THE RALEIGH DENTISTS
IMPLANT AND FAMILY DENTISTRY

DR. SIMON MELCHER
DR. EMILY RODRIGUEZ
919.782.0548
3340 SIX FORKS ROAD • PARK PLACE
RALEIGH, NORTH CAROLINA 27609
WWW.THERALEIGHDENTISTS.COM

PATIENT INFORMATION

Name: _____ Preferred Name: _____
Last First Middle

Date of Birth: _____ ☐ Male ☐ Female ☐ Married ☐ Single

Address: _____
Street City Zip Code

Phone: Home: _____ Work: _____ Cell: _____

Place of Employment: _____

Social Security Number: _____

Email Address: _____

Whom may we Thank for referring you? _____

Physician's Name: _____ Phone Number: _____

SPOUSE INFORMATION

Name: _____
SS#: _____
Birthday: _____
Cell: _____
Employer: _____

How can we best reach you for general questions? ☐ Cell ☐ Text ☐ Work ☐ Home ☐ Email

Time of Day _____ ☐ AM ☐ PM

How can we best reach you for confirming appointments? ☐ Cell ☐ Text ☐ Work ☐ Home ☐ Email

Time of Day _____ ☐ AM ☐ PM

IN CASE OF EMERGENCY, WHOM MAY WE CONTACT?

Name: _____ Home Phone Number: _____ Work Phone Number: _____

Relationship to Patient: _____

INSURANCE INFORMATION

Primary Insurance: (PLEASE PRESENT INSURANCE CARD TO RECEPTIONIST)

Insurance Company: _____ Group Number: _____

Subscriber's Name: _____
Last First Middle

Subscriber's Social Security Number: _____ Subscriber's Date of Birth: _____

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Dependent

Secondary Insurance:

Insurance Company: _____ Group Number: _____

Subscriber's Name: _____
Last First Middle

Subscriber's Social Security Number: _____ Subscriber's Date of Birth: _____

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Dependent

DENTAL HISTORY

☐ YES ☐ NO Do you have a specific dental problem or concern? If yes, please state: _____

☐ YES ☐ NO Have you had an upsetting experience in a dental office or do you feel nervous about having dental treatment? _____

☐ YES ☐ NO Do you have TMJ problems? (Bruxing, grinding teeth / popping, clicking or discomfort around jaw joint)

(Optional) Name of previous dentist where we may obtain prior x-rays, etc: _____

When was your last dental exam? _____

MEDICAL HISTORY

MEDICAL DOCTOR'S NAME: _____ PHONE NUMBER: _____ DATE OF LAST PHYSICAL EXAM: _____

☐ YES ☐ NO Has your physician ever indicated that you should be pre-medicated with antibiotics prior to dental treatment? _____

If so, for what condition were you premedicated? _____

☐ YES ☐ NO Are you under a doctor's care now? For what condition? _____

☐ YES ☐ NO Have you been hospitalized or had surgery in the last 5 years? If yes, please explain: _____

☐ YES ☐ NO Have you had surgery or x-ray treatment for tumor, growth, or other condition of your mouth or lips? _____

☐ YES ☐ NO Have you had abnormal bleeding associated with previous extractions, surgery, or trauma? _____

☐ YES ☐ NO Do you or have you used tobacco products? If so, which _____

☐ YES ☐ NO **Women:** Are you pregnant? How many months? _____ If recently given birth, are you breastfeeding? ☐ YES ☐ NO

☐ YES ☐ NO Are you taking any prescription or over-the-counter medications? (PLEASE LIST): _____

_____

Please check any condition that you have now, or have had in the past:

☐ **Cardiovascular Disease:** (heart attack, coronary insufficiency, coronary occlusion, high/low blood pressure, arteriosclerosis, stroke, pacemaker)

☐ **Heart Problems:** prosthetic valve, endocarditic, congenital heart disease, transplant with valvulophathy

☐ Rheumatic fever, mitral valve prolapsed or heart murmur

☐ Arthritis or Inflammatory Rheumatism

☐ Seizures, fainting spells or epilepsy

☐ Cancer---type: _____

☐ Blood disorder, anemia or slow clotting

☐ Hyper- or hypothyroidism

☐ Is there any condition, not listed above, that we should know about?

