Welcome!

Chart #: _____

Section I: **Patient Information** **Date**_____

Name: _____ ◯ Male ◯ Female

Address: _____ City: _____ State: _____ Zip _____

Date of Birth: _____ Social Security Number: _____

Check Appropriate Box: ◯ Minor ◯ Single ◯ Married ◯ Widowed ◯ Separated ◯ Divorced

Name of Employer: _____

Phone (_____)_____ Cell Phone (_____)_____ Work Phone (_____) _____

The best number to contact me is ◯ Home phone ◯ Work phone ◯ Cell phone

Email Address_____

Whom may we thank for referring you? _____

Person to contact in case of emergency_____ Phone_____

Preferred Pharmacy: _____

Section II **Responsible Party**

Relationship to Patient: ◯ Self (if self, skip this section) ◯ Spouse ◯ Parent ◯ Other

Name:_____ Relationship to Patient: _____

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

DOB_____ SSN#_____ Phone: (____)_____

Section III **Insurance Information**

Name of Insured_____DOB_____Relationship to Patient _____

SSN#:_____ Name of Employer: _____ Work Phone: (____)_____

Insurance Company_____ Grp #_____ ID#_____

Ins Co Address:_____ Ins Co. Phone:_____

---------- DO YOU HAVE ANY ADDITIONAL INSURANCE? ◯ Yes ◯ No ----------

Dental Information

Reason for today's visit _____ Date of last dental visit _____

Former Dentist _____ Date of last dental x-rays _____

Please mark if you have any of the following problems:

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Clicking or popping jaw
- ☐ Food collection between teeth
- ☐ Grinding/clenching teeth
- ☐ Loose teeth or broken filings
- ☐ Periodontal (gum) disease
- ☐ Sensitive to hot/cold/sweets
- ☐ Sensitivity when biting
- ☐ Sores or growths in your mouth

How often do you floss? _____ How often do you brush? _____

Medical Information

Physician's Name _____ Date of last visit _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Have you had any serious illness or operations? ☐ Yes ☐ No If yes, describe _____

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates _____

Have you ever had a total joint (hip, knee, elbow, other) replacement? ☐ Yes ☐ No If yes, when _____

Have you ever had any complications following dental treatment? ☐ Yes ☐ No

If yes, please explain _____

Women Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Mark if you have or have had any of the following:

- ☐ Anemia
- ☐ Alzheimer's /Dementia
- ☐ Arthritis / Rheumatism
- ☐ Artificial Heart Valve
- ☐ Asthma
- ☐ Back problems
- ☐ Bleeding Abnormally
- ☐ Blood Disease
- ☐ Blood Thinner
- ☐ Cancer
- ☐ Chemotherapy / Radiation
- ☐ Chest Pain / Angina
- ☐ Cortisone Treatments
- ☐ Diabetes ☐ Type 1 ☐ Type 2
- ☐ Other _____
- ☐ Dialysis
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting / Ear Problems
- ☐ Glaucoma
- ☐ Headache / Migraine
- ☐ Heart Attack / Trouble
- ☐ Heart Murmur / MVP
- ☐ Hemophilia
- ☐ Hepatitis ☐ A ☐ B ☐ C
- ☐ High / Low Blood Pressure
- ☐ HIV / AIDS
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Mental Disorder (Bipolar/Schizophrenia)
- ☐ Pacemaker
- ☐ Rheumatic / Scarlet Fever
- ☐ Shortness of Breath
- ☐ Sickle Cell Disease
- ☐ Sinus Problems
- ☐ Stroke
- ☐ Swelling of Feet / Ankles
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ ADHD / ADD
- ☐ Bowel Disorder

List medications/vitamins/herbs you are currently taking

_____

_____

_____

_____

Are you allergic to any of the following:

- ☐ Aspirin
- ☐ Codeine
- ☐ Metal
- ☐ Household Bleach
- ☐ Latex
- ☐ Local Anesthetic
- ☐ Penicillin
- ☐ Other _____
- ☐ Sulfa
- ☐ Tetracycline
- ☐ Erythromycin

Authorization and Release

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health. The dentist may use my health care information and may disclose such information to the insurance company for the purpose of obtaining payment for service and determining insurance benefits or the benefits payable for related services.

