ALL FAMILY
DENTISTRY

PATIENT INFORMATION

Date _____

Name _____ Birthdate _____

Address _____ City _____ State _____ Zip _____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Patient's or Parent's Employer _____ Work Phone (___) _____

Patient's Social Security # _____ Insured or Resp. Party's SS # _____

Spouse or Parent's Name _____ Employer _____ Work Phone (___) _____

If Patient is a Student, Name of School/College _____ City/State _____

How did you hear about our office? _____

Person to Contact in Case of Emergency _____ Phone (___) _____

CONTACT INFORMATION

Home Phone (___) _____ Work Phone (___) _____

Cell Phone (___) _____ E-Mail Address _____

RESPONSIBLE PARTY (if patient is a minor)

Name of Person Responsible for this Account _____ Relation to Patient _____

Address _____ Home Phone (___) _____

Driver's License # _____ Birthdate _____

Employer _____ Work Phone (___) _____

Currently a Patient in our Office? ☐ Yes ☐ No

INSURANCE INFORMATION

Name of Insured _____ Relation to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Employer _____ Work Phone (___) _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Union or Local # _____

Phone # _____

ADDITIONAL INSURANCE

Name of Insured _____ Relation to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Employer _____ Work Phone (___) _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Union or Local # _____

Phone # _____

OVER

DENTAL HISTORY

Reason for today's visit _____ Date of last dental visit _____

Former Dentist _____ Date of last dental X-rays _____

Address _____

Check (✓) if you have had any of the following:

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Clicking or popping jaw
- ☐ Food collection between the teeth
- ☐ Grinding teeth
- ☐ Loose teeth or broken fillings
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to heat
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores or growths in your mouth

How often do you floss? _____ How often do you brush? _____

MEDICAL HISTORY

Physician's Name _____ Date of last visit _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Have you had any serious illnesses or operations? ☐ Yes ☐ No If yes, describe _____

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates _____

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Check (✓) if you have had any of the following:

- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Cortisone Treatments
- ☐ Cough, Persistent
- ☐ Cough up Blood
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV / AIDS
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Skin Rash
- ☐ Stroke
- ☐ Swelling of Feet or Ankles
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease

Medications:

List medications you are currently taking and the correlating diagnosis: _____

_____

_____

Allergies:

_____

_____

_____

_____

AUTHORIZATION AND RELEASE

I have read and answered the above questions to the best of my knowledge. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all insurance submissions.

_____ _____

Signature of patient or parent if minor Date

Payment is due in full at time of treatment unless prior arrangements have been approved.

ALL FAMILY
DENTISTRY

Financial Policies

Thank you for choosing us as your dental provider. We are committed to providing you with the best dental care and appreciate your decision to be a part of our family practice. We are looking forward to forming a lasting relationship with you and would like to tell you about our office policies.

1. **Payment Options:** Payment is expected at the time of service. We accept cash, check or credit card. There is a return check fee of $30 for any dishonored checks. A *5% discount* will be given to *senior citizens* who pay for their treatment at the time of service. We also offer different forms of *financing* and an *in-house dental plan*. Please ask for details.

2. **Insurance:** We participate in most dental insurance plans. We can estimate your out of pocket expenses and will require this amount to be paid at the time of the visit. **PLEASE NOTE**: We can only *estimate* the amount your insurance carrier may pay towards your services and cannot guarantee that any and/or all procedures will be covered. Final determination is made by your insurance carrier and we will bill you for any remaining balance after they have paid.

3. **Proof of insurance:** We must obtain a copy of a current valid insurance card to provide proof of insurance. If you fail to provide the correct insurance information in a timely manner, you may be responsible for the balance of the claim. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

4. **Claim Submissions:** We will submit your claims and assist you in any way we reasonably can to get your claims paid. Please be aware that the balance of you claim is your responsibility whether or not your insurance company pays your claim. If they have not paid within **60** days, the balance will be billed to you.

5. **Nonpayment:** Invoices shall be deemed to be accepted by you unless we are notified within **14** days of the invoice that you dispute it. Please be aware that if a balance remains unpaid past **90** days, we may refer your account to a Collection Agency authorized to credit report all debts to the four major National Credit Agencies. Any collection agency fees, attorney fees, and/or court costs, will be the responsibility of the undersigned.

We are happy to discuss your questions and concerns pertaining to our billing procedures. It is our practice to work with our patients in establishing mutually acceptable financial arrangements, if necessary. Thank you and once again welcome to our practice.

I have read and understand the payment policy and agree to abide by its guidelines.

Print Patient Name: _____ **Date:** _____

Patient Signature or Responsible Party (if minor): _____ **Date:** _____

ALL FAMILY
DENTISTRY

Office Policies

Signature on File

(For Patients with Dental Insurance, Only)

I, _____ (Patient), herby authorize _____ (Insurance Co. Name), to pay and hereby assign directly to Luz Chavez DDS and our Associate all dental benefits, if any, otherwise payable to me for services as described on the attached forms. I understand I am financially responsible for all charges incurred less any dental benefits when received by and paid to Luz Chavez DDS and our Associate Authorization is hereby given to release all information necessary to the payment of said benefits.

Patient Signature or Responsible Party (if minor): _____ **Date:** _____

Photo Consent

_____ **(Initials)** I authorize the use of my x-rays and/or photographs for educational and promotional use. Consent is voluntary.

Cancellation Policy

_____ **(Initials)** Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, All Family Dentistry reserves the right to charge a fee of $50.00 for all missed appointments which, absent a compelling reason, are not cancelled within 48-hour advance notice. We respect your time and set time aside especially to see you. We ask that you give us the same consideration.

Privacy Notice Policy

_____ I am allowing the staff of All Family Dentistry to talk to those listed below regarding my treatment or appointments. _____

_____ I **DO NOT** give permission for the staff of All Family Dentistry to talk to my spouse or other family members regarding my treatment or appointments.

I understand and direct that this authorization will remain in effect until it is revoked by me in writing.

Patient Signature or Responsible Party (if minor): _____ **Date:** _____

HIPAA

NOTICE OF PRIVACY PRACTICES FOR THE OFFICES OF:

ALL FAMILY DENTISTRY

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact

All Family Dentistry

Of our office at

9912 Monroe Rd.
Mathews NC 28105
Tel. (704) 847-0161
info@dentistmatthewsnc.com

WHO WILL FOLLOW THIS NOTICE

This notice describes the information privacy practices followed by our employees, staff and other office personnel. The practices described in this notice will also be followed by health care providers you consult with by telephone (when your regular health care provider from our office is not available) who provide "call coverage" for your health care provider.

YOUR HEALTH INFORMATION

This notice applies to the information and records we have about your health, health status, and the health care and services you receive at this office. We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment

We may use health information about you to provide you with medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, office staff or other personnel who are involved in taking care of you and your health.

For example, your doctor may be treating you for a heart condition and may need to know if you have other health problems that could complicate your treatment. The doctor may use your medical history to decide what treatment is best for you. The doctor may also tell another doctor about your condition so that doctor can help determine the most appropriate care for you.

Different personnel in our office may share information about you and disclose information to people who do not work in our office in order to coordinate your care, such as phoning in prescriptions to your pharmacy, scheduling lab work and ordering x-rays. Family members and other health care providers may be part of your medical care outside this office and may require information about you that we have.

For Payment

We may use and disclose health information about you so that the treatment and services you receive at this office may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about a service you received here so your health plan will pay us or reimburse you for the service. We may also tell your health plan about a treatment you are going to receive to obtain prior approval, or to determine whether your plan will cover the treatment.

For Health Care Operations

We may use and disclose health information about you in order to run the office and make sure that you and our other patients receive quality care. For example, we may use your health information to evaluate the performance of our staff in caring for you. We may also use health information about all or many of our patients to help us decide what additional services we should offer, how we can become more efficient, or whether certain new treatments are effective.

Appointment Reminders

We may contact you as a reminder that you have an appointment for treatment or medical care at the office.

Treatment Alternatives

We may tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Health-Related Products and Services

We may tell you about health-related products or services that may be of interest to you.

Please notify us if you do not wish to be contacted for appointment reminders, or if you do not wish to receive communications about treatment alternatives or health-related products and services. If you advise us in writing (at the address listed at the top of this Notice) that you do not wish to receive such communications, we will not use or disclose your information for these purposes.

SPECIAL SITUATIONS

We may use or disclose health information about you without your permission for the following purposes, subject to all applicable legal requirements and limitations:

To Avert a Serious Threat to Health or Safety

We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Required By Law

We will disclose health information about you when required to do so by federal, state or local law.

Research

We may use and disclose health information about you for research projects that are subject to a special approval process. We will ask you for your permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the office.

Organ and Tissue Donation

If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate such donation and transplantation.

Military, Veterans, National Security and Intelligence

If you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about you. We may also release information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation

We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks

We may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.

Health Oversight Activities

We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes

If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order.

Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.

Law Enforcement

We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.

Coroners, Medical Examiners and Funeral Directors

We may release health information to a coroner or medical examiner.

This may be necessary, for example, to identify a deceased person or determine the cause of death.

Information Not Personally Identifiable

We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.

Family and Friends

We may disclose health information about you to your family members or friends if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection.We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgment that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse when you bring your spouse with you into the exam room during treatment or while treatment is discussed.

OTHER USES AND DISCLOSURES OF HEALTH INFORMATION

We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written Authorization. If you give us Authorization to use or disclose health information about you, you may revoke that Authorization, in writing, at any time. If you revoke that Authorization, in writing, at any time. If you revoke your Authorization, we will no longer use or disclose information about you for the reasons covered by your written Authorization, but we cannot take back any uses or disclosures already made with your permission.

If we have HIV or substance abuse information about you, we cannot release that information without a special signed, written authorization from you that complies with the law governing HIV or substance abuse records.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the following rights regarding health information we maintain about you:

Right to Inspect and Copy

You have the right to inspect and copy your health information, such as medical and billing records, that we use to make decisions about your care. You must submit a written request to:

All Family Dentistry

Of our office at

9912 Monroe Rd.
Mathews NC 28105
Tel. (704) 847-0161
info@dentistmatthewsnc.com

in order to inspect and/or copy your health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other associated supplies. We may deny your request to inspect and/or copy in certain limited circumstances. If you are denied access to your health information, you may ask that the denial be reviewed. If such a review is required by law, we will select a licensed health care professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

Right to Amend

If you believe health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by this office.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

a) We did not create, unless the person or entity that created the information is no longer available to make the amendment.

b) Is not part of the health information that we keep.

c) You would not be permitted to inspect and copy.

d) Is accurate and complete.

Right to an Accounting of Disclosures

You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you for purposes other than treatment, payment and health care operations. To obtain this list, you must submit your request in writing to:

All Family Dentistry

Of our office at

9912 Monroe Rd.
Mathews NC 28105
Tel. (704) 847-0161
info@dentistmatthewsnc.com

It must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically). We may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions

You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

We are Not Required to Agree to Your Request

We may not (and are not required to) agree to your restrictions with one exception: If you pay in full (out of pocket) for a service you receive from us, and you request that we not submit the claim for this service to your health insurer or health plan for reimbursement, we must honor that request.

If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice

You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive it electronically, you are still entitled to a paper copy. To obtain such a copy, contact:

All Family Dentistry

CHANGES TO THIS NOTICE

We reserve the right to change this notice, and to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a summary of the current notice in the office with its effective date in the top right hand corner. You are entitled to a copy of the notice currently in effect.

To request restrictions, you may complete and submit a Request For Restricting Uses and Disclosures and Confidential Communications Form Information to:

All Family Dentistry

Right to Request Confidential Communications

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.
To request confidential communications, you may complete and submit the Requests For Restricting Uses and Disclosures and Confidential Communications to:

All Family Dentistry

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact:

All Family Dentistry

9912 Monroe Rd.
Mathews NC 28105
Tel. (704) 847-0161
info@dentistmatthewsnc.com

You will not be penalized for filing a complaint.

Signature _____