PATIENT REGISTRATION

First Name:_____ Last Name:_____ Middle Initial:____

Preferred Name:_____

Patient is : □ Responsible Party □ Policy Holder

Responsible Party: (if someone other than the patient)

First Name:_____ Last Name:_____ Middle Initial:____

Address:_____ Address 2:_____

City, State, Zip:_____

Home Phone:_____ Work Phone:_____ Cell Phone:

Birth date:_____ Social Security #:_____ Drivers Lic#:_____

○ Responsible Party is Policy Holder for Patient ○ Primary Policy Holder ○ Secondary Policy Holder

Patient Information:

Address: _____ Address 2:_____

City, State, Zip:_____

Home Phone:_____ Work Phone:_____ Cell Phone:

Sex: ○ Female ○ Male Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Birth date:_____ Social Security #:_____ Drivers Lic#:_____

E-mail:_____ □ I would like to receive email correspondences

Patient Information (section 2):

Employment Status: ○ Full Time ○ Part Time ○ Self Employed ○ Retired ○ Unemployed

Student Status: ○Full Time ○ Part Time

Employer:_____ Preferred Pharmacy:_____

Occupation:_____

Referred By:_____

Primary Insurance Information:

Name of Insured:_____ Relationship to Insured: ○Self ○Spouse ○Child ○ Other

Employer ID: _____ Carrier ID:_____

Insured Social Security #: _____ Insured Birth date:_____

Employer:_____ Insurance Company:_____

Address:_____ Address:_____

Address 2: _____ Address 2: _____

City, State, Zip:_____ City, State, Zip:_____

Continue On The Back

Secondary Insurance Information:

Name of Insured:_____ Relationship to Insured: ○Self ○Spouse ○Child ○ Other

Employer ID: _____ Carrier ID: _____

Insured Social Security #: _____ Insured Birth date: _____

Employer:_____ Insurance Company: _____

Address:_____ Address: _____

Address 2: _____ Address 2: _____

City, State, Zip:_____ City, State, Zip: _____

PLEASE INITIAL EACH OFFICE PROTOCOL REQUIREMENTS

1. Appointments that are not confirmed within 24 hours of the appointment time will be cancelled _____
2. There will be a $50.00 fee for all No Show appointments & for appointments that are scheduled for 2 hours or more, there will be a $75.00 charge. These must be paid before the patient will be rescheduled. _____
3. ○ I certify that I **don't** have dental x-rays at any prior dental office within the past 5 years _____
   ○ I certify that I **do** have current x-rays and have signed the enclosed release form _____
4. Insurance is filed as a courtesy. If there is a remaining balance that insurance does not cover or if there is a code that is not covered by insurance, I know I am responsible for the balance _____
5. If you do not have a current panorex x-ray within the past 12 months, we require that we take one here at your first appointment at our office. The charge for this service is $120.00. If we estimate that your insurance will not cover this x-ray, you will be responsible for paying that on the same day as your visit. _____

Time 1:16 PM

Oceanside Family Dentistry

Eaglesoft Medical History

Date 11/9/2022

Patient Name: Birth Date: Date Created:

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, c

Are you under a physician's care now?	○ Yes ○ No	If yes
Have you ever been hospitalized or had a major operation?	○ Yes ○ No	If yes
Have you ever had a serious head or neck injury?	○ Yes ○ No	If yes
Are you taking any medications, pills, or drugs?	○ Yes ○ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	○ Yes ○ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	○ Yes ○ No	If yes
Are you on a special diet?	○ Yes ○ No	
Do you use tobacco?	○ Yes ○ No	
Do you use controlled substances?	○ Yes ○ No	If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic

☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other? ☐ If yes

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 Problems	○ 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 If yes

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:

X_____ Date:_____

Oceanside Family Dentistry
G. Thomas Ward Jr, D.D.S., PA

Appointment Cancellation Policy

Our office takes pride in providing an extra amount of time during appointments for the personal needs of our patients, allowing them to have the excellent quality of work done they deserve. We respect your time and schedules, and it is with great effort that we try not to keep you waiting for long periods of time. As a result, the specific appointment time given to you in our office is reserved entirely for you.

Oceanside Family Dentistry reserves the right to charge a **fee of $50.00** to patients who fail to keep an appointment without prior notice, or who do not reschedule within the given amount of time stated in our policy.

How to Cancel or Reschedule Your Appointment

In order to be courteous to all of our patients here at Oceanside Family Dentistry, if for any reason you may need to cancel or reschedule your reserved appointment, we require that you give our office a **48 HOUR NOTICE**. This allows others in need to be given sufficient notice in order to access these appointment times.

To **cancel** your appointment, please call our office at **(252)247-5683**. If you are unable to reach us, please leave a detailed message on our answering machine explaining why you need to cancel your appointment.

No Show Policy

A "no show" appointment happens when a patient misses their appointment *without* a 48 hour notice of cancellation. No shows are an inconvenience to our patients who are in desperate need of dental care. *Last minute/late cancellations are considered to be "no show" appointments!*

Failure to show up at your reserved appointment time will be recorded in your chart as a "no show." *ALL* "no show" appointments will result in a **$50.00 fee** that will be applied to your account. Exceptions to this policy must be approved by Dr. Ward.

*****NEW PATIENTS that miss their first appointment will *not* be rescheduled*****

By signing below, I certify that I have read and understand the terms and conditions of Oceanside Family Dentistry's appointment cancellation policy:

X_____ _____

Patient Signature Date

Oceanside Family Dentistry
G. Thomas Ward Jr. D.D.S., PA

Financial Guidelines

Thank you for choosing us as your dental health provider. Please understand payment of your bill is considered part of your treatment. The following is a statement of our Financial Guidelines that we require you read, agree to and sign prior to beginning treatment.

Payment is due at the time services are rendered. As a courtesy to you, we will gladly file your primary dental insurance. If we are unable to verify insurance coverage, you will be expected to pay in full for your visit on the day of service. If your insurance has not paid within 30 days of your visit, you are responsible for the balance. If your insurance pays more than expected, a refund will be issued to you. **It is also your responsibility to inform us of any changes in your insurance coverage prior to receiving treatment.**

The parent or guardian who brings in a child that is under the age of 18 years old is responsible for payments regardless of what individual circumstances may be or what a divorce decree may state. Reimbursement must be made between the divorced parents. We will not intervene.

We accept cash, money orders, Visa, Mastercard, Discover and personal checks. We do not accept American Express.

All accounts with an outstanding balance after 90 days of rendered treatment will be assessed a non-refundable finance charge of 1.5%.

Treatment plan fees are valid 90 days from date of issue. Treatment must be completed within 6 months of issue date of treatment plan. If not completed within 6 months, treatment must be re-evaluated. Treatment in office is subject to change and will be verbally discussed. I understand that I am responsible for any additional charges due to treatment changes.

We file insurance AS A COURTESY. Insurance coverage is only an estimate. We cannot guarantee what your insurance is going to cover for your treatment. At your request, we will be happy to file a pre-treatment estimate to your insurance company for your treatment plan. You will be responsible for all non-covered charges that are left on the account.

I have read, understand and agree to the provisions of this Financial Guideline.

Signature_____

Date_____

(Signature of Person Financially Responsible for Account)

Authorization to Release Dental Information

Patient Information:

Name of Patient:_____ Date of Birth:_____

Address: _____

City, State, Zip:_____ Phone:_____

_____ **may release the following information:**
(Name of the entity)

☒ X-rays

*Financial compensation is received for this communication.

Entity or person who will receive the information:

Name: Oceanside Family Dentistry

Address: 4251 Arendell Street Suite I

City, State, Zip: Morehead City NC 28557 Phone: 252-247-5683

☒ **Send the information electronically. Email address:** oceansideddsstaff@gmail.com

☒ For **email communication** I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to move forward to allow email communications to occur.

This authorization shall be in effect until the information has been forwarded as requested or until the course of treatment is complete.

Patient Rights:

- I have the right to revoke this authorization at any time by contacting our office.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the 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 may no longer be protected by federal or state law.
- I may refuse to sign this authorization and that my treatment will not be conditioned on signing.
- I understand released information may include a communicable disease diagnosis such as HIV.

This authorization will remain in effect until revoked by the patient.

Signature of Patient or Personal Representative: _____ Date: _____

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

☐ Revoked by patient or personal representative on _____.
DATE

How revoked: ☐ orally (in person or via phone) ☐ in writing (place copy in patient's file)

YOUR PHOTOS & MULTIMEDIA

	Photos/Images may be used/posted:
☐ Photo received from you or personal representative	☐ In office
☐ Photo taken by staff (e.g., pre/post procedure)	☐ On office's website
☐ Other:_____	☐ Other: _____

PATIENT RIGHTS & SIGNATURE

- You can end this authorization at any time in writing. See our Notice of Privacy Practices for exceptions. A termination will not apply to any releases of information that happen before we receive a written termination from you.
- The recipient of the information could use or release it in a way that federal or state laws do not protect. This practice is not responsible for the privacy or security of your health information afterit is sent to those listed on this authorization.
- You can review or copy the information that will be used or released as described in this authorization.
- You do not have to sign this authorization to receive treatment from this practice.
- You understand that the information that will be used or released might include a communicable disease diagnosis such as HIV or a diagnosis related to mental health or substance abuse unless you exclude it above.
- All changes or updates to this form must be made in writing and signed by you (patient) or your personal representative. Minor edits (e.g., new phone number) can be made on this form, initialed, and dated instead of requiring a new form.

_____ _____

Patient/Personal Representative Signature Date

Printed name and description of Personal Representative's authority (e.g., healthcare power of attorney)
(Attach documentation to support the personal representative's authority if not already on file with the practice)

_____

FOR OFFICE USE & REFERENCE ONLY

☐ This authorization has been terminated: _____ mm/dd/yyyy

The termination must be in writing and filed with the original authorization.

Date original signed authorization received: _____

☐ Copy of original authorization provided to patient/personal representative (check if yes) mm/dd/yyyy

Notes: _____

_____

_____

It is recommended that the practice review this form with the patient or their personal representative periodically for changes (e.g., annually with insurance verification).

AUTHORIZATION TO RELEASE HEALTH INFORMATION

Communications between Patients and their Families, Friends, or Caregivers

This form allows Oceanside Family Dentistry (Name of Practice) to communicate information about your care (e.g., appointments, labs, medication, treatment plans, billing information) to you and those you list on this form. Signing this form is optional, is not required to receive treatment, and does not expire until you end it in writing.

Patient Name: _____
(Last) (First) (Middle Initial)

Date of Birth: _____ (mm/dd/yyyy) **Main Contact Number:** (___) _____
☐ Home ☐ Cell* ☐ Work

Mailing Address: _____
(Street)

_____
(City) (State) (Zip)

COMMUNICATING WITH YOU

PHONE

☒ Main Contact Number Above	☒ text (SMS)*	☒ voicemail/answering machine	☐ None
☐ Other: (___) _____ ☐ Home ☐ Cell* ☐ Work	☐ text (SMS)*	☐ voicemail/answering machine	☐ None

EMAIL*

☒ _____

- ☒ All information from this practice
- ☐ Appointment information only (request/confirm/cancel)
- ☐ Data breach notifications
- ☐ Billing/insurance information

COMMUNICATING WITH YOUR FAMILY, FRIENDS, OR CAREGIVERS

☒ This practice may communicate to the family members, friends, or caregivers listed below.

Spouse/Partner: _____ (First and Last Name)
Phone: (___) _____
Email:* _____

Other: _____ (First and Last Name)
Phone: (___) _____
Email:* _____
Relationship: _____

Check the box next to each type of information this practice may share.

☒ All information ☐ Prescriptions ☐ Appointments (request/confirm/cancel) ☐ Billing/Insurance
☐ Other: _____

Do not include:

☐ Mental health records ☐ Communicable diseases (e.g., HIV/AIDS) ☐ Alcohol/drug abuse treatment

* I understand that emails and texts are not always secure ways to communicate and could be intercepted and read by a third party. I am willing to accept this risk.
This practice is not responsible for the privacy or security of your health information once it is sent to you, or the recipient(s) listed above.

Notice of Privacy Practices

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect (04/15/03), and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:
Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.
Payment: We may use and disclose your health information to obtain payment for services we provide to you.
Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.
Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.
To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.
Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.
Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.
Required by Law: We may use or disclose your health information when we are required to do so by law.
Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence,

counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.
Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $20.00 for each page, $10.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)
Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.
Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).
Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.
Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.
Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.
If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.
We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

CONTACT: Cathy Cain
Telephone: 252-247-5683 or 252-247-1104
Email: Oceansideddsstaff@gmail.com
Address: 4251 Arendell Street Suite I, Morehead City, NC 28557

Oceanside Family Dentistry

Acknowledgement of Receipt Of Notice of Privacy Practices

Patient Name & Address: _____

_____

_____

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

_____ _____

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 & 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 _____