Carolina Lakes Family Dental
Laurence R. Mester, Jr. DDS & Associates, PA
468 NC Hwy 24-87
Cameron, NC 28326
Phone: (919) 498-0575

Account #: _____
Today's Date: _____

PATIENT INFORMATION

Name: Birth date: Social Security #

Address: City: State: Zip Code:

Home Phone: ( ) Work Phone: ( ) Cell Phone: ( ) Sex: M □ F □

Employer: Employer Phone: ( )

Email: Spouse or Parent's Name: Phone: ( )

Who to contact in case of emergency Phone: ( )

How did you hear about us?

RESPONSIBLE PARTY

Name of Person: Relation to Patient:

Address: City: State: Zip Code:

Birth date: Social Security # Email:

Employer: Work Phone#: ( )

PRIMARY DENTAL INSURANCE INFORMATION

Name of Insured: Relation to Patient:

Birth date: Social Security #

Employer: Insurance Company:

ID #: Group #: Ins. Phone #:

ADDITIONAL DENTAL INFORMATION

Name of Insured: Relation to Patient:

Birth date: Social Security #

Employer: Insurance Company:

ID #: Group #: Ins. Phone #:

For the following questions, please (X) whichever applies, your answers are for our records only and will be kept confidential in accordance with applicable laws. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

DENTAL INFORMATION

Reason for Today's Visit_____ Former Dentist_____
Date of Last Dental Exam_____ Date of Last Dental X-Rays_____
Former Dentist Contact Information_____
Please (X) a response to indicate if you have or have not had problems with any of the following:

Yes/No	Yes/No	Yes/No
□ □ Bad Breath	□ □ Grinding or Clenching	□ □ Biting Pain
□ □ Bleeding Gums	□ □ Loose or Broken Teeth	□ □ Mouth Sores or Ulcers
□ □ Clicking or Popping	□ □ Bone Loss	□ □ History of Oral Trauma
□ □ Food Impaction	□ □ Sensitivity_____	___ Dental Anxiety (scale 1-10)

□ □ Have you had a serious/difficult problem associated with any previous dental treatment? If yes, explain:
_____

MEDICAL INFORMATION

Are you in good health?_____
Has there been any change in your general health within the past year?_____
Have you had any serious illness, operation, or been hospitalized in the past 5 years? _____
If yes, what was the illness or problem?_____
_____
_____
_____
Date of Last Physicial Exam: _____
Physician Name: _____
Phone: _____
Address: _____
Have you ever taken any drug for cancer treatment or osteoporosis? (Examples are Fosamax, Actonel, Boniva, Zometa)_____
Currently Taking/How long? _____
Do you smoke or use tobacco products? _____
How Long? _____
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?
_____
If yes, what antibiotic and dose? _____
Physician Name _____
Phone: _____

ALLERGIES

Are you allergic to or have you had a reaction to?
Yes/ No

- □ □ Local Anesthetics
- □ □ Aspirin
- □ □ Penicillin or other antibiotics
- □ □ Sulfa drugs
- □ □ Codeine or other narcotics
- □ □ Latex
- □ □ Metals

Other _____

WOMEN ONLY

Are you pregnant or nursing?_____
Are you taking birth control pills or hormonal replacement?
_____

Please (X) a response to indicate if you have or have not had any of the following diseases or problems.

Yes/No	Yes/No	Yes/No
□ □ Abnormal Bleeding	□ □ Diabetes	□ □ Pacemaker/Heart Surgery
□ □ Anemia	□ □ Epilepsy/Seizures	□ □ Psychiatric Disorders
□ □ Arthritis, Rheumatism	□ □ Fainting	□ □ Radiation Treatment
□ □ Artifical Heart Valves	□ □ Glaucoma	□ □ Respiratory Disease
□ □ Artifical Joints	□ □ Headaches	□ □ Rheumatic Fever
□ □ Asthma	□ □ Heart Murmur	□ □ Shortness of Breath
□ □ Autoimmune Disorder	□ □ Heart Problems	□ □ Stroke
□ □ Back Problems	□ □ Hepatitis A/B/C/D	□ □ Swollen Feet or Ankles
□ □ Blood Disease	□ □ High Blood Pressure	□ □ Thyroid Problems
□ □ Cancer	□ □ HIV/AIDS	□ □ Tuberculosis
□ □ Chemotherapy	□ □ Kidney Disease	□ □ Ulcer/Colitis
□ □ Circulatory Problems	□ □ Liver Disease	□ □ Venereal Disease/STDs
□ □ Cough, Persistent	□ □ Mitral Valve Prolapse	

MEDICATIONS

List medications you are currently taking: (include OTCs, herbals):

AUTHORIZATION AND RELEASE

I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

SIGNATURE OF PATIENT/LEGAL GUARDIAN DATE

Patient Financial Responsibility Form

As your family dentist, our staff works as a team to provide you with the best possible care as well as old-fashioned courtesy and compassion. We are committed to do this at an affordable cost. In order to achieve these goals, we need your assistance and your understanding of our financial policy.

