PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name:

Responsible Party (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Soc Sec: Drivers Lic:

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: Address 2:

City: State / Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

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

Birth Date: Age: Soc Sec: Drivers Lic:

E-mail: ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg:

Section 3

Primary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

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

Rem. Benefits: Rem. Deduct:

Secondary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

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

Rem. Benefits: Rem. Deduct:

Bikram Singh DMD

Eaglesoft Medical History

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, 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
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	

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 use controlled substances?	○ Yes ○ No	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 ○ 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:_____

Cary Dental Rejuvenation

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 _____

Authorization for Release of Information

Name of Patient _____ Date of Birth _____

Practice/Dentist name: _____ is authorized to release protected health information referring the above named patient to the entities named below. The purpose is to obtain permission (or instructions) from the patient or guardian if minor to release specific protected health information, related appointments, and/or related financial information.

Entity to Receive Information. Check each person/entity that you approve to receive information.	**Description of information to be released.** Check each that can be given to person/entity on the left in the same section.
❑ Voice Mail on Cell Phone ❑ Voice Mail on Home Phone	❑ Results of lab tests/x-rays ❑ Financial ❑ Medical as follows: _____ ❑ Appointment Reminders
❑ Spouse (provide name & phone number) _____	❑ Financial ❑ Medical as follows: _____ ❑ Appointment Reminders
❑ Parent (provide name & phone number) _____	❑ Financial ❑ Medical as follows: _____ ❑ Appointment Reminders
❑ Other (provide name & phone number _____	❑ Financial ❑ Medical as follows _____ ❑ Appointment Reminders

Patient Information

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward. I understand that 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 understand that I have the right to refuse to sign this authorization and that my treatment will not be conditional upon signing this form. This authorization shall be in effect until revoked by the patient.

_____ **Date** _____

*Signature of Patient or if minor Parent, Guardian or Personal Representative

Description of Personal Representative's Authority : _____

*attach necessary documentation such as: Legal Guardianship Documentation or Health Care Power of Attorney

CARY DENTAL REJUVENATION

FIVE STAR DENTAL EXPERIENCE

Release of Records Authorization Form

I _____ am requesting my records from the dental office of:

_____ On this date _____. I am authorizing the practice to release any information including the diagnosis and the records of any treatment or examination rendered to me or my family members during the period of such Dental care to the following. I am authorizing _____ (dental office) to release any records to Cary Dental Rejuvenation via email:

Name Cary Dental Rejuvenation

Address 155 Parkway Office Court Suite #104

Fax 919-460-3939 Email admin@carydentalrejuvenation.com

Patient Signature _____ Date:_____

We are agreeing to provide our patients with access to their records in accordance with state and federal laws. You have the right to request restrictions in the use of your protected heath information and to request change in certain policies used within the office concerning you PHI. However, we are not obligated to alter internal policies to conform your request.

CARY DENTAL REJUVENATION

FIVE STAR DENTAL EXPERIENCE

HIPPA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPPA) provides safeguards to protect your privacy. Implementation of HIPPA requirements officially begun on April 14, 2003. Many of the policies have been our practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPPA provides certain rights and protections to you as the patient. We balance these needs with our goals of providing you with quality professional services and care. Additional information is available from the U.S. Department of Health and Human Services. ww.hhs.gov.

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff . You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, email, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manger or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____date_____do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

CARY DENTAL REJUVENATION

FIVE STAR DENTAL EXPERIENCE

Financial Policy

Thank you for choosing Cary Dental Rejuvenation. Our primary mission is to provide our patients with a five star experience, delivering the best and most comprehensive dental care available. Your clear understanding of our financial policy is important to our professional relationship.

We accept several payment options:

- Cash, Check, Visa, Master Card, Discover and American Express
- Patients 62 years and older **WITHOUT INSURANCE** are eligible for a 10% senior discount when they pay their dental treatments in full by cash, check or credit card at the time of service.
- No interest payment plans from Care Credit (subject to approval)

For Patients with Insurance: Insurance is a contract between you and your insurance company. For patients with dental insurance we are happy to work with your carrier to maximize your benefits. Any cost estimate that we provide to you is based off of the information provided to us by your insurance company and will bill them accordingly. There is not a guarantee that your dental benefit company will provide any benefits.

However, our contract is with you and not your insurance company. Our staff is not responsible for knowing all the terms and limitation of the many policies of our patients. It is your responsibility to familiarize yourself with your dental care policy and to be aware of any uncovered charges or limitations of your plan.

Cary Dental Rejuvenation requires payment at the start of your treatment. Please be prepared to pay your deductible and any estimated amount not covered by your insurance plan at the time of your visit.

For those insurance policies that the patient directly, payment in full is required for those completed services. For treatment that requires major work or more length of time, payment will be required at time of scheduling. If you decide to discontinue the course of treatment before it is completed then a refund will be determined upon review of your case. Fore treatment plans that require multiple appointments, alternate payment arrangements may be provided.

Our office requires **2 BUSINESS** days notice to change or reschedule an appointment. We assess a charge for ALL returned checks. We reserve the right to transfer any credits to another family member with an outstanding balance.

Patients are responsible for all charges whether or not paid by insurance. Unpaid balances over 60 days will be assessed a finance charge, and over 90 days will be processed through a collection service and the patient will be responsible for any additional collection charges. If you have any questions please do not hesitate to ask. We are here to help you get the dentistry you want and deserve.

I have read and fully understand the above financial policy.

PATIENT OR GUARDIAN SIGNATURE:_____**DATE:**_____

CARY DENTAL REJUVENATION

TRANSFORMING ORAL CARE

MISSED APPOINTMENT POLICY

We want our patients to know how much we value your business. In an effort to provide the highest quality dentistry at affordable prices, we require **2 FULL BUSINESS DAYS NOTICE** for any schedule changes that you may need in the future. Our office understands that sometimes emergency situations arise and we will handle each circumstance on an individual basis. We would like our patients to understand that missed or broken appointments are hurtful in many ways. First, they delay your treatment and our ability to keep your oral health at optimum levels. Second, they may prevent another patient who needs treatment from getting the necessary care in a timely manner. Lastly, missed appointments increase our business expenses which ultimately results in fee increases. With this in mind, we want you to be informed of our appointment policy so there are no misunderstandings in the future.

After two appointments that have been broken or rescheduled without 2 business days notice will not be actively rescheduled and will be added to the "Quick Fill" list to help reduce the risk of cancellations in the future.

Thank you for your cooperation. We remain committed to your oral health.

I, _____, have received a copy of this office's notice of Missed Appointment Policy.

Signature _____Date_____

CARY DENTAL REJUVENATION

FIVE STAR DENTAL EXPERIENCE

VIDEO/PHOTOGRAPH/REVIEW RELEASE FORM

I hereby grant Cary Dental Rejuvenation the irrevocable right to permission to use reviews I have written, photographs and/or video recordings of me on their websites, social media sites for any similar purpose.

I understand and agree that such written reviews, photographs and/or video recordings of me may be placed on the internet. I also understand and agree that I may be identified by the name and/or title in printed. Internet and broadcast information that might accompany the written reviews, photographs and/or video recordings of me. I hereby irrevocable authorize Cary Dental Rejuve3nation to edit, alter, copy, exhibit, publish or distribute these reviews, photos, and videos for any lawful purpose. In addition, I waive the right to approve the final product. I agree that all such reviews, photographs, videos, audio recordings and an reproductions thereof shall remain the property of Cary Dental Rejuvenation.

I hereby release, acquit and forever discharge Cary Dental Rejuvenation, its owner and employees from any and all claims, demands, rights, promises, damages and liabilities arising out of or in connection with the use or distribution of said reviews, photographs and/or video recordings, including but not limited to any claims for invasion of privacy, appropriation of likeness or defamation. Furthermore, I grant permission to use my statements that were given during an interview or video with or without my name for the purpose of advertising and publicity without restriction. I waive my right to any compensation.

I give Consent for using: ☐ Photographs ☐ Videos ☐ Reviews

I hereby warrant that I am eighteen (18) years old or more and competent to contract in my own name or if I am less than eighteen years old that my parent or legal guardian has signed this release form below. This release is binding on me and my heirs, assignees and representatives.

_____ _____

Signature of Individual or Legal Guardian Date

Printed Name of Individual or Legal Guardian: _____

_____ _____

Signature of Witness Date