ELIZABETHTOWN
FAMILY DENTISTRY
Justin M. DeGarmo, DMD & Ann Hamill Greene, DDS, P.A.

Welcome! We thank you for selecting our practice to be a partner in optimizing your oral health! Please complete this form.

Who may we thank for your referral? _____

GENERAL PATIENT INFORMATION

Name: _____ Date: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Physical Address: _____ City: _____ State: _____ Zip: _____

Email Address: _____ Phone Number: _____

Social Security Number (SSN): _____ Date of Birth (DOB): _____

Please select one: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Patient/Parent's Employer: _____ Work Phone: _____

Business Address: _____ City: _____ State: _____ Zip: _____

Spouse/Parent's Name: _____ If minor, who does patient live with? _____

Person to contact in case of an emergency: _____ Phone: _____

RESPONSIBLE PARTY

Person responsible for payment of this account:

_____

Relationship to patient: _____

Responsible party address: _____

_____

Home Phone: _____ DL#: _____

DOB: _____ SSN: _____

Financial Institution: _____

Employer: _____

Work Phone: _____

Best time to reach you: _____

Is this person also a patient here? Y/N

INSURANCE INFORMATION

Insurance company: _____

Group #: _____

Is patient covered by additional insurance: Y / N

Subscribers Name: _____

DOB: _____ SSN: _____

Relationship to patient: _____

Insurance Company: _____

Group #: _____

ASSIGNMENT AND RELEASE: *I, the undersigned, certify that I (or my dependent) have insurance coverage with the above insurance company and assign directly to Elizabethtown Family Dentistry all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment benefits. I authorize the use of this signature on all insurance submissions.*

Responsible Party Signature: _____

Relationship: _____ Date: _____

For your convenience, we offer the following methods of payment. Please select the option you prefer. Payment in full and/or insurance payments are due at each visit.

☐ *Cash* ☐ *Personal Check* ☐ *Credit Card (VISA or Mastercard)* ☐ *I wish to discuss the office payment policies.*

Justin DeGarmo DMD & Annie Greene DDS

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____

Are you on a special diet? ◯ Yes ◯ No
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs
☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
			Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No _____

Comments: _____

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

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

ELIZABETHTOWN
FAMILY DENTISTRY
Justin M. DeGarmo, DMD & Ann Hamill Greene, DDS, P.A.

AUTHORIZATION FOR RELEASE OF INFORMATION – COMPOUND RELEASE

Name of patient: _____ Date of birth: _____

Justin M. DeGarmo, DMD & Ann Hamill Greene, DDS, P.A. is authorized to released protected health information about the above name patient in the following manner and/or to selected persons.

Entity to release information: *Check each entity that you approve to receive information*	**Description of information to be released:** *Check each that can be given to the person/entity on the left*
☐ **Voicemail** ☐ Spouse (provide name and phone number): _____ ☐ Parent (provide name and phone number): _____ ☐ Other (provide name and phone number): _____	☐ Results of lab tests/X-rays ☐ Appointment reminders: ☐ Financial ☐ Dental/Medical ☐ Other: _____
☐ **Email communication** (provide email address)*: _____ **For email communication, please accept the disclosure below:*	☐ Financial ☐ Dental/Medical ☐ Appointment reminders ☐ Breach notifications
☐ **Text communication** (provide number)*: _____ **For text communication, please accept the disclosure below:*	☐ Appointment reminder ☐ Other: _____
☐ For **email and/or text communication,** I understand that if information is not sent in an encrypted manner, there is risk it could be accessed inappropriately; I still elect to receive email and/or text communication as selected.	

Patient rights:

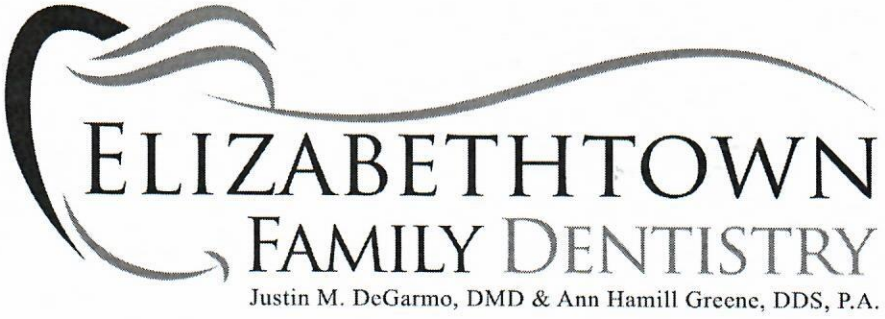
- I understand that I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and 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.

<u>This authorization shall be in effect until revoked by the patient.</u>

_____ _____

Signature of Patient or Personal Representative Date

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



AKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

Patient Name and Address: _____

_____

_____

I have received a copy of the Notice of Privacy Practices for the above named practice.

_____ _____

Patient Signature Date

For office use only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- ☐ An emergency existed and a signature was not possible at the time.
- ☐ The individual refused to sign.
- ☐ A copy was mailed with a request for a signature by return mail.
- ☐ Unable to communicate with the patient for the following reason:

  _____

- ☐ Other:

  _____

_____

Prepared by

_____ _____

Signature Date

401 Doctors Drive • Post Office Box 1736
Elizabethtown, North Carolina 28337
Telephone 910.862.2892 • Fax 910.862.6345

ELIZABETHTOWN
FAMILY DENTISTRY
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FINANCIAL POLICY

In an effort to keep our fee schedule down, payment is due when services are rendered. We accept Visa and MasterCard for your payment convenience. You may apply for a payment plan through Care Credit, but this must be arranged and approved in advance of your appointment.

Lab-related services such as crowns and bridges, partial and full dentures require 50% payment at the time of preparation or initial impression and the remaining 50% at the time of delivery. If you have insurance benefits on these services, you must similarly pay half of your portion at the start date and the remaining half of your portion at the time of delivery.

As a courtesy to our patients who have dental insurance coverage, we will be happy to file your claim electronically. Your deductible and co-payment is due the day of service. We will estimate these amounts for you using the information provided by your plan. Any amount exceeding your annual maximum is due when your services are rendered. In the event your insurance claim is not processed in a timely manner, we will file the claim a second time. However, further delays caused by the insurance company will require you to make full payment to our office, so to expedite processing, you will need to contact the insurance company directly.

Claims to secondary insurance carriers are also filed for patients as an office courtesy; however, we do not accept payment assignments from secondary insurance carriers. The remaining balance after the primary carrier's payment is the patient's responsibility, and the second carrier will submit the benefit payment directly to the patient.

An 18% APR finance charge is automatically tabulated into accounts with balances of 30 or more days. Delinquent accounts are handled by the American Agencies Collection Agency.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THIS DOCUMENT.

_____ _____

Signature Date

401 Doctors Drive • Post Office Box 1736
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