1. **Payment Due.** Payment is due at the time services are rendered. We welcome cash, checks, Carecredit, Citi HeathCard, MasterCard and Visa. Each returned check will be subject to a $25 fee.
2. **Dental Insurance**. If you have a dental insurance, we will be glad to file claims and accept payments directly from your insurance company. While we file insurance claims as a courtesy to our patients, please understand that:
    a. Your insurance is a contract between you and your insurance company. As a dentist, we are not a part of that contract and we have no control over what insurance would pay and what your copayment would be. We will make every effort to help you achieve maximum-allowed-benefits under your plan. However, your cooperation is needed to facilitate the claim process and there is no guarantee that your insurance company would pay as expected.
    b. Insurance benefits and coverage may vary from time to time. Not all services are covered benefits. Some insurance companies may arbitrarily select certain services they will not cover or downgrade them to low-cost alternatives. Since your insurance company may pay all, some, or none of your bill, you are ultimately responsible for the balance. If your insurance does not make payment within 30 days, you will be billed for the unpaid balance.
3. **Payment Estimates.** To improve the collection process, our office will estimate your copayment when the service is rendered. However, please keep in mind that this is only an estimate. For an insured patient, your final copayment is based on the Explanation of Benefits (EOB) sent from your insurance company. For a self-pay patient, your copayment is based on our Office Fee Schedule. Should there be any difference between our estimate and the actual copayment due, you will receive a statement from us in 30 days requesting paid-in-full.
4. **Treatment Plans.** After your visit at our office**,** we will provide you with a copy of your treatment plans, which lists the dental work recommended by your dentist along with the estimated cost. Please understand that the treatment plan is an estimate only and it is time-sensitive. The cost information contained in the treatment plan may not be accurate and is subject to change over time with or without notice. The procedures we perform may also change during the treatment with or without notice due to circumstances.
5. **Broken Appointment Fee.** There is a $25 charge for each broken appointment cancelled without 48 hours (2 business days) advance notice. The office reserves the rights to dismiss patients who repeatedly break their appointments.
6. **Deposits.** There are a $50-$100 deposit required for large procedures such as Root Canals, Crowns, Bridges, Wisdom Teeth Extractions and Implants. The deposit is collected at the time of making the appointment and will be applied toward your copayment. Should you cancel the appointment without 48 hours (2 business days) notice, the deposit is non-refundable regardless of the reason.
7. **No Refund.** Medical conditions, remaining tooth structure, density of bones, infection, sensitivity, gum disease or accidents are among many critical factors that affect the success rate of a dental procedure. In addition, the patient's general health, good oral hygiene, regular dental checkups, diet, and allergy can all play an important role. Because of this, no guarantees can be made or assumed to be made about the longevity and success rate of any dental procedures. No refund will be rendered for services that have been performed.
8. **Account Balance.** Balances older than 30 days will be subject to an interest charge of 1 ½ % per month and additional collection charges. We reserve the right to send the overdue accounts to collection agencies and pursue all available legal remedies to satisfy the unpaid balance including but not limited to credit bureau reporting and court proceedings.

We realize that dental treatment can be costly and temporary financial problems may occur that affect the payment of your account. If such problems do arise, please don't ignore the bills that you can't pay. Instead, contact us promptly for assistance in the management of your account. If you have any questions about the above information or any uncertainty regarding insurance coverage, please don't hesitate to ask us. We are here to help you!

I hereby authorize Laurence R. Mester, Jr. DDS & Associates, P.A. to submit claims and assign benefits, on my behalf to

_____ Insurance Company.

I have read and understand the above.

Signed: _____ Date: _____

(Patient / Legal Guardian)

Carolina Lakes Family Dental

Acknowledgement of Receipt Of Notice of Privacy Practices

Patient Name & Address: _____
_____
_____

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 _____ _____

Authorization for Release of Information – Compound Release

Name of Patient _____ Date of Birth _____

_____ is authorized to release protected health information about the above named patient in the following manner and to persons listed.

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_____
❑ Spouse (provide name and phone number) _____	❑ Financial ❑ Medical
❑ Parent (provide name and phone number) _____	❑ Financial ❑ Medical
❑ Email communication-Provide email address* _____ *In order for email communication to occur, please accept the disclosure below:	❑ Financial ❑ Medical ❑ Appointment reminders ❑ Breach notification
❑ For **email communication** I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to move forward to allow email communications to occur.	

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

The information is released at the patient's request and this authorization will remain in effect until revoked by the patient.

_____Date _____

Signature of Patient or Personal Representative

*Description of Personal Representative's Authority (attach necessary documentation)