Welcome !

Thank you for selecting our dental healthcare team.
We will strive to provide you with the best possible dental care.
To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us – we will be happy to help you.

REGISTRATION FORM

Michael T. Jones DMD, P.A.
Gentle Family Dentistry

Section I: Patient Information Date________________

Name:____ I Prefer to be called: ____________________
Address:____City:______________State:__________Zip______________
Phone (______)_________________ Work Phone (_____) _______________ Cell Phone (______)__________________
The best time to contact me is:________________ ☐ A.M. ☐ P.M. on my ☐ Home phone ☐ Work phone ☐ Cell phone
Email address: ____

You may leave a message ☐ with family member ☐ on voice mail ☐ email
Date of Birth:_____________ Social Security Number:____________________

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
If Student, Name of School____________________________ City/State___________________________ ☐ FT ☐ PT
Spouse or Parent's Name:_____________________________ Employer__________________ Work Phone____________
Whom may we thank for referring you? ____
Person to contact in case of emergency____________________________________ Phone__________________________

Section II Responsible Party

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other
Same as above ☐
Name:____ Relationship to Patient: ____________________
Address:____
City:________________________________ State:__________ Zip:____________ Phone: (____)_____________________
Employer_________________________ Work Phone (____)_________________ SSN#__________________________

Section III Insurance Information

Name of Insured_________________________________DOB______________Relationship to Patient ______________
SSN#:_______________________ Name of Employer:__________________________ Work Phone: (____)_______________
Subscriber/Member id # ____
Address of Employer:___________________________________City__________________State:________Zip ___________
Insurance Company_____________________________ Grp #_____________________ ID#_______________________
Ins Co Address:____ Ins Co. Phone:_____________________________

Patient Medical History

Physician ______________ Office Phone ______________ Date of Last Exam ______________

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?	☐	☐
If yes, please explain ______________		
3. Are you taking any medication(s) including non-prescription medicine?	☐	☐
If yes, what medication(s) are you taking? ______________		
4. Have you ever taken Fen-Phen/Redux?	☐	☐
5. Do you use tobacco?	☐	☐
6. Do you use controlled substances?	☐	☐
7. Are you wearing contact lenses?	☐	☐

9. Are you allergic to or have you had any reactions to the following?

	Yes	No
Local Anesthetics (e.g. Novocain)	☐	☐
Penicillin or any other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (e.g. nickel, mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Other (please list) ______________	☐	☐
10. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)	☐	☐
11. Women Only:		
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking oral contraceptives?	☐	☐

8. Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pains	☐	☐
Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Easily Winded	☐	☐
Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐
Swollen Ankles	☐	☐	Angina	☐	☐	Hay Fever / Allergies	☐	☐
Fainting / Seizures	☐	☐	Frequently Tired	☐	☐	Tuberculosis	☐	☐
Asthma	☐	☐	Anemia	☐	☐	Radiation Therapy	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Epilepsy / Convulsions	☐	☐	Cancer	☐	☐	Recent Weight Loss	☐	☐
Leukemia	☐	☐	Arthritis	☐	☐	Liver Disease	☐	☐
Diabetes	☐	☐	Joint Replacement or Implant	☐	☐	Heart Trouble	☐	☐
Kidney Diseases	☐	☐	Hepatitis / Jaundice	☐	☐	Respiratory Problems	☐	☐
AIDS or HIV Infection	☐	☐	Sexually Transmitted Disease	☐	☐	Mitral Valve Prolapse	☐	☐
Thyroid Problem	☐	☐	Stomach Troubles / Ulcers	☐	☐	Other ______________	☐	☐

Patient Dental History

Name of Previous Dentist and Location ______________ Date of Last Exam ______________

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have you ever experienced any of the following problems in your jaw?		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing	☐	☐

	Yes	No
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you ever had any difficult extractions in the past?	☐	☐
12. Have you ever had any prolonged bleeding following extractions?	☐	☐
13. Have you had any orthodontic treatment?	☐	☐
14. Do you wear dentures or partials?	☐	☐
If yes, date of placement ______________		
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐
16. Do you like your smile?	☐	☐

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X ______________________________

Signature of patient (or parent/guardian if minor)

