PATIENT REGISTRATION

Date:_____

Patient (First and Last name): _____

Address: _____

City: _____ State:_____ Zip:_____

Home Phone: _____Work Phone_____ Cell Phone: _____

Sex: ○ Female ○ Male Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Birth date: _____Social Security #:_____Drivers Lic#:_____

E-mail: _____ □ I would like to receive email correspondences

Patient Information (section 2):

Employment Status: ○ Full Time ○ Part Time ○ Self Employed ○ Retired ○ Unemployed

Student Status: ○Full Time ○ Part Time

Preferred Dentist: _____Preferred Hygienist: _____

Referred By: _____

Responsible Party: (if someone other than the patient)

First Name: _____Last Name: _____Middle Initial: _____

Address: _____

City: _____ State:_____ Zip:_____

Home Phone: _____Work Phone: _____Cell Phone: _____

Birth date: _____Social Security #:_____Drivers Lic#:_____

○ Responsible Party is Policy Holder for Patient ○ Primary Policy Holder ○ Secondary Policy Holder

Primary Insurance Information:

Name of Insured: _____Relationship to Insured: ○Self ○Spouse ○Child ○Other

Employer ID: _____ Group ID: _____

Insured Social Security #:_____Insured Birth date: _____

Employer: _____Insurance Company: _____

Address: _____

City, State, Zip: _____

Emergency Contact

Patient (First and Last name): _____

Home Phone: _____Work Phone_____ Cell Phone: _____

Email Address: _____

Carolina Bright Smiles DENTISTRY

Assignment of Benefits Form and Authorizations

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits: I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), private insurance and any other health/medical plan, to issue payment check(s) directly to

Carolina Bright Smiles

For Medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance or the agreed amount for services rendered.

Authorization to Release Information I hereby authorize:

Carolina Bright Smiles

To: (1) release any information necessary to insurance carriers regarding my illness and treatments;

(2) Process insurance claims generated in the course of examination or treatment; and

(3) Allow a photocopy of my signature to be used to process insurance claims for the period of lifetime.

This order will remain in effect until revoked by me in writing. I have requested medical services from:

Carolina Bright Smiles

On behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I understand that Carolina Bright Smiles is **in network** with **Delta Dental** and **Blue Cross Blue shield**. We will file other insurances except for Medicaid and Medicare as a complimentary service for our patients. Our insurance coordinator will be more than happy to assist you in understanding the limitations of your dental insurance plan. However we do not have a contract with your insurance company, only you do. We can only assist you in estimation your portion of the cost of treatment. After 60 days the patient is responsible for any balance on their account that insurance has not covered. I hereby affirm that any payment made to me by my Insurance Carrier will be immediately transferred to

Carolina Bright Smiles

Upon receipt for services rendered.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement EOB or Check.

A photocopy of this assignment is to be considered as valid as the original.

Patient/Responsible Party Signature / Date: _____

Witness Signature / Date: _____

Cancellation and or Broken Appointments

- I understand that the practice requires at least a **24 hour notice** to cancel or reschedule an appointment and that I may be charged a fee for a broken appointment.
- I understand that I will be charge a fee of $25 for a cancelled or broken dental cleaning appointment.
- I understand to schedule any treatment needs 1/3 of my out of pocket will be collected when scheduling.
- I understand answering service messages after 4:00pm the day before will not be considered 24 hour notice.
- I understand that not giving at least 24 hour notice on multiple occasions could result in my dismissal from the practice, in which the office will offer you emergency services only for the next 30 days while you seek a new dental practice.
- I understand that Carolina Bright Smiles is ONLY **in network** with **Delta Dental** and **Blue Cross Blue shield**. We will file other insurances **except** for Medicaid and Medicare as a complimentary service for our patients.

Patient Name (Please Print): _____

Signature: _____

Date: _____

Notice of Privacy Practices
Acknowledgement of Receipt

Patient Information:_____ **DOB:** _____

_____

_____

I have received a copy of the Notice of Privacy Practices for the above named practice.