_____ _____

Signature of Patient, Guardian or Personal Representative Date

_____ _____

Please print name of Patient, Guardian, or Personal Representative Relationship to Patient

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original. **MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.**

_____ _____

Please ***print*** name of Patient Please ***sign*** for Patient / Guardian of Patient

_____ _____

Legal Representative / Guardian Relationship of Legal Representative / Guardian

Your comments regarding Acknowledgements or Consents: _____

_____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:

◯ First Name Only ◯ Proper Sur Name ◯ Other _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION: (This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

☐ Phone Message
☐ Text Message
☐ Email
☐ **Any of the Above**
☐ **None of the above** (opt out)

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment ____
I could not communicate with the patient ____
The patient refused to sign ____
The patient was unable to sign because ____
Other (please describe) ____

_____
Signature of Privacy Officer

James Hardy Family Dentistry
Appointment and Financial Policy

One of the most time consuming chores of our office is confirming appointments. We make every effort possible to confirm each appointment. Many times we have to leave a message on an answering machine, or with a child. But we need your help! We need a confirmation call back if we have not been able to speak with you personally. If you are unable to keep the scheduled appointment we require at least 48 hours notice. There are other patients who may be waiting for an appointment time such as the one for which you were scheduled. Our overhead continues even when the chair you were to occupy is vacant. We have instituted a strict broken appointment policy. This is not meant as a punishment, but rather as an incentive for you to keep your commitment to us. Until recently we have not been an advocate of charging for broken appointments. However, for this office to continue quality care and service, we must adopt management policies that will assure us of continue financial viability. We will be happy to schedule and appointment for you at the time most suitable for your schedule; however, should there be a change in your schedule, we do ask for a 48 hour notice of cancellation. We also ask for a confirmation call back if we have been unable to speak with you personally. If you miss, cancel or change an appointment without a 48 hour notification there will be a charge of $50.00 per thirty minutes of appointment time. That fee would have to be paid before another appointment could be scheduled. In our effort to service our patients' needs, we may not be able to reschedule you after your first broken appointment. After the second broken appointment, we will no longer schedule you for an appointment in our office.

I understand and agree to accept full financial responsibility for any outstanding debts, (including collection fees and legal fees) that may be applied to this account in effort to collect the balance due for services rendered.

Emergency contact name: _____

Emergency contact number: _____

Signature of Patient: _____

Date: _____

(James G. Hardy, DDS) AND YOUR INSURANCE PLAN- HOW THEY WORK TOGETHER

The staff at (James G. Hardy, DDS) is pleased that you have insurance benefits to help with the cost of your dental care. We would like to help you obtain the maximum use of these benefits. With this in mind, please complete the information on our insurance claims process so that we can work together to ensure this benefit.

DO YOU ACCEPT MY INSURANCE? HOW MUCH WILL THEY PAY?

We currently accept all private care insurance plans (plans that do not require you to select a dentist from a list, they require our office to accept a reduced fee for services). This means that we work with literally thousands of insurance companies. Although we can maintain computerized histories of payment by a given company, they do change; therefore it is impossible to give you a guaranteed quote at the time of service. We estimate your portion based on the most up-to-date information we have, but it is ONLY AN ESTIMATE. If you would like to know your exact insurance benefit, we will be happy to file a "pre-treatment authorization" with your insurance company prior to treatment. This does delay treatment but will give you the exact out of pocket figures you may require.

I THOUGHT I PAID MY PORTION BUT I GOT A BILL, WHY?

We base the patient portion of your bill on our most current data but there are many factors that can affect this estimate. There may be a deductible (individual or family) or you may have received treatment in another office prior to joining the (James G. Hardy, DDS) family, which is not calculated into our database. Sometimes you may need to see a specialist for care, which also uses your annual benefit. Insurance companies don not (and cannot in most cases) notify us of changes to your benefits, they only notify you. If these situations apply to you, please let us know when we estimate your treatment plans so we may adjust accordingly.

INSURANCE DIDN'T PAY, NOW WHAT?

We bill your insurance as a courtesy. If insurance does not pay within 90 days, (James G. Hardy, DDS) reserves the right to request payment in full for services from you and let you collect the insurance funds that are due to you. This is rare but it is important that you recognize that insurance you have is a legal contract between YOU and your insurance company. Our office is not, and cannot be a part of that legal contract. Ultimately, you are responsible for all charges incurred in our office.

FINANCIAL OPTIONS

(James G. Hardy, DDS) does request payment in full for your portion at the time of service. We accept most major credit cards. If you are in need of an extended finance option, we also work with Care Credit, who offers a twelve month "same as cash" or longer terms with an interest bearing revolving charge designed to meet your treatment plan needs. Just ask one of the patient services staff for an application.

We welcome you to our family and look forward to helping you get the healthy, beautiful smile you've always wanted. If there is anything we can do to make your visits here more pleasant, please don't hesitate to ask one of our staff members.

I have read, understand, and accept the terms of the above outlines policies for insurance handling and finance commitments that I may incur as a result of treatment at (James G. Hardy, DDS).