Doctor's Comments ______________________________

____

Signature ______________ Date ______________

ITEM 07-0511014/16306 © 1997 COLWELL 1-800-637-1140

MICHAEL T. JONES, D.M.D., P.A. & ASSOCIATES

1201 Ridge Road • Raleigh, NC 27604 • (919) 835-1710 • Fax: (919) 828-8939
914 N.E. Maynard Road •Cary, NC 27513 • (919) 468-2030 • Fax: (919) 468-2613

OFFICE POLICY

Thank you for choosing us as your dental care provider. We are committed to providing you with the finest and most comprehensive dental care services today. We would like to assist you in optimizing the benefits you obtain from your insurance carrier and in minimizing your concerns about the cost of the services you receive. In order to achieve these goals, your assistance is needed. We will gladly file your Primary Insurance for you when the following requirements are met:

- It is verified by us that you have current dental insurance coverage, and
- Your Insurance company agrees to pay us directly.

Insurance:

However, all deductibles, co-payments and estimated amounts not covered by your insurance company are due at the time services are rendered. **We are not responsible for any exclusion(s) that may cause your claim to be denied in full, or in part. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract.** Patients who carry a PPO, PDP, or PDO type of insurance program, are responsible for certain co-payments set by your insurance company. These payments are due at the time service is rendered. Any changes in your insurance must be called in prior to any scheduled appointment, so that we may have time to verify your new benefits. Inform us if there is a change in your address, employment, home and work numbers so that we may update our records and keep your account information current.

Children & Minors:

An adult must accompany any minors under the age of 18, or treatment will be denied. **The adult accompanying the minor is responsible for payment.** We as your caregivers cannot enter into domestic disputes. For unaccompanied minors, non-emergency treatment will be denied unless payment arrangements have been made. We suggest you send your child with a signed, blank check, or supply us with your credit card number and expiration date, which we can keep on file for their use.
NOTE: Due to health & safety reason, children under the age of 10 will not be allowed in the operatory room(s). Children under the age of 10 will not be left unattended in the waiting area. Childcare arrangement(s) must be made prior to patients' appointment.

Appointment:

An appointment written in our schedule with your name on it is a bond of trust that we will be here to serve you, and you will be present for that appointment. We reserve the right to cancel an appointment that has not been confirmed **48 hours prior** to scheduled appointment. We reserve the right to charge for all cancellations made **less than 48 hours** in advance, for broken appointments, and short notice changes.

(Over)

A **$35.00** broken appointment fee will be charged to your account should you break a hygiene appointment and a **$75.00 per hour** will be charged to your account should you break a doctor's appointment. The fee must be paid prior to your rescheduled appointment. Please help us serve you better by keeping scheduled appointments. We provide an answering machine during non-business hours, for your convenience in leaving a message. We also reserve the right to reschedule your appointment if you arrive late, dependent upon the schedule that day.

Payment Options:

In order to assist you with your dental care investment, we offer long term dental financing with an outside financing company. Upon qualifying you will be extended a line of credit for a specific period of time. If interested please ask us for details. Other payment options are cash, check, and most credit cards. We reserve the right to ask for prepayment on some procedures. If you present a check for insufficient funds, you will be charged a **$25.00** fee for processing. Additional checks will not be accepted until the non-sufficient check and related fees have been paid.

Collection:

If you have an outstanding balance on your account beyond 120 days, your account will automatically be turned over to a collection agency. The responsible party will be liable for any collection fees that the account may incur.

Dental Record / X-ray(s):

There is a fee of **$35.00** for dental record transfer or obtaining duplicate copies of X-ray(s).

Agreement:

Patients who carry dental insurance do hereby agree to assign the benefits that he/she is eligible to receive for the care rendered in this office to Michael T.Jones, D.M.D., PA and you understand and agree that you will be responsible for any expenses not paid by your insurance company.

I HAVE READ, UNDERSTAND, AND AGREE TO THE STATEMENTS OUTLINED ABOVE.

Signature ______________________________ Date________________

Print Name:______________________________

MICHAEL T. JONES, D.M.D., P.A. & ASSOCIATES
5613 Duraleigh Road, Suite 121 Raleigh, NC 27612 • (919) 835-1710 • Fax: (919) 828-8939
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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name ______________________________

Relationship to Patient: ______________________________

Signature: ______________________________

Date ______________________________

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason: