPAA Notice of Privacy Practices*.

I understand that **Leesville Dental Care**'s *HIPAA Notice of Privacy Practices* may change periodically and that I am entitled to receive a copy of **Leesville Dental Care**'s revised *HIPAA Notice of Privacy Practices* upon request. I understand that, if I have questions about **Leesville Dental Care**'s *HIPAA Notice of Privacy Practices*, I may contact:

Justin M. Russo, DDS, PLLC

13220 Strickland Rd, Suite 166

Raleigh, NC 27613

Phone: (919) 890-5147

Fax: (919) 890-5953

Email: frontdesk@leesvilledentalcare.com

I understand that it is my right to refuse to sign this Acknowledgement should I so choose, and that **Leesville Dental Care** will not refuse treatment to me if I refuse to sign this Acknowledgement.

I further understand that I may contact the Secretary of the U.S. Department of Health and Human Services should I have concerns regarding **Leesville Dental Care's** privacy policies and procedures. For information on how to contact the U.S. Department of Health and Human Services, please ask **Justin M. Russo, DDS, PLLC** noted above, for assistance.

_____ _____

Patient Signature Date

_____ _____

Signature of Parent / Guardian Print Name of Parent / Guardian

_____

Relationship to Patient

FOR OFFICE USE ONLY

Leesville Dental Care made a good-faith effort to obtain Acknowledgement, from the patient noted above, of receipt of its *HIPAA Notice of Privacy Practices*. In spite of these efforts, Leesville Dental Care was unable to obtain a signed Acknowledgement for the following reason(s):

- ☐ Refusal to sign Acknowledgement on _____, 20_____.
- ☐ Communication barriers prohibited us from obtaining a signed Acknowledgement.
- ☐ An emergency situation prohibited us from obtaining a signed Acknowledgement.
- ☐ Other (Describe):_____

Date Received	Received By	Patient ID