Modern
FAMILY DENTAL CARE

We create a beautiful, confident, and healthy smile for everyone.

New Patient Registration

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

How did you learn of Modern Family Dental Care?
Direct Mailing Friend/Relative Internet Search Insurance Plan Newspaper Ad Exterior Sign Facebook Twitter
Other_____ If you were referred, whom may we thank for referring you?_____

Patient Information

Name _____ Nickname _____ Sex M F
SSN _____ Birth date _____ Cell Phone _____
Address _____ Home Phone _____
City _____ State _____ Zip _____ Work Phone _____
Email _____ Facebook _____ Twitter _____
Check appropriate box: Minor Single Married Divorce Widowed Separated
If student, name of school _____ FT / PT City _____ State _____ Zip
Patient or parent/guardian's employer _____ Work Phone _____
Employer Address _____ City _____ State _____ Zip _____
Emergency Contact _____ Phone _____

Responsible Party

Name of person responsible for account _____ Relationship to Patient _____
Address _____ Cell Phone _____
City _____ State _____ Zip _____ Home Phone _____
Email _____ DOB _____ Work Phone _____
Are you currently a patient of this office? Yes No Drivers License # / State _____
Employer _____ SSN _____

Insurance Information

Name of Insured _____ Relationship to Patient _____
DOB _____ SSN _____ Date Employed _____
Name of Employer _____ Address _____ Work Phone _____
City _____ State _____ Zip _____ Home Phone _____
Insurance _____ Group # _____ Policy/ID # _____
Insurance Address _____ City _____ State _____ Zip _____

Consent

I will answer all health questions on the Medical History From to the best of my knowledge_____ (Initials)

After explanation by the doctor, I hereby authorize the performance of dental services upon the above named patients and whatever procedures that the judgment of the doctor may decide in order to carry out these procedures. I also authorize and request the administration of any anesthetics and x-rays as may be deemed necessary and advisable by the doctor.

Signature _____ Date_____ Relationship to Patient_____

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Your name_____ Today's date_____

Your regular dentist is_____ Your physician is_____

Ever been a patient here before? ☐YES ☐NO Your current age_____

(Check all that apply)

Have you ever had an adverse reaction to:

☐ Local Anesthetics/Novocain ☐ Codeine ☐ Antibiotic _____
☐ Other_____ ☐ Aspirin/Advil ☐ Latex

Do you take:

☐ Blood thinners (e.g Coumadin, Plavix, etc.) if yes, date and score of most recent INR _____
☐ Any other medications, vitamins or supplements, if so, please list:

Name of medication	What condition you take it for
_____	_____
_____	_____
_____	_____

(List any additional meds you take on separate sheet)

What is your level of anxiety/stress/fear when going to the dentist? ☐None ☐Mild ☐Mod ☐Severe

1. **Please list your height_____ Please list your weight_____**

Being overweight is now recognized as a strong risk factor for gum disease. Obesity and gum disease are both risk factors for heart disease and diabetes. Thus, if you are over your ideal weight it is vitally important for you to eliminate any gum inflammation to lower your risks for more serious health problems.

2. **Tobacco use**

☐ Never
☐ Previous tobacco user, if so, how long ago did you quit_____
☐ Currently using tobacco, if so please answer the following:
What type do you use? ☐ Cigarettes ☐ Chew ☐ Cigar ☐ E-Cig ☐ Other
How much/day_____ For how long_____
Every tried to quit? ☐ Yes ☐ No

Tobacco users are more likely to develop gum disease. Gum disease itself has recently been linked with an increased risk for heart disease. Since tobacco users are already at an increased risk for heart disease (and since gum disease only worsens that risk) it is vitally important for tobacco users to do whatever is necessary to eliminate gum disease.

3. **Have you ever been diagnosed with heart disease?**

☐ Yes
☐ No ☐ Do you have any of the following risk factors for heart disease? Check all that apply
☐ Family history of heart disease ☐ Elevated cholesterol ☐ High blood pressure
☐ Poor diet ☐ Lack of exercise

Gum disease is now a recognized risk factor for heart disease. If your gums are inflamed, bacteria from your mouth can get into your blood stream and lodge in your heart vessels. Finding out if you have gum disease and then keeping it at bay over your lifespan can lower your risk for heart disease and stroke.

4. **Vitamin D Status**

Have you ever had your Vitamin D level checked?
☐ No
☐ Yes If so, how long ago?_____ What was it?_____

Low vitamin D levels have been linked with a higher risk for gum disease and many other diseases. Many people are chronically low in Vitamin D. It is important to find out your vitamin D level and optimize it if your level is low.

