RUSSO DENTISTRY

Russo Dentistry
3811 Ed Dr STE 120, Raleigh, NC 27612
(919) 890 5147
russoddsraleigh.com/

NEW PATIENT FORM

Basic Information

Name:		Gender:	
Preferred Name:		DOB:	
SSN #:		Marital status:	
Referral source:			
Referred by:			

Contact Information

Mobile phone:	
Home phone:	
Email:	

Address Information

Street address:	
City:	
State:	
ZIP:	

Emergency Contact

Full Name:	
Phone number:	
Relation:	

Work Information

Street address:	
City:	
State:	
ZIP:	

Patient's signature:

Date:

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DENTAL INSURANCE INFORMATION

| DOB:

Created at: **07/20/2023 9:31:41 AM**

Primary Insurance Information

Do you have a dental insurance?	
Would you like to upload insurance card photo?	
Patient's relationship to the Insurance Holder	
Policy Holder's Name	
Policy Holder's Date of Birth	
Policy Holder's SSN	
Policy Holder's Address	
Policy Holder's City	
Policy Holder's State	
Policy Holder's ZIP	
Policy Holder's Phone Number	
Policy Holder's Employer	
Dental Insurance Company	
ID Number	
Group Number	
Phone number on the back of your insurance card	
Address on the back of your insurance card	

Secondary Insurance Information

Do you have a secondary dental insurance?	
That's all! If you would like to add secondary insurance, you need to provide primary insurance first.	
Would you like to upload insurance card photo?	
Patient's relationship to the Insurance Holder	
Policy Holder's Name	
Policy Holder's Date of Birth	
Policy Holder's SSN	
Policy Holder's Address	
Policy Holder's City	
Policy Holder's State	
Policy Holder's ZIP	
Policy Holder's Phone Number	
Policy Holder's Employer	
Dental Insurance Company	
ID Number	
Group Number	

Phone number on the back of your insurance card

Address on the back of your insurance card

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HEALTH HISTORY

| DOB:

Summary

Medical Conditions	**none listed**
Allergies	**none listed**
Medications	**none listed**

Medical History

General Health Information

Are you under a physician's care now?
Have you ever been hospitalized or had a major operation?
Have you ever had a serious head or neck injury?
Are you taking any medications, pills, or drugs?
Do you take, or have you taken, Phen-Fen or Redux?
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?
Are you on a special diet?
Do you use tobacco?
Do you use controlled substances?

Women are you:

Pregnant/Trying to get pregnant?
Taking oral contraceptives?
Breastfeeding?

Are you allergic to any of the following?

Aspirin
Penicillin
Codeine
Acrylic
Metal
Latex
Sulfa Drugs
Local Anesthetics
Other?

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

AIDS/HIV Positive
Alzheimer's Disease
Anaphylaxis
Anemia
Angina
Arthritis/Gout

Artificial Heart Valve
Artificial Joint
Asthma
Blood Disease
Blood Transfusion
Breathing Problems
Bruise Easily
Cancer
Chemotherapy
Chest Pains
Cold Sores/Fever Blisters
Congenital Heart Disorder
Convulsions
Cortisone Medicine
Diabetes
Drug Addiction
Easily Winded
Emphysema
Epilepsy or Seizures
Excessive Bleeding
Excessive Thirst
Fainting Spells/Dizziness
Frequent Cough
Frequent Diarrhea
Frequent Headaches
Genital Herpes
Glaucoma
Hay Fever
Heart Attack/Failure
Heart Murmur
Heart Pacemaker
Heart Trouble/Disease
Hemophilia
Hepatitis A
Hepatitis B or C
Herpes
High Blood Pressure
High Cholesterol
Hives or Rash
Hypoglycemia
Irregular Heartbeat
Kidney Problems

Leukemia
Liver Disease
Low Blood Pressure
Lung Disease
Mitral Valve Prolapse
Osteoporosis
Pain in Jaw Joints
Parathyroid Disease
Psychiatric Care
Radiation Treatments
Recent Weight Loss
Renal Dialysis
Rheumatic Fever
Rheumatism
Scarlet Fever
Shingles
Sickle Cell Disease
Sinus Trouble
Spina Bifida
Stomach/Intestinal Disease
Stroke
Swelling of Limbs
Thyroid Disease
Tonsillitis
Tuberculosis
Tumors or Growths
Ulcers
Venereal Disease
Yellow Jaundice
Have you ever had any serious illness not listed above?
Comments:

Patient's signature: Date:

Doctor's signature: Date:

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DENTAL HISTORY
| DOB:

General Information

Who was your previous Dentist and how long were you a patient there?

Date of your last dental exam

Date of your last cleaning

Do you have any immediate concerns you'd like us to address?

Office Relationship

What do you value most in your dental visits?

Is there anything you prefer during your visits to make you more comfortable during your time with us?

On a scale from 1-5, 5 being most terrified, are you fearful of dental treatment?

Personal History

Please answer the following questions

Are you concerned about the appearance of your teeth?

Are you interested in improving your smile?

Have you had any cavities within the past 2 years?

Are any teeth currently sensitive to biting, sweets, hot, or cold?

Do you avoid or have difficulty chewing or biting heavily any hard foods?

Do you have any problems sleeping, wake up with a headache or with sore or sensitive teeth?

Do you clench your teeth in the daytime?

Do you wear, or have you ever worn a bite appliance? Either for clenching at night (a night guard) or for sleep apnea?

Do you bite your nails, chew gum or on pens, hold nails with your teeth, or any other oral habits?

Does the amount of saliva in your mouth seem too little or do you find yourself with a dry mouth often?

Have you ever noticed a consistently unpleasant taste or odor in your mouth?

Dental Structural History

Please answer the following questions

Do your gums bleed when brushing or flossing?

Is brushing or flossing typically painful?

Have you ever experienced or been told you have gum recession?

Have you ever been treated for or been told you have gum disease?

Have you had any teeth removed for braces or otherwise?

Do you know of any missing teeth or teeth that have never developed?

Have you ever had braces, orthodontic treatment or spacers, or had a "bite adjustment?"

Are your teeth becoming more crowded, overlapped, or "crooked?"	
Are your teeth developing spaces?	
Do you frequently get food caught between any teeth?	
Have you noticed your teeth becoming shorter, thinner, or flatter over the years?	
Do you have problems with your jaw joint? (TMD, popping, clicking, deviating from side to side when opening or closing?)	
Is it often difficult to open wide?	
Do you have more than one bite? Or do you notice shifting your jaw around to make your teeth fit together?	

Patient's signature: Date:

Doctor's signature: Date:

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HIPAA – RELEASE OF INFORMATION AUTHORIZATION FORM

| DOB:

HIPAA - RELEASE OF INFORMATION AUTHORIZATION FORM

In compliance with federal and state law, the release of information for any person 18 years or older (including the information regarding a spouse or adult child), **must first be authorized**. Authorization includes the signature of the individual authorizing the release of their information. Information **will not be available** to anyone other than the covered patient (i.e. a member, a spouse, or any dependent age 18 or older) without first having this Release of Information Authorization on file. For example, if a subscriber calls about the status for a claim on a 19-year old dependent, that information will not be given to the subscriber without the written consent of the dependent. The same situation holds true for spouse-to-spouse information. However, parents do have a right to information on children under the age of 18 without the childs consent.

I want to provide the authorization	

Information Regarding Person Authorizing Releasing His/Her Information

Name of person authorizing release	
Date of Birth person authorizing release	
Personal Information to be released	
The above information may be released and/or received by	

The following is an authorization allowing Russo Dentistry to release information to whomever you designate. Russo Dentistry is authorized to make the disclosure of my benefits information, claim(s) status, claim(s) history, general claim information, dentist information, lab cases, and enrollment information, unless otherwise specified to the following individual(s) or organization(s):

Name of person/organization that the office may release my information to	
Relation of person/organization that the office may release information to	
Phone number of person/organization that the office may release information to	
I want to add a second person/organization	
Name of person/organization that the office may release my information to	
Relation of person/organization that the office may release information to	
Phone number of person/organization that the office may release information to	
I want to add a third person/organization	
Name of person/organization that the office may release my information to	
Relation of person/organization that the office may release information to	
Phone number of person/organization that the office may release information to	
I want this consent to	

AUTHORIZATION CONSENT

I understand that consent may be revoked by me at any time in writing. I understand why I have been asked to disclose this information and am aware that my patient rights are identified in the practices Notice of Privacy Practices.

Patient's signature: Date:

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FINANCIAL POLICY

FINANCIAL POLICY

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy which we require that you read and sign prior to any treatment. We strongly believe that financial concerns should not be an obstacle to obtaining dental services necessary to restoring and/or preserving good oral health.

PAYMENTS & FEES

FULL PAYMENT is due at the time of service. If insurance benefits apply, ESTIMATED PATIENT CO-PAYMENTS and DEDUCTIBLES are due at the time of service, unless other arrangements are made.

WE ACCEPT: Cash, Cashier's Checks, Money Orders, Visa, Master Card, Discover and American Express.

PAYMENT PLANS: Our practice currently accepts/offers Care Credit, Greensky and Lending Club which offer monthly payments plans, promotional interest-free programs, based upon application approval. We will be happy to assist you with the application process and answer any questions you may have.

UNPAID BALANCE *over **60 days old** will be subject to a monthly interest of **1.0% (APR 12%).** If payment is delinquent, the patient will be responsible for payment of collection, attorneys fees, and court costs associated with the recovery of the monies due on the account.*

RETURNED CHECKS will be assessed at $75.00 fee plus any other fees incurred by our financial institution.

MISSED 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 you treatment and may be subject to a broken appointment fee. Appointments that are cancelled short notice or rescheduled with **less than a 2 business days in advance**, will be charged **$150.00** or up to **30%** of the total scheduled treatment cost, whichever is greater. All scheduled appointments require a credit card on file and will be charged in accordance to the above fees. This fee is subject change at the practice's discretion. Please help us maintain the highest quality of care by keeping scheduled appointments.

INSURANCE

Dental "insurance" differs from that of medical insurance. Please remember your insurance policy is a contract/agreement between you, your employer and your insurance carrier. We are not a party to that contract. We file insurance claims as a Courtesy to our patients. While we do our **BEST** to verify coverage for all services rendered it is physically impossible for us to have the knowledge and keep track of every aspect of your insurance. As a courtesy to you, our office provides certain services, including a pre-treatment estimate which we send to the insurance company at your request. It is up to you, the patient, to contact your insurance company and inquire as to what benefits your employer has purchased for you.

Because plans differ in coverage, please check with your insurance company regarding the specifics of **YOUR** benefits prior to your dental treatment to minimize any confusion on your behalf. Most insurance companies have strict limitations related to the timing and frequency of covered procedures. Insurance benefits, frequency limitations and remaining maximums and deductibles are the patient's responsibility.

Please be advised that **YOU ARE RESPONSIBLE FOR ANY AND ALL SERVICES NOT COVERED BY YOUR INSURANCE,** including but not limited to co-payments, deductible, 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.** If your insurance pays and there is an outstanding balance on the account the credit card we have on file will be charged for that remaining balance. If your insurance pays more than we estimated and you have a credit, we will refund the credit card you have on file.

ACKNOWLEDGEMENT

I hereby acknowledge that I have read, understand, and agree to adhere to the practice's Financial Policy as outline 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.

I have read, understand and agree to the terms and conditions of this Financial Agreement.

Patient's signature: Date:

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COMMUNICATION CONSENTS

EMAIL CONSENT FORM

PURPOSE: This form is used to obtain your consent to communicate with you by email regarding your Protected Health Information. Russo Dentistry offers patients the opportunity to communicate by email. Transmitting patient information by email has a number of risks that patients should consider before granting consent to use email for these purposes. Russo Dentistry will use reasonable means to protect the security and confidentiality of email information sent and received. However, Russo Dentistry cannot guarantee the security and confidentiality of email communication and will not be liable for inadvertent disclosure of confidential information.

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with communication of email between Russo Dentistry and myself, and consent to the conditions outlined herein. Any questions I may have, been answered by Russo Dentistry.

Patient's signature: Date:

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CARD AUTHORIZATION FORM

| DOB:

CREDIT CARD AUTHORIZATION FORM

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until canceled.

Card Type	
Cardholder Name	
Card Number	
CVV Code	
Expiration Date	
Cardholder ZIP Code	

CREDIT CARD AUTHORIZATION FORM

I authorize Russo Dentistry to charge my card above for agreed upon charges as stated in Russo Dentistry's Financial Policy, specifically cancellation and no show policies. I understand that my information will be saved to file for future transactions on my account.

Patient's signature: Date:

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PRIVACY POLICY CONSENT

CLIENT RIGHTS AND HIPAA AUTHORIZATIONS

The following specifies your rights about this authorization under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time (HIPAA).

1. Tell your provider if you do not understand this authorization, and the provider will explain it to you.

2. You have the right to revoke or cancel this authorization at any time, except: (a) to the extent information has already been shared based on this authorization; or (b) this authorization was obtained as a condition of obtaining insurance coverage. To revoke or cancel this authorization, you must submit your request in writing to the provider at the following address: 3811 Ed Dr STE 120, Raleigh, NC 27612:

3. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment, payment, enrollment or your eligibility for benefits. However, you may be required to complete this authorization form before receiving treatment if you have authorized your provider to disclose information about you to a third party. If you refuse to sign this authorization, and you have authorized your provider to disclose information about you to a third party, your provider has the right to decide not to treat you or accept you as a patient in their practice.

4. Once the information about you leaves this office according to the terms of this authorization, this office has no control over how it will be used by the recipient. You need to be aware that at that point your information may no longer be protected by HIPAA. If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations.

5. You may inspect or copy the protected dental information to be used or disclosed under this authorization. You do not have the right of access to the following protected dental information: psychotherapy notes, information compiled for legal proceedings, laboratory results to which the Clinical Laboratory Improvement Act (CLIA) prohibits access or information held by certain research laboratories. In addition, our provider may deny access if the provider reasonably believes access could cause harm to you or another individual. If access is denied, you may request to have a licensed health care professional for a second opinion at your expense.

