alliance dentistry™

Welcome to Our Practice!

We are committed to providing exceptional dental care to our patients in a compassionate, professional environment. The following information is provided to introduce you to our practice philosophy and policies.

Appointments

Appointments are scheduled so we can provide the most efficient care in a relaxed setting. We make every effort to honor time commitments and we appreciate patients extending us the same courtesy. Patients are reminded of their appointments 2-3 days in advance by email, text, or phone. Patients are kindly asked to confirm their appointment at least 48 hours prior to their appointment through the reminder method employed.

New Patient Appointments

We reserve 90 minutes for each new adult patient visit and 60 minutes for each new child visit. This allows time for us to listen to patient concerns and to properly diagnose and develop appropriate treatment plans.

Continuing Care

Our practice is focused on prevention and maintaining optimum oral health. We recommend comprehensive treatment and continuing care on an appropriate recall schedule.

Urgent Care After Hours

We accommodate patients of record who experience dental emergencies after hours. A patient of record is one who has been seen and treated in the office during the past 18 months. If you are a patient of record and have a dental emergency, you can call the office for information on how to contact us. An after hours fee may be charged.

Children and Adolescents

We are happy to start seeing children at the age of three. Parents are welcome to accompany their children in the operatories. We require that parents remain in the office with children under the age of 18 for the entire appointment. Failure to comply may result in the appointment being rescheduled.

Cancellations and Missed Appointments

We require 48 hours advance notice of a cancellation. Patients who do not provide 48 hours notice of a cancellation or who do not present for a scheduled appointment may be charged a fee. Patients who fail to present for a second appointment may be dismissed from the practice.

Payments and Insurance

Payment for treatment is due and payable the day services are rendered. It is our goal, however, to assist all of our patients in obtaining the dental treatment they deserve. As a result, we offer several payment options, including cash, check, credit card, and third party financing. For patients with dental insurance, we will file the appropriate claim forms.

Patient Information

Name: _____ Preferred Name: _____

Home Address: _____ City: _____ State _____ Zip: _____

Home #: _____ Work #: _____ Mobile #: _____

Email: _____

Sex: M / F Birth Date: ___ /___ /_____ SS#:_____

Family Status (circle): Single Married Divorced Child Spouse's Name: _____

How did you first hear about our office? (circle one):

Another Patient	Another Dental Office	Brochure	Online Search
Facebook	Work	School	Insurance Website
Sign –Drive by	Walk in	Other:_____	

Whom may we thank for referring you to our practice?_____

Person Responsible for Account

Name of responsible party: _____

Relationship to patient (Circle): Self Spouse Parent Other: _____

Home Address: _____ City: _____ State: _____Zip: _____

Home #: _____Work #: _____ Mobile #: _____

Email: _____

Birth Date: ___ /___ /_____ SS#:_____

Contact Information

What is the best way to communicate with you? Home Phone / Mobile Phone/ Text / Email

In the event of an emergency, whom should we contact? Name _____

Relationship_____ Home #: _____ Work #: _____ Mobile #: _____

Insurance Information (Primary)

Name of Insured: _____ Relationship to patient: _____

Insured Birth Date: ___ /___ /_____

Insurance Plan Name: _____ Insurance Co Phone #: _____

Claims Address _____

City, State, Zip _____

Group #: _____ ID #: _____

Insurance Information (Secondary)

Name of Insured: _____ Relationship to patient: _____

Insured Birth Date: ___ /___ /_____

Insurance Plan Name: _____ Insurance Co Phone #:_____

Claims Address _____

City, State, Zip _____

Group #: _____ ID #: _____

Employment Information

Employer Name: _____ Phone: _____

Address: _____

City, State, Zip: _____

Cancellations and Missed Appointments

We require 48 hours advance notice of a cancellation. Patients who do not provide 48 hours notice of a cancellation or who do not present for a scheduled appointment may be charged a fee. Patients who fail to present for a second appointment may be charged a fee or dismissed from the practice. After the first missed appointment, a letter will be mailed reiterating our policy and reminding the patient of the risk of dismissal should another appointment be missed.

I have read the Cancellation and Missed Appointment Policy. I understand and agree to this Policy.

Patient Signature_____Date_____

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Child's Dental/Medical History

Patient Name _____ **Date of Birth** _____

Dental History

What is the reason for today's visit? _____
Is this the child's first visit to a dentist? ☐ Yes ☐ No If no, when was the last dental visit?_____
Former dentist, if any? _____ _____ Phone _____
Has the child ever had any dental X-rays? ☐ Yes ☐ No
Has your child ever had any injuries to the mouth, head or teeth? _____
Has your child ever had any problem with dental treatment in the past? _____
Has your child ever had any orthodontic treatment? _____
What type of water does your child drink? ☐ City water ☐ Well water ☐ Bottled water ☐ Filtered water
Has your child ever received fluoride supplements? ☐ Yes ☐ No If yes, what age? _____
How many times are the child's teeth brushed per day? _____ When? _____
Has the child sucked his or her thumb, fingers, or pacifier? ☐ Yes ☐No Does the habit still exist? _____
Does the child grind his or her teeth? ☐ Yes ☐ No

