NORTH ASHEVILLE FAMILY DENTISTRY

674 Merrimon Ave. Suite 230 Asheville, NC 28804

To serve you properly, we request the following information. All information will be strictly confidential.

1 PATIENT INFORMATION

NAME: _____ BIRTHDATE: _____

ADDRESS: _____
STREET ADDRESS, CITY, STATE, AND

HOME PHONE: _____ CELL: _____ EMAIL: _____

GENDER: FEMALE MALE SOCIAL SECURITY #: _____

MARITAL STATUS: M S D W SPOUSE OR PARENT NAME: _____

EMERGENCY CONTACT: _____ PHONE: _____

THEIR RELATIONSHIP TO YOU: _____

2 DENTAL INSURANCE INFORMATION (*in lieu of filling out this section, provide us a copy of your insurance card*)

NAME OF INSURED: _____ INSURED BIRTHDATE: _____

RELATIONSHIP TO YOU: _____ INSURED SOC. SEC. #: _____

INSURANCE COMPANY: _____ NAME OF EMPLOYER: _____

POLICY/ID #: _____ GROUP #:_____

INS. COMPANY ADDRESS: _____ PHONE #: _____

DO YOU HAVE SECONDARY DENTAL INSURANCE? Y N

I authorize the release of any information, including diagnosis and the records of any treatment or examination rendered to me, my child or ward, during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I understand and agree that I am responsible for payment for all services rendered on my behalf or my dependents. This authorization shall remain valid and effective for two years from the date of signing.

SIGNATURE: _____ DATE: _____
PATIENT OR RESPONSIBLE PARTY SIGNATURE

3 RESPONSIBLE PARTY (if someone other than yourself)

****IMPORTANT:** All patients under the age of 18 must be accompanied by a parent or guardian. Parent/Guardian is required to stay in the office for the duration of the minor's appointment. **

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT: _____

RELATIONSHIP TO PATIENT: _____ PHONE #: _____

ADDRESS OF RESPONSIBLE PARTY: _____
STREET ADDRESS, CITY, STATE, AND

IS THIS PERSON CURRENTLY A PATIENT OF OUR OFFICE? Y N

4 DENTAL HISTORY QUESTIONAIRE

When was your last professional dental cleaning? _____ Were dental radiographs taken? ☐ Yes ☐ No
How many times a day do you brush? _____ How many times a week do you floss? _____
Please list any additional hygiene products you use regularly (mouth rinse, tongue scraper, ect.) _____
Have you ever been told that you have a gum or periodontal problems? ☐Yes ☐ No If yes, please explain:_____
_____
Do you have any sores or growths in or around your mouth? ☐Yes ☐ No If yes, please explain:_____
Do you clench your teeth? ☐ Yes ☐ No Do you grind your teeth? ☐ Yes ☐ No
Do you have pain in your jaw joints (TMJ)? ☐ Yes ☐ No Do you suffer from dry mouth? ☐ Yes ☐ No
Have you ever worn any type of appliance or night guard? ☐ Yes ☐ No
Do you experience excessive snoring or sleep apnea? ☐Yes ☐ No
Describe any difficulties you may experience when chewing: _____
Do you feel nervous about having dental treatment? ☐ Yes ☐ No
Have you ever bleached your teeth? ☐Yes ☐ No Are you interested in doing so? ☐ Yes ☐ No
Are you happy with your smile? ☐Yes ☐ No If no, please describe why: _____

ACKOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

A copy of this policy is kept at our front desk. If the policy isn't readily available, please ask our front desk team for a copy for you to review. If you would like your own paper copy please request a copy with the front desk team.

Your signature below indicates that you have received a copy of North Asheville Family Dentistry's Notice of Privacy Practices.

_____ _____
Patient Name (Printed) Date of Birth

_____ _____
Patient or Legally Authorized Individual (Signature) Today's Date

VERBAL COMMUNICATION RELEASE

Many times, our patients may want us to verbally communicate with a friend or family member about scheduled appointments, treatment, and finances. Please list below any friends or family members whom you authorize us to discuss your dental care or financial information with. I understand that North Asheville Family Dentistry is not responsible for the information provided as long as it is given to a person that is listed below.

