Third Creek Dentistry

Date_________________

Patient (Mr. Mrs. Ms. Dr.) ____

Last First Middle Nickname

☐ Male ☐ Female

Mailing ______________________________ Street ______________________________

City ______________________________ State ________________ Zip __________

Home # ________________ Work # ________________ Ext. ________________

Date of Birth ______________________ Cell # ______________________________

Social Security Number ______________________ Employer ______________________

Which phone # is better to reach you during the day? ☐ Home ☐ Work ☐ Cellular ☐ Email ________________

Have you ever been a patient of our practice? ☐ Yes ☐ No

Who will be responsible for your account? ☐ Self ☐ Spouse ☐ Father ☐ Mother

Marital Status? ☐ Married ☐ Divorced ☐ Legally Separated ☐ Widowed ☐ Single

Name ____

Last First Middle Nickname

Mailing ______________________________ Street ______________________________

City ______________________________ State ________________ Zip __________

Home # ________________ Work # ________________ Ext. ________________

Cell # ______________________ Employer ______________________________

Social Security Number ______________________ Date of Birth ______________________

Whom may we thank for referring you to our office?

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Dentist ______________________________

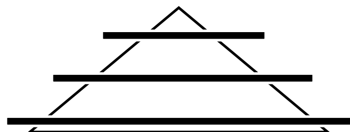
Medical Doctor ______________________________

Name of relative or friend not living with you.

Name ______________________________

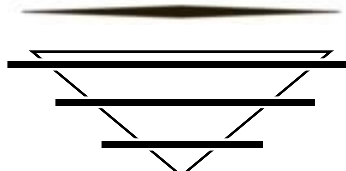
Address ______________________________

Phone #________________ Relation ____________



Mission Statement

Our team is dedicated to providing you with the highest quality dental care. We strive to give you a gentle and caring experience in a professional manner.



Date: ____________________

MEDICAL HISTORY

(Please circle Yes or No)

NAME: ____________________________________ DATE OF BIRTH: ______________________ AGE: _________

Have you ever had:

Diabetes	Yes	No
Epilepsy	Yes	No
Hepatitis	Yes	No
HIV/AIDS	Yes	No
Hemophilia	Yes	No
Cancer	Yes	No
Ulcer	Yes	No
High blood pressure	Yes	No
Radiation treatment	Yes	No
Tuberculosis	Yes	No
Sinus problems	Yes	No
Excessive bleeding	Yes	No
Sickle Cell Anemia	Yes	No

Prosthetic heart valve	Yes	No
History of endocarditis	Yes	No
Organic heart murmur	Yes	No
Mitral valve prolapse	Yes	No
Pacemaker	Yes	No

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Has a medical doctor advised taking antibiotics prior to dental treatment due to concerns for your heart or replacement joint? Yes No

Are you allergic or had a reaction to:

Penicillin	Yes	No
Aspirin	Yes	No
Codeine	Yes	No
Erythromycin	Yes	No
Dental numbing/local anesthetic	Yes	No

Latex	Yes	No
Other Drugs:	Yes	No

what? ______________________________

____

Are you taking aspirin every day?.. Yes No

Are you taking any drugs or medications? .... Yes No

What? ____________________________________ for what? __________________________

What? ____________________________________ for what? __________________________

What? ____________________________________ for what? __________________________

What? ____________________________________ for what? __________________________

Do you have any disease, condition, or problem not listed above that you think I should know about? Yes No

If so, explain ____

Medical Doctor's Name ____________________________ City _____________________ Phone #_______________

Women:

Are you pregnant or nursing? .... Yes No

Are you taking birth control pills? .... Yes No

DENTAL HISTORY

(Please answer ALL questions)

Why are you seeking dental care at this time? ____

Are you having dental pain? ____

Have you had a dental examination in the last 2 years? ____

Were x-rays taken during your last dental examination? ____

Have you had any serious trouble with any previous dental treatment? ____

If so, explain ____

Do you use tobacco products? Yes No What? ____

____ Date ____

Signature of person completing medical history

How did you find us?

Please help us know where our advertising has worked the best. Indicate by checking the line next to the place where you found out about us. If you saw an ad or were referred by another physician or current patient, please fill in the blank next to that option telling us the name of the specific patient or doctor. Thanks for your assistance!