Medical History

1.) Is your child taking any prescription and/ or over the counter medications? ☐ No ☐ Yes
If yes, please list _____
2.) Is your child allergic to any medications? ☐ No ☐ Yes
If yes, please list _____
3.) Is your child allergic to any foods or materials? ☐ No ☐ Yes
If yes, please list _____
4.) Has your child been hospitalized? ☐ No ☐ Yes
When? _____ Reason? _____

Has your child had any history or ever been diagnosed with any of the following:

☐ Anemia
☐ Allergy/ Hay Fever
☐ Artificial heart valve
☐ Artificial joint/ limb
☐ Asthma
☐ Attention Deficit Disorder
☐ Autism
☐ Behavior/ learning disabilities
☐ Epilepsy/ seizure
☐ Birth defects
☐ Bleeding Disorder
☐ Bone/ joint/ orthopedic problem
☐ Brain injury
☐ Cancer, type _____
☐ Cerebral Palsy
☐ Chemotherapy
☐ Chicken Pox
☐ Chronic sinusitis
☐ Cleft lip/ palate
☐ Diabetes
☐ Digestive disturbances
☐ Eye problems
☐ Fainting
☐ Growth problem
☐ Hearing loss/ aids
☐ Heart murmur
☐ Heart problem
☐ Heart surgery
☐ Hepatitis
☐ HIV+ / AIDS
☐ Hormonal disturbances
☐ Kidney problems
☐ Liver problems
☐ Measles
☐ Mumps
☐ Nervous disorders
☐ Pneumonia
☐ Rheumatic Fever
☐ Scarlet Fever
☐ Shunt
☐ Sickle cell anemia
☐ Tetanus
☐ Tuberculosis
☐ Other:
_____
_____

Pediatrician/ Physician Name _____ **Phone** _____

I understand that the above information will be used for my child's dental health. I have answered the questions to the best of my ability. If further information is needed you may contact my child's health care physician for any other information.

Parent Signature_____ **Date**_____

Financial Guidelines

Payment for treatment is due and payable the day services are rendered. It is our goal, however, to assist all of our patients in obtaining the dental treatment they deserve. Therefore, we are pleased to offer several payment options. Please read the following carefully. Our financial coordinator will answer any questions you may have, and assist you in selecting the appropriate financial plan for your needs.

For your convenience, we offer the following financial options:

1. In addition to personal checks and cash, we also accept payment through MasterCard/Visa, American Express, and Discover.

2. We offer extended payment plans for amounts up to $25,000 upon approved credit. This plan has the following features:

- No down payment
- Extended terms with low monthly payments.
- No prepayment penalty.
- No interest up to 12 months.

3. Dental Insurance

We are happy to file insurance claims and assist you in obtaining the maximum benefits specified in your contract. However, please keep the following in mind:

- Your insurance is a contract between you, your employer, and your insurance company. We are not a party to that contract. We will do our best to ESTIMATE your coverage, and file your insurance on your behalf. Not all dental services are necessarily covered under your dental insurance plan. It is essential that you read and understand your coverage and pay special attention to any preauthorization requirements, exclusions and waiting periods.

- Our office policy states that you are totally responsible for your bill. The ESTIMATED patient portion of the fee is due at the time of service. If a balance remains after we receive payment from your insurance carrier within 30 days we will notify you. Failure of your insurance carrier to reimburse our office within 30 days will result in our billing you directly for the remaining balance.

- We are committed to providing the highest quality of care. Our treatment recommendations and the dental services we provide are in the best interest of the patient's health. The patient is responsible for payment in full regardless of an insurance company's arbitrary determination of treatment necessity.

- Our participation in a Preferred Provider Organization (PPO) is a contract between this office and the organization to provide dental services for the negotiated network fee schedule. Individual coverage and benefits will vary within the organization and are dependent on the contract between you, your employer and the insurance company. While we guarantee our fees will not exceed the network fee schedule, we cannot be responsible for variances in coverage and benefits

within the PPO.

- If your coverage changes for any reason, please notify the office immediately.

By signing this form, you have read and understand our policy. Any denials or insurance payments less than estimated will be your responsibility. Payment will be due upon our billing cycle. All estimated out of pocket fees and deductibles are due the day of treatment. Ask our office regarding our financial options before your visit, or if you have any questions regarding your insurance and our policy.

Usual and Customary Fees

Our practice is committed to providing the best treatment for our patients, and we charge what is usual and customary for our area and experience. You are responsible for payment regardless of any insurance company's arbitrary determination for usual and customary fees. **All accounts not paid within 60 days will accrue a finance charge of 1.5% (18% APR).**

I have read the Financial Policy. I understand and agree to this Policy.

_____ _____

Signature of Patient or Responsible Party Date

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: _____

State and federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with a Notice of Privacy Practices. Our Notice is available online. If you prefer a paper copy, please ask a team member for a copy of our Notice.

I acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

_____

Signature Date

----------FOR OFFICE USE ONLY----------

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining the acknowledgement
- ☐ Other (Please Specify)

Authorization for Release of Information to Family and/or Friends

Name of Patient_____ Date of Birth_____

Alliance Dentistry is authorized to discuss my dental care and may release my confidential health information to the following:

_____ _____
Name Relationship

_____ _____
Name Relationship

Rights 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 **Alliance Dentistry, 202 Davis Grove Circle Ste 102, Cary, NC 27519.** 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 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 understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing this authorization.

This authorization shall be in force and effective until revoked by the patient or representative signing the authorization.

_____ Date_____
Signature of Patient or Personal Representative

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