Zen Triangle Dentistry 970 Northwoods Drive, Cary, NC 27513 (919) – 465 - 0799 Fax (919) - 465 - 0797

Patient Information

Last Name: ________________________ First Name: _____________________ Date: ___________________

Date of Birth _______________________ SS #: ___________________________ Gender: _________________

Home Address: ____

City: _________________________________ State: _________________________ Zip: _________________

Mobile #: _________________________ Home #: _____________________ Work #: ___________________

Email: ____

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐Another patient, relative

☐ Dental Office ☐ Google ☐ Insurance Website ☐ School ☐ Work ☐ Other__________________

Name of person or office referring you to our practice: ____

Responsible Party Same as above

Last Name: ___________________________________ First Name: ___________________________________

DOB: ____ SSN#: _______________________________________

Employer: ____________________________________ Work # _______________________________________

Insurance Information

Insurance Company: ____________________________ ID#: ____

Claims Address: ____

City: _________________________ State: ___________________________ Zip: _______________________

Phone: _________________________________ Group #: ____

Policy Holder: ______________________ DOB: _________________ Relationship to patient: _______________

GroupName/Employer: ____

Additional Insurance Information

Secondary Dental Plan: _________________________________ Group#: _______________________________

Policy Holder: ______________________________ ______________ DOB: ___________________________________

Group Name/Employer: ___________________ _____________ SSN: ____________________________________

Dental Health

What is your immediate concern?____

____

____

Have you ever had any of the following? Please check those that apply:

☐ AIDS
☐ Allergies
____
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Diabetes
☐ Dizziness
☐ Epilepsy

☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Growths
☐ Hay Fever
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis
☐ High Blood Pressure
☐ Jaundice
☐ Kidney Disease

☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Pacemaker
☐ Pregnancy
Due date: __________
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems

☐ Stomach Problems
☐ Stroke
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Venereal Disease
☐ Codeine Allergy
☐ Penicillin Allergy
OTHER:
☐
☐ ______________

Please select any of the following that apply to you:

Personal History

Are you fearful of dental treatment?
Have you had an unfavorable dental experience?
Have you ever had complications from past dental treatment?
Have you ever had trouble getting numb or had reactions to local anesthetic?
Did you ever have braces, orthodontic treatment or had your bite adjusted?
Have you had any teeth removed?

Gums & Bone

Do your gums bleed or are they painful when brushing or flossing?
Have you ever been treated for gum disease or been told you have lost bone around your teeth?
Have you ever noticed an unpleasant taste or odor in your mouth?
Is there anyone with a history of periodontal disease in your family?
Have you ever experienced gum recession?
Have you ever had any teeth become loose on their own (without injury)?
Have you experienced a burning sensation in your mouth?

Tooth Structure

Have you had any cavities within the past three years?
Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing food?
Do you feel or notice any holes on the biting surface of your teeth?
Are your teeth sensitive to hot, cold, biting, sweets or brushing?
Do you have grooves or notches on your teeth near the gum line?
Have you ever broken teeth, chipped teeth or had a toothache or cracked filling?
Do you frequently get food caught between any teeth?

Bite & Jaw Joint

Do you have any problems with your jaw joint? (pain, sounds, limited opening, locking, popping)
Do you feel like your lower jaw is being pushed back when you bite your teeth together?
Do you avoid or have difficulty chewing gum, carrots, nuts or other hard foods?
Have your teeth changed in the last 5 years, become shorter, thinner or worn?
Are your teeth crowding or developing spaces?
Do you have more than one bite and have to squeeze to make your teeth fit together?
Do you chew ice, bite your nails, use your teeth to hold objects or have any other oral habits?
Do you clench your teeth in the day time or make them sore?
Do you have any problems with sleep or wake up with an awareness of your teeth?
Do you wear or have you ever worn a bite appliance?

Smile Characteristics

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

Please use the space below to indicate any other problems, concerns or questions. We will make every effort to listen attentively to your concerns so that we can present you with the best possible treatment options.

____

____

____

Medical Health

Name of Physician: ____

Have you been under the care of a physician in the past 2 years? No Yes if yes, why?

____

____

Have you been treated in a hospital in the past 2 years? No Yes if yes, why?

____

____

Are you now or have you taken any prescription drugs during the past year? If so, please list.

____

____

Do you use tobacco products? ____

Have you ever been told that you need antibiotics prior to dental treatment? _________________________

Are you allergic or sensitive to any medication? ____

Do you have any diseases, conditions, or problems not previously listed?_________________________

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Have you recently used illegal drugs? No Yes If yes, please list: _____________________________

Financial Policy

At Zen Triangle Dentistry we want all of our clients to be able to comfortably afford dental care. We proudly offer the following financial policies so that our clients have the opportunity to decide which payment option is best for their needs.

Insurance: Your insurance is a contract between you, your employer, and your insurance company. Zen Triangle Dentistry will gladly work with you to help you get the maximum benefit available to you. Most insurance plans do not cover 100% of the treatment cost. Because of this, we ask that you pay your deductible as well as your ESTIMATE co-pay for the charges on the day services are rendered. We will estimate your coverage as closely as possible, but can make no guarantees as to what your insurance will pay. We understand that dental benefits are important to our clients. After all treatment, we will promptly file and follow up on your dental claims to ensure that your receive the correct maximum benefits. We offer several financial options for your portion of diagnosed treatment so that your care is not compromised due to financial concerns.

Payment Options

1. Cash or Check (There is a $35 fee for all returned checks)

2. MasterCard,Visa, Discover, or American Express

3. Care Credit: A convenient line of credit can be arranged, on approval, for your health care needs. Interest free plans are available.

Our Appointment Policy

Because we reserve time specifically for you, it is vital that we receive appropriate notice for cancellations. If you find that you are unable to keep an appointment, please call our office 24 hours in advance. Appointments not cancelled within 24 hours, or no-show appointments will be charged a $75 fee for doctor appointment and $35 for hygienist appointment. For larger, more extensive appointments, a 25% reservation fee will be collected at the time the appointment is reserved. This amount collected will be put towards your treatment balance. We understand that circumstances may arise when an appointment may need to be rescheduled. Please make all attempts to do so within 24 hours. Unfortunately, due to expenses we acquire in preparing for your larger cases, the 25% cannot be returned if the appointment has to be cancelled and not rescheduled.

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

________________________________ Date: ______________ Relationship to Patient: ______________
Signature of patient, parent or guardian

_________________________________Date: ______________ Relationship to Patient: ______________
Signature of guarantor of payment/responsible party

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HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

Date: __________________ The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original. **MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.**

________________________________ ________________________________

Please ***print*** name of Patient Please ***sign*** for Patient / Guardian of Patient

________________________________ ________________________________

Legal Representative / Guardian Relationship of Legal Representative / Guardian

Your comments regarding Acknowledgements or Consents:____

____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:¨

First Name Only Proper Sir Name Other ____________________________

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: ___________________________ Relationship: _______________________________

Name: ___________________________ Relationship: _______________________________

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

Cell Phone Confirmation Home Phone Confirmation Work Phone Confirmation
Text Message to my Cell Phone Email Confirmation **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

Cell Phone Confirmation Home Phone Confirmation Work Phone Confirmation
Text Message to my Cell Phone Email Confirmation **Any of the Above**

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment ____

I could not communicate with the patient ____

The patient refused to sign ____

The patient was unable to sign because Other (please describe) ____

____

Signature of Privacy Officer