6. If this office initiated this authorization, you must receive a copy of the signed authorization.

7. Special Instructions for completing this authorization for the use and disclosure of Psychotherapy Notes. HIPAA provides special protections to certain medical records known as Psychotherapy Notes. All Psychotherapy Notes recorded on any medium by a mental health professional (such as a psychologist or psychiatrist) must be kept by the author and filed separately from the rest of the clients medical records to maintain a higher standard of protection. Psychotherapy Notes are defined under HIPAA as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint or family counseling session and that are separate from the rest of the individuals medical records. Excluded from the Psychotherapy Notes definition are the following: (a) medication prescription and

monitoring, (b) counseling session start and stop times, (c) the modalities and frequencies of treatment furnished, (d) the results of clinical tests, and (e) any summary of diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date. Except for limited circumstances set forth in HIPAA, in order for a medical provider to release Psychotherapy Notes to a third party, the client who is the subject of the Psychotherapy Notes must sign this authorization to specifically allow for the release of Psychotherapy Notes. Such authorization must be separate from an authorization to release other dental records.

8. You have a right to an accounting of the disclosures of your protected dental information by the provider or its business associates. The maximum disclosure accounting period is the six years immediately preceding the accounting request. The provider is not required to provide an accounting for disclosures: (a) for treatment, payment, or dental care operations; (b) to you or your personal representative; (c) for notification of or to persons involved in an individuals dental care or payment for dental care, for disaster relief, or for facility directories; (d) pursuant to an authorization; (e) of a limited data set; (f) for national security or intelligence purposes; (g) to correctional institutions or law enforcement officials for certain purposes regarding inmates or individuals in lawful custody; or (h) incident to otherwise permitted or required uses or disclosures. Accounting for disclosures to dental oversight agencies and law enforcement officials must be temporarily suspended on their written representation that an accounting would likely impede their activities.

Patient's signature: Date:

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TEXT MESSAGE TO MOBILE CONSENT FORM

PURPOSE: This form is used to obtain your consent to communicate with you by mobile text messaging regarding your Protected Health Information. Russo Dentistry, offers patients the opportunity to communicate by mobile text messaging. Transmitting patient information by mobile text messaging has a number of risks that patients should consider before granting consent to use mobile text messaging for these purposes. Russo Dentistry will use reasonable means to protect the security and confidentiality of mobile text messaging information sent and received. However, Russo Dentistry cannot guarantee the security and confidentiality of mobile text messaging communication and will not be liable for inadvertent disclosure of confidential information.

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of mobile text messaging between Russo Dentistry and myself, and consent to the conditions outlined herein. Any questions I may have, been answered by Russo Dentistry.

Patient's signature: Date:

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HIPAA – RELEASE OF INFORMATION AUTHORIZATION FORM

| DOB:

HIPAA - RELEASE OF INFORMATION AUTHORIZATION FORM

In compliance with federal and state law, the release of information for any person 18 years or older (including the information regarding a spouse or adult child), **must first be authorized**. Authorization includes the signature of the individual authorizing the release of their information. Information **will not be available** to anyone other than the covered patient (i.e. a member, a spouse, or any dependent age 18 or older) without first having this Release of Information Authorization on file. For example, if a subscriber calls about the status for a claim on a 19-year old dependent, that information will not be given to the subscriber without the written consent of the dependent. The same situation holds true for spouse-to-spouse information. However, parents do have a right to information on children under the age of 18 without the childs consent.

I want to provide the authorization

Information Regarding Person Authorizing Releasing His/Her Information

Name of person authorizing release

Date of Birth person authorizing release

Personal Information to be released

The above information may be released and/or received by

The following is an authorization allowing Russo Dentistry to release information to whomever you designate. Russo Dentistry is authorized to make the disclosure of my benefits information, claim(s) status, claim(s) history, general claim information, dentist information, lab cases, and enrollment information, unless otherwise specified to the following individual(s) or organization(s):

Name of person/organization that the office may release my information to

Relation of person/organization that the office may release information to

Phone number of person/organization that the office may release information to

I want to add a second person/organization

Name of person/organization that the office may release my information to

Relation of person/organization that the office may release information to

Phone number of person/organization that the office may release information to

I want to add a third person/organization

Name of person/organization that the office may release my information to

Relation of person/organization that the office may release information to

Phone number of person/organization that the office may release information to

I want this consent to

AUTHORIZATION CONSENT

I understand that consent may be revoked by me at any time in writing. I understand why I have been asked to disclose this information and am aware that my patient rights are identified in the practices Notice of Privacy Practices.

Patient's signature: Date: