NIGHT & DAY DENTAL

WELCOME TO NIGHT AND DAY DENTAL. PLEASE SIGN WHERE INDICATED.

NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully. The privacy of your health information is important to us.

This notice describes how we may use and disclose your protected health information to provide treatment, obtain payment and conduct health care operations and for other purposes permitted or required by law. It also describes your rights concerning your protected health information. "Protected health information" is information about you, including demographic information that may identify you and relate to your past, present or future physical or mental health condition and related health care services.

We are required by law to follow the practices described in this notice. We may change the terms of this notice at any time. The new notice will be effective for all protected health information we maintain at that time, including health information we created or received before we made the changes.

You may obtain a copy of our notice of privacy practices at any time by calling our office or requesting one at your next appointment.

Uses and Disclosures of Health Information

Treatment: We will use and disclose your health information to provide, coordinate and manage health care and related services for you. For example, we will disclose information to a specialist to whom you have been referred to ensure the provider has enough information to diagnose and/or treat you. We may also disclose information to a laboratory that, at our request, becomes involved in your treatment.

Payment: We will use and disclose your information to obtain payment for services we provide for you. For example, we will send the necessary information to your health or dental insurance company to obtain payment for the treatment provided.

Healthcare Operations: We will use and disclose your health information to conduct business activities of this office. These activities include, but are not limited to, quality assessment and improvement activities, review of the performance and qualifications of employees, evaluating practitioner and provider performance, conducting training programs, accreditation, and certification, licensing or credentialing activities.

We may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call your name in the waiting room when we are ready to begin your treatment.

We will share your protected health information with business associates that perform specific functions for our practice, such as billing When a business arrangement of this type requires the use of your information, we will have a written contract with the third party to protect the privacy of your protected health information.

Others involved in your health care: We must disclose your health information to you as described in the Patient Rights section of this notice. We may disclose your health information to a family member or other person to the extent necessary to help with your health care or with payment for your health care, but only if you agree. If we determine it is in your best interest based on our professional judgement or experience with common practices, we may allow another person to pick up filled prescriptions, medical supplies, x-rays or other forms of health information.

We may use or disclose protected health information to notify or assist in notifying a family member, a personal representative or any other person responsible for your care of your location, your general condition or death. If you are present prior to the use or disclosure of your protected health information, we will provide you with the opportunity to object to such uses or disclosures. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family members or others involves in your health care.

Emergencies: In the event of your incapacity or in emergency circumstances, we may use or disclose your projected health information to treat you.

Uses and disclosures of protected health information based upon your written authorization: Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that an action has already been taken in reliance on the authorization.

Signature of Patient, Parent, or Guardian _____ **Date** _____

Welcome To Our Practice!

Our practice takes pride in our dentistry and in the relationships with our patients who believe in quality care. Cooperation is a key element to successful treatment. From the very first appointment, we try to establish open communication with all of our patients. The purpose is twofold: we understand you, as you have an understanding with us. Listed below are our office policies, which we believe will ensure this understanding.

Please read all accounts and feel free to discuss any questions with our office manager.

1. **If you are unable to keep your appointment, please call 24 hours in advance. After 3 broken appointments, we reserve the right to not reschedule you in the future.**
2. No food or drinks allowed in the office at any time.
3. To prevent interruption in patient care, we ask you to **please turn off cell phones in the treatment rooms.**
4. To ensure patient confidentiality, please remain seated in the treatment rooms during the appointment.
5. The use of profanity or loud and disruptive language will not be permitted within the confines of our building or on property.
6. If we believe a procedure needs to be re-done within the first year and is not related to any trauma, we will re-do that procedure at no cost to the patient or the patient's insurance.
7. We do not accept checks. Fees must be paid in cash or by credit card **at the time of service.**
8. Due to the nature of our business, we sometimes have emergencies that must be seen along with scheduled appointments. Therefore, patients are frequently called out of order. We appreciate your understanding in this matter.
9. If you have a Pregnancy Medicaid card, dentistry is not covered after you are no longer pregnant.
10. To eliminate interruptions between the Doctor and patient care, no one is allowed in the treatment room with the patient. Parents with infants/small children need to make babysitting arrangements prior to the appointment.
11. **In case of default, debtor-patient is responsible for any and all collections fees and or reasonable attorney fees.**
12. **FOR NEW PATIENTS:**
    A. Patients over 18 years old must bring a picture ID.
    B. Medicaid patients over 21 years old must pay a $3.00 copay at time of check-in.
    C. All patients must arrive 15 minutes early to complete paperwork.
    D. A current Medicaid or insurance card is required to be treated. If you do not bring a copy of your card, we reserve the right to reappoint you to another day.
    E. Please bring all x-rays and other information from previous dentist and medical providers.
13. Patients **must** remain inside the office while waiting to be treated.
14. Children seventeen years and under must have an adult in the building at all times and the adult must remain in the lobby during treatment. This adult must be a parent or legal guardian. **We are not responsible for children left unattended.**
15. Please use rest room facilities before being called back for treatment.

Signature of Patient, Parent, or Guardian _____ **Date** _____

Authorization

- I have read the Privacy Act Law.
- I authorize my insurance to pay the dentist or dentist group all insurance benefits otherwise payable to me for services rendered.
- I authorize the use of this signature on all insurance submissions.
- I authorize the dentist to release all information necessary to secure the payment of benefits.

Signature of Patient, Parent, or Guardian _____ **Date** _____

NIGHT AND DAY DENTAL
FINANCIAL POLICY

Payment is due in full at time of check-in

ACCEPTABLE FORMS OF PAYMENT

- Cash, Major Credit Cards (Visa/Master Card/American Express/Discover), or Care Credit. Personal checks are NOT accepted.

SELF-PAY PATIENTS

- Payment for services are due at the time of treatment.

INSURANCE PATIENTS

- Insurance is a contract between you and your insurance company. You are held financially responsible for any fees not paid by your insurance provider. Our office will file your insurance claim on your behalf for services provided. **Co-payments and deductible are due in full at the time of service.**

X-RAYS

- As part of your dental care plan, you will receive multiple x-rays during your preventive and diagnostic visit. Self-pay patients are responsible for the cost of the images in full. Insurance patients - most insurance plans will cover bite-wings & panoramic images under your plan. However, periapical (PA) images may not be covered in full by your provider leaving the patient responsible for any unpaid balance thereafter. These images are required by our facility as part of a complete dental care plan.

TREATMENT PLANS

- **This is an ESTIMATE of recommended treatment.** You will receive an itemized list of recommended treatment; this document is only an **ESTIMATE** of your recommended treatment. This is not a guarantee of payment by your insurance company toward the fees for the listed treatment. You are ultimately responsible for all fees generated from any treatment received. It is recommended that you contact your insurance company to review your itemized estimate and fees.

PAST DUE ACCOUNTS

- **Payment is due at the time of service.** Any past due charges on your account must be brought current PRIOR to any upcoming visit in the office. The internal accounting department will work with you to bring your account current or create a viable means of repayment. Should an agreement not be made or in the case of default, your account will be referred to our outside Collection Agency for further action.

I have read, understand, and agree with the above information regarding the Financial Policy for all services provided by Night and Day Dental. Once I have signed this agreement, I agree to all terms and conditions contained herein and the agreement will be in full force and effect.

First Name _____ **Last Name** _____

Signature of Patient, Parent, or Guardian _____ **Date** _____

NIGHT & DAY DENTAL

WELCOME TO NIGHT AND DAY DENTAL.
PLEASE FILL OUT ALL PERTINENT SECTIONS AND CIRCLE WHERE INDICATED.

Patient Information

Last Name:

First Name: M.I.:

Parent or Guardian Name (if <18 years old):

Street Address:

Apt # Zip Code:

City: State: Age:

Date of Birth: Social Security #:

Marital Status: Married Single Child Other

Today's Date: Gender: Male Female Other

Home Phone: Cell Phone:

Email:

Employment Status: Employed Unemployed Student

Employer Name:

Occupation: Work Phone:

I prefer to be reminded for my appointments by (circle one):

Work Phone Email Text Message
Home Phone Cell Phone

Emergency Contact Information

Emergency Contact Name:

Emergency Contact Phone Number:

How did you hear about our office:
Internet Search Family/Friends Advertisement
Insurance Provider Our Website

Other: _____

Dental History

Previous Dentist Name:

Date of Last Dental Visit:

Do you usually see a dentist every six (6) months?
Yes No

Describe the purpose of your visit today:

Describe any current pain or concerns you have about your teeth:

Have you ever needed antibiotics prior to your dental appointment?
Yes No

Do you have any dental anxiety or phobia?
Yes No

If yes, please explain:
_____

How often do you brush your teeth?
< 1x a day 1x a day 2x a day >2x a day

How often do you floss your teeth?
< 1x a day 1x a day 2x a day >2x a day

Do you use a daily mouth rinse (mouthwash)?
Yes No

Have you ever had a deep cleaning or scaling?
Yes No

Do your gums ever bleed when you brush or floss?
Yes No

Do you ever grind your teeth or have you been told you have bruxism?
Yes No

Have you ever had any pain in your jaw or have TMD?
Yes No

Have you ever had any kind of orthodontic treatment (braces)?
Yes No

Do ever feel like your mouth is dry or have xerostomia?
Yes No

Are you interested in whitening or straightening your teeth?
Yes No

Are you interested in discussing cosmetic dental treatment?
Yes No

Last Name: _____ First Name: _____

Physician History

Are you currently under the care of a physician?
Yes No

If Yes, please explain:

Physician Name: Phone #:

Have you been hospitalized or had any major surgery/operation within the last five (5) years?

Yes No If Yes, please explain:

Have you ever had a serious head or neck injury?
Yes No

Social History

Do you use any of the following: Cigarettes Vape

Smokeless Tobacco (Snuff, Dip) Controlled Substances

If you use cigarettes, how much do you smoke a day? _____

Have you ever thought about quitting smoking?
Yes No

Allergies - Please Circle All That Apply

Codeine Norco or Vicodin Aspirin Sulfa Drugs Acrylic Metal Local Anesthesia

Penicillin Clindamycin Tetracycline Latex Other: _____

Medications

Are you taking any blood thinner such as warfarin or coumadin?
Yes No

Have you ever taken a bisphosphonate medication, including Fosamax, Boniva, or Actonel? Yes No

Please list ALL medications you are currently taking:

Medical History - Please Circle All The Apply

Women Only: Pregnant or think you may be pregnant Nursing Taking oral contraceptive (birth control) None of the above

AIDS or HIV Positive	Cancer	GERD or other intestinal disease	Kidney Problems or Dialysis	Sinus Trouble
Alzheimer's Disease or Dementia	Chemotherapy or Radiation Treatment	Heart attack	Liver Disease	Sleep Apnea
Anemia	Chest pains or Angina	Heart pacemaker	Low Blood Pressure	Stroke
Artificial Joint Replacement	Cold sores or ulcers	Heart trouble/disease	Osteoporosis	Thyroid Disease
Arthritis	COPD	Hepatitis A B C	Psychiatric Care	Tuberculosis
Asthma	Cortisone or Steroid medication	High Blood Pressure	Rheumatic Fever	Tumors/Growths
Bacterial Endocarditis	Diabetes	High Cholesterol	Seizures or Epilepsy	
Bleeding Problem	Drug addiction or abuse	Irregular heartbeat or murmur	Sickle Cell or Blood Disease	**NONE OF THE ABOVE**

If you have any condition not listed above or answered yes to any question, please explain:

To the best of my knowledge, the questions of this form have been accurately and truthfully answered. I understand that providing incorrect information can be dangerous to my (or my patient's) health. It is my responsibility to inform Night and Day Dental of any changes in my medical status.

Signature of Patient, Parent, or Guardian _____ **Date** _____