_____ _____

Signature Date

HARDY SMILES
FAMILY DENTISTRY

122 Jolly Street
Louisburg. NC, 27549
919.496.3088

CONSENT FOR PATIENT EMAIL COMMUNICATIONS

We are pleased to provide our patients with the ability to utilize e-mail in sending and receiving information or copies of pertinent documents. **I hereby authorize and grant permission to James G. Hardy DDS PLLC to communicate with me via Email.**

I acknowledge and understand the following:

Conditions for the Use of Email: We will use reasonable means to protect the security and confidentiality of Email information sent and received. However, because of the risks normally associated with e-mail we cannot guarantee the security and confidentiality of Email communication, and will not be liable for improper disclosure of confidential information that is not caused our intentional misconduct. Consent to the use of Email includes agreement with the following conditions:

- We may forward Emails internally to the practice's staff and agents as necessary for the handling of your dental services. We will not, however, forward Emails to independent third parties without the client's prior written consent.
- Although we will endeavor to read and respond promptly to an Email, we cannot guarantee that any particular Email will be read and responded to within any particular period of time. Thus, no one shall use Email for emergencies.
- If the individual's Email requires or invites a response from us, and the individual has not received a response within a reasonable time period, it is the individual's responsibility to follow up to determine whether the intended recipient received the Email and when the recipient will respond. Our email address is: info@hardysmiles.com.
- We use Email to notify you of inclement weather, changes in policy, offerings and discounts for dental services as well as appointment requests and changes.
- The individual is responsible for protecting his/her password or other means of access to Email. We are not liable for breaches of confidentiality caused by the
- We also provide the same service and gladly text as well at the request of the patient. You simply need to let us know if you prefer to receive notification from us via text.

Acknowledgment and Agreement

My email address is: _____

My phone number for text is: _____ ☐ Please text do not email

I acknowledge that I have read and fully understood this consent form

Dated: _____ _____
Signature of Client

Dr. James G. Hardy, D.D.S.
Dr. Alecia Hardy, D.D.S.

HARDY SMILES
FAMILY DENTISTRY
Making North Carolina smile from the mountains to the coast.

Additional Patient Acknowledgements and Agreements:

Restorative Dentistry Office Policy

In an effort to reduce the need for future dental procedures through recommended preventative care, Hardy Family Dentistry would like to collaborate with you with the following offer:

We extend a **5-year limited warranty** on crowns, fixed bridges, and porcelain veneers that were completed at our office under the following terms: You must maintain your doctor's recommended hygiene recall interval including routine professional exams, x-rays and cleanings with our practice. (minimum of every 3 to 4 months)

Our practice is unable to offer warranty services:

1. If patient misses recommended professional exams, xrays, cleanings, or oral hygiene is neglected
2. If the dentist's instructions are not followed properly
3. If a night guard is recommended but not worn
4. In case of accidents or suffering facial trauma (Teeth that have been exposed to a traumatic injury following placement of a restoration)
5. If a patient smokes
6. If an illness is present, which has an unfavorable effect on the mouth (e.g. diabetes, epilepsy, osteoporosis, chemotherapy)
7. If there is periodontal problem or unforeseen root canal treatment (ie. Teeth that require a more involved procedure than originally performed, ie. Root canal, gum surgery, etc..)
8. If dental work is performed by another dental office.

Other exclusions: fillings, bonded plastic restorations, sealants, surgery, or root canals.

The warranty applies if the crown, fixed bridge, or veneer has failed or has been determined to be unsatisfactory by both the patient and the dentist.

Timeframe for coverage

1) If crown breaks between years 0-3, patient will not incur any out-of-pocket cost
2) If crown breaks between year 3-5, patient will incur lab cost only
3) If crown breaks after 5 years, patient will incur cost of a new crown
4) In no case shall a refund be given to a patient after treatment with the above mentioned procedures. (Also see Interrupted Services below)

Refund Policy

While our office strives to make every effort to achieve optimal oral health and high patient satisfaction, patients may request refunds on uncompleted dental work. Patients may do so by obtaining a Refund Request form from one of our front desk staff members. Forms may be returned in person to our front office or mailed to: Hardy Family Dentistry, Attn: Refund Processing, 122 Jolly Street, Louisburg, NC 27549. The request will then be reviewed and submitted to our Accountant. After receipt of the request form, there is a 60 day administrative period to process the refund and there is a 10% administrative fee. Hardy Family Dentistry will refund patient's existing credit balance for treatment that was not received. All refunds will be processed back to the original form of payment, except cash payments which will be refunded by check.

Payments made by credit card must be refunded to the originating credit card account. Please contact your credit card company regarding the number of days it takes for them to post the refund to your credit card account.

Patient payments originating from a third party lender must be refunded to the original account. Please contact the lender for information regarding their processing time. The refund may not be reflected on your account for approximately 2 billing cycles. We have no control over the lender policies on crediting refunds.

Interrupted services: For prosthetic procedures such as crown, bridge, and veneer work in which teeth have been prepared or altered for the prosthetic, patients are responsible for the full estimated cost of the services even if they choose not to complete treatment. For other prosthetic procedures where lab work has been completed for the patient, patients choosing not to complete treatment are responsible for the lab costs that were incurred.

Patient Signature:_____ Date:

_____

Witness Signature:_____ Date:

_____

Submit