5. **Sleep**

How many hours of sleep do you typically get each night?_____

Have you ever been diagnosed with sleep apnea? ☐ Yes ☐ No

Please check yes or no for the following questions:	YES	NO
Do you snore loudly (loud enough to be heard through closed doors)?		
Do you often feel tired, fatigued, or sleepy during daytime?		
Has anyone observed you stop breathing during your sleep?		
Do you have or are you being treated for high blood pressure?		

Lack of quality sleep and sleep apnea are very serious. Sleep apnea is linked to gum disease and many other diseases. Part of overall wellness is keeping any gum inflammation in your mouth to a minimum. This is especially important if you have any sleep abnormalities.

6. **Diabetes**

Have you ever been diagnosed with Diabetes?
☐ No ☐ Do you have a family history of diabetes? ☐ Yes ☐ No
☐ Yes If so, please answer the following:
How is your diabetes control? ☐ Good ☐ Fair ☐ Poor
Date of last A1c_____What was the A1c score?_____
Who is your diabetes Doctor_____

Diabetes is a well- known risk factor for gum disease. Research is confirming that untreated gum disease makes it harder for you to control your blood sugar. Elimination of gum disease can improve your blood sugar control reducing your risk for the serious complications of diabetes.

7. **Have you ever been diagnosed with Rheumatoid Arthritis?** ☐ Yes ☐ No

Research is confirming a two-way relationship between rheumatoid arthritis and gum disease. If you have RA you are at an increased risk for gum disease. If gum disease develops it can make your RA symptoms worse. Thus, if you have RA it is important to continually monitor for and treat any gum disease.

8. **Do you have a family history of Alzheimer's Disease?** ☐ Yes ☐ No ☐ Don't know

Gum disease has been linked with an increased chance for developing Alzheimer's Disease later in life. If you have a family history you are already at increased risk. Keeping gum disease at bay over your life span can lower your risk for developing Alzheimer's Disease.

9. **Do you have a family history of gum disease?** ☐ Yes ☐ No ☐ Don't know

Some people are genetically prone to developing gum disease even if they take decent care of their mouths.

10. **How would you rate your stress level?** ☐ None ☐ Low ☐ High

Stress is a well- known risk factor for gum disease.

Life altering events (loss of job, divorce, death in family, moving to new location, etc.) can lead to the type of stress that can lower your resistance to diseases liked gum disease. Are you currently going through any life altering events? ☐ Yes ☐ No

11. **Other Medical conditions** (Check all that apply)

☐ Asthma if yes, where do you keep your inhaler?_____

☐ Bleeding problems	☐ Epilepsy	☐ Prosthetic heart valve	☐ Artificial joint
☐ Hepatitis	☐ Tuberculosis	☐ HIV/AIDS	☐ Thyroid Disease
☐ Cancer	☐ Chemo/radiation	☐ Vertigo	☐ Steroid Use
☐ Kidney Problems	☐ Psychiatric therapy	☐ Change in health in last year	☐ Any Addiction
☐ Breathing/COPD	☐ Cold Sores/fever blisters		

☐ Spouse with gum disease (Gum disease may be transmissible, family members should be screened for gum disease)

☐ Taking Dilantin, Ca+ Channel Blockers, or Immunosuppressants for organ transplantation

☐ History of gastric ulcers	☐ Respiratory disease
☐ Kidney Disease	☐ Family history of colon cancer

FEMALES Are you: ☐ Pregnant ☐ Nursing ☐ Taking birth control pills

Gum disease is linked with an increased risk of osteoporosis and even breast cancer in post-menopausal women.

☐ Ever diagnosed with breast cancer? ☐ Family history of breast cancer? ☐ Post-menopausal?

Do you have osteoporosis? ☐ Yes ☐ No

Have you ever been tested for osteoporosis? ☐ Yes ☐ No

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Receipt of Privacy Practices and Authorizations

Patient's Name: _____ Birth Date _____
Address _____

authorizes:

Modern Family Dental Care
Taj M. Haynes DMD, PA
8455 Pit Stop Ct NW, Ste 140
Concord, NC 28027

to use or disclose protected health and account information to the person(s) listed in the sections below for the following patient:

- Receiving Entity:_____ Birth Date:_____
  Address:_____
  Contact:_____ Relationship:_____

- Receiving Entity:_____ Birth Date:_____
  Address:_____
  Contact:_____ Relationship:_____

This authorization shall be enforced until revoked by the patient. This practice will verify the identity of any entity requesting protected health information by photo ID.

Rights of the Patient
I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

I understand that I have the right to revoke this authorization at any time by sending a written notification to the address listed at the top of this form I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I hereby acknowledge that I have received the Notice of Privacy Practices for the above office.

_____Date _____
Signature of Patient or Personal Representative (as defined by HIPAA)

_____
Description and/or relationship of Personal Representative's Authority:

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Patients with Commercial Health Insurance (Manage Care Plans)

This letter is to help you better understand the complexities of dental insurance; we realize how confusing it can be. To begin, the manage care plans, like Preferred Provider Organizations (PPO), are not designed to pay for all dental care. They will only pay for dental care services that are determined medically needed and are considered "covered services." Covered services are defined in the managed care plan's group dental agreement. Most contracts have limits and/or various degrees of co-payment. If a managed care plan determines that a service is not medically necessary or not covered, as defined in group dental agreement, then the manage care plan will not pay for the service or pay for the lowest cost alternative option.

All levels of payment by insurance companies, including allowed fees, usual and customary (UCR), are governed by the premiums paid. They have nothing to do with the actual charges. Our fees are based upon a combination of our costs, our time, and our constant dedication to delivering to our patients with the highest quality dental care. The treatment recommended by our office is never based on what your insurance company will pay; your treatment should not be governed by your insurance contract.

In certain cases, your doctor, based on his or her medical opinion, may request that the service, x-ray and/or test be performed that may not be considered a covered service as defined in your group dental agreement. Services a provider may request that may not be considered "covered services" may include, but not limited to:

- Periodic oral health maintenance examinations
- Certain screening or diagnostic tests
- Diagnostic x-rays or scans
- Oral biopsies
- Preventative treatments and services
- Other special procedures

However, it should be understood, **that the dental insurance contract is between the insurance company and the patient**, whom bears the ultimate financial responsibility.

Please take the time to review your contract thoroughly so we may best serve you. If you have a question or concern about a procedure that may not be covered by your insurance company, we encourage you to contact your insurance company directly. As always, you may feel free to ask any member of our staff for clarification on services, billing, and insurance.

_____ _____

Patient /Responsible Party Signature Date

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Acknowledgement of Receipt of Notice of Privacy Practices

Taj M. Haynes DMD, PA
8455 Pit Stop Ct NW, Ste 140
Concord, NC 28027
(704) 262-3436

Patient Name: _____

Patient Phone #: _____

I hereby acknowledge that I have received the Notice of Privacy Practices for the above office.

_____

Signature: Patient's Name / Personal Representative (as defined by HIPAA) Date

_____

Description of Personal Representation and please attach copy of documentation.

Documentation of "Good Faith" Attempt to get acknowledgement signature.

- ☐ Document presented to patient, but patient refused to sign acknowledgement.
- ☐ Patient presented with an emergency situation and there was no time to give the Notice or receive a signature. Attempt to get give the Notice, and get any acknowledgement will be handled as soon as possible.
- ☐ Documentation was presented to the patient but a communication failure prevented us from receiving the acknowledgement.
- ☐ The documentation was mailed to the patient but never returned to us.
- ☐ Other _____
  _____

Employee preparing document Date

_____

Employee signature _____

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FINANCIAL POLICY

Welcome:
Thank you for choosing us as your dental care provider. Our doctors and staff members are dedicated to serving your dental needs with the best professional advice, care, and service obtainable. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our financial policy which we require you to read and sign prior to any treatment being rendered. We are glad that you are here and we want to do our very best for you. We sincerely hope that your visit will be a pleasant and rewarding experience. If you have any questions during your dental exam today, please do not hesitate to ask.

Payment:
We want to help remove financial barriers so you and your family can get the dental treatment that you need. Many patients have some type of dental insurance, and we are able and pleased to assist you in maximizing your benefits. We also understand that not all of our dental families have dental insurance, and we want you to rest assured that we do have payment options available to meet most patient's needs.

We accept cash, checks, VISA, MasterCard, Discover and American Express. We offer several flexible financing options because we do understand that monthly payments can help fit dental care into your budget. The first option is **Lending Club** (for those who qualify). With **Lending Club**, you can finance 100% of your treatment with no annual fees and allows you to finance treatment plans from $500 to $50,000. **Lending Club** offers several payment options: 0% financing from (6)-(24) months, and low-interest extended plans from (6) months to (84) months dependent upon approval. This allows for flexible monthly payments – the length of term is determined by the amount financed. Much like Lending Club, we also offer **Proceed Finance** (for those who qualify). **Proceed Finance** offers low-interest financing all the way up to (96) months, dependent upon approval, with no required down payment. This financing option can be used for treatment plans anywhere from $2,500 to $60,000. We also accept **CareCredit** card payments (for those who qualify). **CareCredit** offers the same payment options as Lending Club. The major difference between Lending Club and **CareCredit** is that **CareCredit** serves as a credit card and can be used at a variety of health/wellness institutions. For patients that do not qualify for the above mentioned options, a two payment option is available, the first payment is drafted upon signup, the second payment is automatically drafted 14 days later. Prior to treatment being placed on the schedule, a financial arrangement must be agreed upon and endorsed by the responsible party.

Minors:
The parent or legal guardian that accompanies the minor child/children to the appointment is responsible for any payment due. In case of an emergency situation, all minors must be accompanied by a parent or legal guardian throughout the entire duration of the appointment.

Insurance:
We file all insurances outside of Medicare/Medicaid. We are contracted with Delta Dental, Cigna, MetLife and BlueCross & BlueShield of North Carolina. Insured patients will receive cost estimates broken down by insured and uninsured costs. For patients covered by insurance, we will accept assignment of benefits. This means that you sign the portion of your insurance that "assigns" payment to our office. Please note that estimates are based on information provided by your insurance and are not a guarantee of payment. Only after a claim is submitted and processed by your insurance company can final payment be determined. As a courtesy, we file claim forms electronically, provide postage for special claims, and track claims for you.

In order for us to file your insurance we have to verify your current insurance benefits. To do so we will need your current insurance card, photo ID, subscriber ID, and social security number. If we're unable to verify your insurance information at your first visit, full payment will be due at the time of service. Also, you are responsible for all co-pays and deductibles.

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Your claim will be filed immediately, and the benefits expected are typically paid within 30 days. The filing of an insurance claim does not relieve you from the responsibility of your bill or the timely payment on your account. If the claim is not paid by your carrier in 60 days, the unpaid portion will automatically become "self-pay" and notification will be issued for the unpaid portion.

We file claims to many different insurance companies, and it is virtually impossible for us to know your individual insurance policies. Please be aware that some, and perhaps all, of the services provided may be considered by your insurance company to be NON-covered services and/or might be subject to a deductible in addition to your co-pay. You are responsible for any amounts your insurance company chooses not to pay, for whatever reason.

We will not become involved in disputes between you and your insurance company regarding non-covered charges, diagnoses, co-pays or deductibles. Please refrain from asking our office to change a diagnosis or procedure code in order for the visit to be covered by your insurance company.

It is your responsibility to let us know of any insurance changes in a timely manner. Feel free to contact your insurance company regarding unpaid benefits. We will gladly provide you with a letter which would include all pertinent information which you may sign and mail.

Secondary Insurance:
We do not file and do no accept assignment of benefits for secondary insurance; however, we are happy to provide you with the information that you need, allowing you to file and be reimbursed by your secondary carrier. You will need to request a dental claim form from your secondary carrier as we do not have these at the office since all of our claim filing is done electronically.

Late Payments
If your payments are late, declined, or if you request a change in date or amount not in accordance to your agreement, a $25 processing charge will incur for each instance. In the event that multiple payments are declined, treatment will cease until payment is current and future treatment is paid in full. If treatment has been completed, full payment will be due immediately.

Credits
After all payments have been received and the patient account has a negative balance, the credit card on file will be credited the exact amount within 60 days.

Collections:
If this account is assigned to an attorney or collection agency, I agree to be responsible for any attorney fees, collection fees, and court costs incurred. I understand that all future scheduled appointments will be canceled if my account is turned over to the collection agency.

Missed Appointments:
Once an appointment has been made, that time is reserved specifically for you. If you need to cancel an appointment, we ask for at least a 48-hour notice. This allows us to offer the appointment to another patient. If you fail to keep your appointments without letting us know in advance, a $50.00 charge will be applied to your account.

Returned Check:
A returned check fee of $35 will be added to your account for any returned check. Before we accept another payment by check, the $35 fee plus full payment for the check that did not clear must be paid in cash, or by Visa, MasterCard, AMEX, or Discover.

Records Release Fee

Should a patient request records be released, we will provide a records release form that the patient must sign prior to the release of the records. Once records are released, a $30 fee will be applied to the patient's account and is due immediately.

I understand and agree to this financial policy. I have read the financial policy and agree that a photocopy of the financial policy shall be considered as effective and valid as the original. Regardless of what insurance coverage I have, I am ultimately responsible for the timely payment of my account and I hereby authorize the payment of insurance benefits to be made directly to Modern Family Dental Care.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

Patient or Responsible Party (Print): _____ Date: _____

Signature of Patient or Responsible Party: _____