Date of Birth must be provided so that our office can verify that we are speaking to the correct person.

☐ I do not authorize North Asheville Family Dentistry to release any of my protected medical information to anyone other than the entities that are discussed in the Notice of Privacy Practices.

_____ _____ _____
Name (Printed) Date of Birth Relationship

_____ _____ _____
Name (Printed) Date of Birth Relationship

_____ _____
Patient or Legally Authorized Individual (Signature) **Date**

NORTH ASHEVILLE FAMILY DENTISTRY- Office Policies

Part of our mission at the office of North Asheville Family Dentistry is to provide you with cost effective, state-of-the-art dental care. It is our goal to assist you in obtaining and maintaining the highest level of personal dental health available today. In order to maintain an enduring partnership between our patient and practice, we have developed the following policies to serve as an agreement between the responsible party and our practice. We want you to have the smile you desire and deserve!

--- Payments & Insurance:

- For your convenience, we accept Cash, Check, Visa, Mastercard, Discover, American Express and CareCredit. We now offer online payments by visiting our website: www.northashevillefamilydentistry.com
- Patient is responsible to notify us of any dental insurance plan changes and to present dental insurance card when those changes occur. North Asheville Family Dentistry will make every reasonable effort to obtain payment from patient's insurance company. If the insurance carrier rejects a claim, denies payment or a portion of payment, patient/guardian is responsible for the charges.
- Payment for all treatment and services rendered are the patients/guardian's responsibility. Your estimated copayment for treatment, which is the amount not covered by your insurance, is due at the time treatment is rendered. Your estimated copayment may be adjusted after the time of treatment depending upon the final reconciliation of insurance payments.
- If your account is 90 days or more delinquent a 25% finance charge will be applied to the account and if you have not contacted our office about payment the account will be turned over to an outside collection's agency. Once the account has been turned over to collections, all future appointments for patient and patient's family linked to the account will be canceled and dismissed from the practice. We expect patients to make payments in a timely manner.
- If there is a returned check, a 50.00 fee will be applied to patient's account. This fee may increase depending on the bank's fee. This fee will be added to the outstanding balance and may incur a finance charge if not paid within the 30-day grace period.

--- Cancellation Policy:

- In order to provide quality dental care in an effective manner, we ask that you give us 1-full business day notice of a cancellation. Cancellations with less than 1-full business day notice and no shows are subject to a 50.00 charge to one's account. Our office is closed every Friday. Appointments on Monday would need to be canceled on Thursday the previous week to avoid the cancellation fee. We understand that there are unavoidable situation and inconveniences in everyone's life, but patients will be dismissed from our office after three missed appointments (without proper notice).

--- Code of Conduct Policy:

- North Asheville Family Dentistry is committed to the safety of our patients, their families, and our staff. Any verbal abuse, threats, aggressive and destructive behavior will not be tolerated and patient and family members linked to the account will be dismissed from the practice. While we understand that disagreements may occur, these need to be resolved in a respectful and civilized manner.

--- Consent to Treatment:

- **I** authorize and give consent to Nhung Dao D.M.D and associate to perform dental services agreed upon between doctor and patient. I am responsible for informing the doctor about any changes about medical history prior to treatment. I understand that this medical information will be used as necessary for diagnosis and treatment. Patient's medical power of attorney is responsible for providing all documentation at patient's first dental visit or immediately after authorization is given.
- All patients under the age of 18 must be accompanied by a parent or guardian. Parent/Guardian/Power of Attorney are required to stay in the office for the duration of the dental appointment**.** If the patients Parent/Guardian/Power of Attorney does not accompany the patient to the appointment, the dental visit will have to be rescheduled after the 50.00 cancellation fee is paid.

I have read the policy's above and I understand and accept my responsibilities as a patient in this office.

Patient Name: _____ Date of Birth:_____

Patient's Signature/Responsible Party: _____ Date: _____