_____ Website
_____ Flyer/Brochure
_____ Phonebook
_____ Coffee News
_____ Newspaper, if so which one? ______________________________
_____ Current patient, if so who? ______________________________
_____ Doctor, if so who? ______________________________

Primary Dental Insurance Company

Employer ____

Address ____

Phone # _______________________________ Years Employed _____________

Insurance Company Name ____

Address ____

Phone # ______________________________________ Group # _______________________________

Insured Party __________________________________ ☐ Male ☐ Female

Relation __________________________________ Date of Birth ___________________________

Address ____

Home # _________________________________ Social Security # _____________________________

I attest that this is the only insurance policy I am aware of. This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize and direct payment of any benefit otherwise payable to me directly to the treating physician or practice.

Policy Holder's Signature ____

Third Creek Dental
11701 Statesville Blve. Cleveland. NC 27013

NOTICE OF PRIVACY PRACTICES

THE DENTAL PRACTICE OF DR. KEN RASBORNIK understands that your medical and dental information is personal and we are committed to protecting it. We create a record of the care and services you receive at our office. We need this record to provide you with quality dental care and to comply with certain legal requirements. This notice will tell you about the way we may use and share your Protected Health Information (PHI). We have a Legal Duty to:

Keep your personal health information private

1. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information
2. Follow the terms of the current notice
3. Notify you in a timely manner of an accidental disclosure of your private health information

We Have the Right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices: When we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

USE AND DISCLOSURE OF YOUR PRIVATE HEALTH INFORMATION

The following describes different ways that we use and disclose your private health information. Not every use or disclosure is listed. However, we have listed all the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical or dental information for any purpose not listed below without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

1. **For Treatment**: We may use your PHI to provide you with dental treatment or services. We may disclose information about you to healthcare providers who may be involved in your treatment both directly and indirectly.
2. **For Payment**: We may use and disclose your PHI for payment purposes. A bill may be sent to you, a third-party payer or to a collection agency. The information on or accompanying the bill may include your treatment information.
3. We will not sell or use your personal health information for marketing or fundraising purposes without first obtaining your signed authorization.
4. We are required to inform you if there are any financial conflicts of interest with us and the products or services utilized by us.
5. If you pay for your dental treatment and request that we not disclose the procedure to your insurance company we must comply with your request as long as you pay in full for the procedure in a timely manner.
6. You have the right to request a copy of your health records and to request the type of format you want (paper or electronic). If you request, in writing, that a copy of your records be sent to a specific third party, we are required to send them as directed and in a timely manner.
7. You have the right to be notified of a breach of any of your Protected Health Information.

PATIENT ACKNOWLEDGEMENT

I understand that, by signing this form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations. I understand that I may request in writing that you restrict how my private health information is used or disclosed

PATIENT/GUARDIAN NAME:(PRINT)____________________________________

RELATIONSHIP TO PATIENT:____________________________________

SIGNATURE: ____________________________ DATE: ______________

Financial Policy and Options to Better Serve You

In an effort to keep dental care costs down, while maintaining a high level of professional care, we have established the following options for your benefit:

Option #1 **full payment by cash, check, or credit/debit card**

Option #2 **Care Credit**

Insurance: If you have dental insurance, we will be happy to help you determine coverage available to you. Our computer is set up to provide this estimate. *Professional care is provided to you and not the insurance company.* Please realize that if you have dental insurance, you are responsible for payments to your account. We provide a service to our patients by filing claims to your insurance company but ultimately the relationship is between you, the insured, and your insurance company. The amount paid by the insurance company will be a percentage of the allowable benefit (UCR) that is determined by your individual company contract. This benefit may be higher or lower than the fee in this office. As a result, the actual percentage of our fee paid by your insurance may be different than the amount listed in your benefit book pending on which type of policy your employer purchased. The computer can estimate the benefit due to you based on past payment history. We deal with over 100 different insurance companies and a variety of different contracts. No two policies are the same. It is not uncommon for insurance companies to delay payment and deny claims to increase their profits. **If your insurance company chooses to not pay your claim within thirty (30) days, the balance will be due and payable by you.** If you have any questions about your insurance, do not hesitate to contact our office immediately. We are here to help you!

Finance charge: *If I do not pay the entire New Balance within 6 days of the billing date, the finance charge will be a periodic rate of 1.5% per month.*

Signed:____Date______________________