_____

☐ Liver: Jaundice, Hepatitis A/B/C, Cirrhosis

☐ Kidney: Renal failure, Shunt, Dialysis

☐ Tuberculosis

☐ Diabetes

☐ Glaucoma

☐ Chemotherapy or radiation

☐ Blood transfusion ---year: _____

☐ Cold sores or Herpes Virus

☐ Positive HIV, AIDS, or AIDS related complex

☐ Frequent allergies, hives or rash

☐ Artificial prosthesis/implants (joints, hip screws, etc.?) year: _____

Please check if you are taking any of the following medications:

☐ Antibiotics or Sulfa Drugs

☐ Medicine for High Blood Pressure

☐ Tranquilizers

☐ Aspirin

☐ Digitalis or Drugs for Heart Trouble

☐ Antidepressants: _____

☐ Anticoagulants (Blood Thinners)

☐ Bisphosphonates (Boniva, Actonel, Fosamax, Skelid, or Didronel)

☐ Antihistamines

☐ Insulin (for Diabetes)

☐ Nitroglycerin

☐ OTHER: _____

Please check is you are allergic or have reacted adversely to any of the following medications:

☐ Local Anesthetics

☐ Sulfa Drugs

☐ Aspirin, Tylenol, Ibuprofen

☐ Barbiturates, Benzodiazepines, Sleeping Pills

☐ Penicillin or other Antibiotics

☐ Latex

☐ Codeine or other Narcotics (e.g. Tylenol 3, Vicodin, Percocet)

☐ OTHER: _____

The information provided on this medical history form is correct, to the best of my knowledge:

_____

(SIGNATURE OF PATIENT OR RESPONSIBLE PARTY) (DATE)

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STATEMENT OF PRIVACY PRACTICES

Our office is dedicated to protect the privacy rights of our patients and the confidential information entrusted to us. The commitment of each employee to ensure that your health information is never compromised is a principal concept of our practice. We may, from time to time, amend our privacy policies and practices but will always inform you of any changes that might affect your rights.

PROTECTING YOUR PERSONAL HEALTHCARE INFORMATION

We use and disclose the information we collect from you only as allowed by the Health Insurance Portability and Accountability Act. This includes issues relating to your treatment, payment, and our healthcare operations. Your personal health information will never be otherwise given to anyone - even family members - without your written consent. You, of course, may give written authorization for us to disclose your information to anyone you choose, for any purpose.

Our offices and electronic systems are secure from unauthorized access and our employees are trained to make certain that the confidentiality of your records is always protected. Our privacy policy and practices apply to all former, current, and future patients, so you can be confident that your protected health information will never be improperly disclosed or released.

COLLECTING PROTECTED HEALTH INFORMATION (PHI)

We will only request personal information needed to provide our standard or quality health care, implement payment activities, conduct normal health practice operations, and comply with the law. This may include your name, address, telephone number(s), Social Security Number, employment data, medical history, health records, etc. While most of the information will be collected from you, we may obtain information from third parties if it is deemed necessary. Regardless of the source, your personal information will always be protected to the full extent of the law.

DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION

We may disclose information as allowed or required by law. We are obligated to provide information to law enforcement and governmental officials under certain circumstances. We will not use your information for marketing purposes without your written consent. We may use and/or disclose your health information to communicate reminders about your appointments including: voicemail messages, answering machines, and postcards. You have a right to request and we will honor your written authorization to withhold disclosure to your dental insurance carrier for all services for which you have made full out-of-pocket payment.

Any breach in the protection of your personal health information, including unauthorized acquisition, access, use, or disclosure, will be fully investigated, addressed, and mitigated as established by the HIPAA Privacy Rule. You have a right to and will be provided all information relating to any breach involving your personal PHI.

YOUR RIGHTS AS OUR PATIENT

You have the right to request copies of your healthcare information; to request copies in a variety of formats; and to request a list of instances in which we, or our business associates, have disclosed your protected information for uses other than stated above. All such requests must be in writing. We may charge for your copies in an amount allowed by law. If you believe your rights have been violated, we urge you to notify us immediately. You can also notify the U.S. Department of Health and Human Services.

Please ask if you have any questions about your privacy rights or the protection of your health information.

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ACKNOWLEDGEMENT OF RECEIPT OF STATEMENT OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of Simon Melcher, DDS. The Statement of Privacy Practices describes the types of uses and disclosures of the protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Simon Melcher, DDS reserves the right to change the privacy practices that are described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed to me.

ADDITIONAL DISCLOSURE AUTHORITY

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the person indicated below.

ANY MEMBER OF MY IMMEDIATE FAMILY	☐ YES	☐ NO
SPOUSE ONLY	☐ YES	☐ NO
OTHER (PLEASE SPECIFY): _____	☐ YES	☐ NO

Name of Patient or Personal Representative

Signature of Patient or Personal Representative

Date

Description of Personal Representative's Authority

OFFICE USE ONLY BELOW THIS LINE

RECORD OF ACKNOWLEDGEMENT NOT OBTAINED

Provided prior to treatment? ☐ YES ☐ NO

Date provided: _____

Reason for denial:

- ☐ Needed more time to review statement of privacy practices.
- ☐ Wanted to consult with another person, before signing.
- ☐ Unable to sign.
- ☐ Reason not given.
- ☐ Other (explain): _____

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APPOINTMENT CANCELLATION POLICY

When you schedule an appointment in our office we reserve that time specifically for you. If you need to cancel or reschedule your appointment, we require a 48 hours advance notice so that we can schedule another patient waiting for treatment. If you miss your appointment or do not give 48 hour notice, there may be a $75/hr charge applied to your account. **PLEASE INITIAL:** _____

OFFICE FINANCIAL POLICY

Insurance

If you have dental insurance, we will make a good faith estimate of the amount your insurance carrier may pay based on the information provided to us. As the insured, it is your responsibility to determine the coverage by your insurance for any dental services provided in our office. As a courtesy, we will file all dental claims on your behalf as well as provide any information required by your insurance carrier to ensure it is processed in a timely manner. If your insurer denies coverage, or if we otherwise do not receive payment within 60 days from filing your claim, the amount will then become due and payable by you. Remember that your coverage is a contract between you and your insurer and/or your employer and your insurer. All questions regarding your insurance benefits must be addressed to your insurance carrier. **PLEASE INITIAL:** _____

Payment

The amount estimated to be your portion of treatment, is due at the time dental treatment is provided. We accept payment in the forms of Cash/Check, Visa, MasterCard, Discover, Debit cards (that bear Visa or MasterCard logos), and Care Credit.

Patient Responsibility, Assignment and Release

- ☐ I acknowledge my responsibility for the total payment of all services performed in this office in accordance with their regular fees and terms.
- ☐ I understand my responsibility is not modified by whether any third party (insurance) pays for all, part, or none of the charges.
- ☐ I understand that any estimated portion, not covered by insurance is due at the time of service for all services rendered.
- ☐ I authorize payment to be made directly to the dentist by my insurance company and I accept financial responsibility for all services not covered by my insurance. I authorize release of any medical/dental care information requested by my insurance carrier, and authorize my insurance company to pay insurance benefits directly to the dentist for all dental services rendered.

We are here to assist you in any way possible. Please make your questions and concerns known to our team. Our goal is to ensure that you have an exceptional experience!

I have read and understand the office financial and appointment cancellation policies.

_____	_____
Name of Patient	Patient Signature
_____	_____
Guardian Signature	Date