_____ _____

Signature Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- ❑ An emergency existed & a signature was not possible at the time.
- ❑ The individual refused to sign.
- ❑ A copy was mailed with a request for a signature by return mail.
- ❑ Unable to communicate with the patient for the following reason:
  _____
- ❑ Other:_____
  _____

Prepared By _____

Signature _____

Date _____

Compound Authorization for Release of Information (HIPAA)

Name of Patient: _____

Date of Birth: _____/_____/_____

The purpose of this authorization is to inform the patient or others with pertinent patient information. The patient has requested that Carolina Bright Smiles is to release the following information about the above named patient to the entities named below:

Entity to Receive Information. Check each person/entity that you approve to receive information.	**Description of information to be released.** Check each that can be given to person/entity on the left in the same section.
❑ Voice Mail	❑ Results of lab tests/x-rays ❑ Other_____
❑ Give information to employer ❑ Give information to school	❑ Appointment absentee information
❑ Spouse (provide name) _____	❑ Family billing information ❑ Financial ❑ Dental/Medical as follows:_____
❑ Parent (provide name)_____	❑ Family Billing Information ❑ Financial ❑ Dental/Medical as follows:_____
❑ Other (provide name) _____ _____	❑ Financial ❑ Dental/Medical as follows _____
❑ Support Group (provide name)_____	❑ Demographic Information

Right of the Patient: I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to Carolina Bright Smiles. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward. I understand that information used or disclosed as result of this authorization may be subject to re- disclosure by the recipient and may no longer be protected by federal or state law. I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

_____

Signature of Patient or Legal Representative

_____ Date_____

Description of Legal Representative Authority (provide supporting documentation)

Carolina Bright Smiles DENTISTRY

Dental Questionnaire

Carolina Bright Smiles would like to help each patient reach their dental goals. Please take a few moments and provide us the following valuable information:

Name: _____

I entered this practice to obtain:

(Please check all that apply)
____ **Comprehensive Exam** of my entire mouth and a consultation concerning my treatment options.
____ **Smile Design Consultation** to learn more about my cosmetic treatment options.
____ **Emergency Exam** for a specific area of concern. **Are you in pain?** ____Yes ____ No
Please describe:
____ **2nd opinion** concerning treatment options presented elsewhere.
____ **Other:** Please explain:

What are your present dental concerns?

I would rate the value I place on my oral health as: _____Very Important to me
_____ Moderately important to me
_____ Very low importance to me

I would rate the condition of my teeth and gums: _____ Very good
_____ Good
_____ Acceptable
_____ In need of treatment
_____ In need of extensive treatment

I would rate my previous dental experiences and quality of care: _____Exceptional
_____Above average
_____Average
_____Below average
_____Poor

Date of last dental visit: _____
On that visit I had: _____ Routine Cleaning
_____ X-Rays
_____ Restorative Care
_____ Emergency Care

I have avoided dental care in the past: _____ Yes _____ No If yes, Why?
I have concerns in pursuing future dental treatment: _____ Yes _____ No
My concerns are:
_____ I am fearful of dental treatment. Please explain:
_____ Financial
_____ Scheduling concerns. Please explain:
_____ Other:

I consider my smile: _____Very appealing
_____ Nice
_____ Acceptable to me
_____ In need of improvement

I experience the following with my teeth/mouth:
(Please check all that apply)
_____ Tenderness when chewing
_____ Food caught between teeth
_____ Loose teeth
_____ Recurring sore in or around mouth
_____ Bleeding sore gums
_____ Jaw aches/feels tired/soreness
_____ Clenching/grinding problem
_____ Jaw clicking/popping
_____ Floss breaking-Explain where:
_____ Bad breath, unpleasant taste

What are your dental expectations?

603 HAMPTON POINTE BLVD SUITE 1
HILLSBOROUGH, NC 27278
FRONTDESK@CAROLINABRIGHTSMILES.COM
(919)644-7400

Dental Record Release

Patient Information:

Name: _____

Date of Birth: _____

Address: _____

Phone: _____

Covered Entity to release or receive information (circle one):

Name: _____

Phone: _____

Email: _____

The patient has requested that the following Protected Health Information is to be released for treatment purposes:

- ☐ Recent X-rays/Panoramic Films
- ☐ Clinical Notes
- ☐ Other
- ☐ Periodontal Charting
- ☐ Complete Record

Patient Rights:

I understand that this authorization may be revoked at any time by giving written notice to the releasing covered entity. I understand that once my dental records have been released, the covered entity cannot revoke the information that has already been disclosed but no further releases will occur.

I understand that I may refuse to sign this Authorization; and that my refusal to sign in no way affects my treatment, payment, enrollment, in a health plan, or eligibility for benefits.

I understand that the information disclosed from this dental record release may be subject to re-disclosure by the recipient for treatment, payment or operational purposes and the releasing covered entity has no control over the use and disclosure of the information.

I understand that his dental record release shall remain in effect until the information has been received by the requesting covered entity.

_____

Signature of Patient or Legal Representative Date

_____

Print Name of Patient or Legal Representative Date

_____

Description of Legal Representative Authority (provide supporting documentation) Date

We at Carolina Bright Smiles use reasonable means to protect the security and confidentiality of emails sent and received, but we cannot guarantee the security and confidentiality of all email communication.