Welcome to Our Practice!

We are committed to providing exceptional dental care to our patients in a compassionate, professional environment. The following information is provided to introduce you to our practice philosophy and policies.

Appointments

Appointments are scheduled so we can provide the most efficient care in a relaxed setting. We make every effort to honor time commitments and we appreciate patients extending us the same courtesy. Patients are reminded of their appointments 2-3 days in advance by email, text, or phone. Patients are kindly asked to confirm their appointment at least 48 hours prior to their appointment through the reminder method employed.

New Patient Appointments

We reserve 90 minutes for each new adult patient visit and 60 minutes for each new child visit. This allows time for us to listen to patient concerns and to properly diagnose and develop appropriate treatment plans.

Continuing Care

Our practice is focused on prevention and maintaining optimum oral health. We recommend comprehensive treatment and continuing care on an appropriate recall schedule.

Urgent Care After Hours

We accommodate patients of record who experience dental emergencies after hours. A patient of record is one who has been seen and treated in the office during the past 18 months. If you are a patient of record and have a dental emergency, you can call the office for information on how to contact us. An after hours fee may be charged.

Children and Adolescents

We are happy to start seeing children at the age of three. Parents are welcome to accompany their children in the operatories. We require that parents remain in the office with children under the age of 18 for the entire appointment. Failure to comply may result in the appointment being rescheduled.

Cancellations and Missed Appointments

We require 48 hours advance notice of a cancellation. Patients who do not provide 48 hours notice of a cancellation or who do not present for a scheduled appointment may be charged a fee. Patients who fail to present for a second appointment may be dismissed from the practice.

Payments and Insurance

Payment for treatment is due and payable the day services are rendered. It is our goal, however, to assist all of our patients in obtaining the dental treatment they deserve. As a result, we offer several payment options, including cash, check, credit card, and third party financing. For patients with dental insurance, we will file the appropriate claim forms.
**Patient Information**

Name: ___________________________ Preferred Name: ___________________________

Home Address: ______________________ City: __________ State ________ Zip: ______

Home #: ___________________________ Work #: ___________________________ Mobile #: ___________________________

Email: ____________________________________________________________________________

Sex: M / F Birth Date: ____ /____ /________ SS#: ___________________________

Family Status (circle): Single Married Divorced Child Spouse’s Name: ___________________________

How did you first hear about our office? (circle one):

- Another Patient
- Another Dental Office
- Brochure
- Online Search
- Facebook
- Work
- School
- Insurance Website
- Sign – Drive by
- Walk in
- Other: ___________________________

Whom may we thank for referring you to our practice? ____________________________________________

**Person Responsible for Account**

Name of responsible party: ___________________________

Relationship to patient (Circle): Self  Spouse  Parent  Other: ___________________________

Home Address: ___________________________ City: __________ State: ________ Zip: ______

Home #: ___________________________ Work #: ___________________________ Mobile #: ___________________________

Email: ____________________________________________________________________________

Birth Date: ____ /____ /_______ SS#: ___________________________

**Contact Information**

What is the best way to communicate with you?  Home Phone / Mobile Phone/ Text / Email

In the event of an emergency, whom should we contact? Name ___________________________

Relationship_____________ Home #: __________ Work #: __________ Mobile #: __________

Alliance Dentistry NC Patient Information Form
**Insurance Information (Primary)**

Name of Insured: ___________________________ Relationship to patient: ___________________________

Insured Birth Date: ___ /___ /____

Insurance Plan Name: ___________________________ Insurance Co Phone #: ___________________________

Claims Address ______________________________________________________________________________________

City, State, Zip _______________________________________________________________________________________

Group #: ___________________________ ID #: ___________________________

**Insurance Information (Secondary)**

Name of Insured: ___________________________ Relationship to patient: ___________________________

Insured Birth Date: ___ /___ /____

Insurance Plan Name: ___________________________ Insurance Co Phone #: ___________________________

Claims Address ______________________________________________________________________________________

City, State, Zip _______________________________________________________________________________________

Group #: ___________________________ ID #: ___________________________

**Employment Information**

Employer Name: ___________________________ Phone: ___________________________

Address: ____________________________________________________________________________________________

City, State, Zip: ______________________________________________________________________________________

**Cancellations and Missed Appointments**

We require 48 hours advance notice of a cancellation. Patients who do not provide 48 hours notice of a cancellation or who do not present for a scheduled appointment may be charged a fee. Patients who fail to present for a second appointment may be charged a fee or dismissed from the practice. After the first missed appointment, a letter will be mailed reiterating our policy and reminding the patient of the risk of dismissal should another appointment be missed.

**I have read the Cancellation and Missed Appointment Policy. I understand and agree to this Policy.**

Patient Signature_________________________Date__________________
# Medical History

**Patient Name:** ____________________________________________  **Date of Birth:** __________

1. **Date of last physical exam:** ____________________________  **Physician’s Name:** ____________________________  
   **Physician’s Phone#:** ____________________________

2. **Have you ever been hospitalized (if yes, explain below)?** Yes No
   _____________________________________________________________________________________________

3. **Have you been under the care of a medical doctor during the past two years?** Yes No
   **If yes, what for?** __________________________________________________________________________

4. **Have you ever had any excessive bleeding requiring special treatment?** Yes No

5. **Women:** Are you pregnant/trying to get pregnant/breast feeding? Yes No

6. **Are you allergic to or have you had an allergic reaction to any of the following (please circle if yes):**
   Local Anesthetic  Penicillin  Codeine  Other Antibiotic: ____________________________
   Latex  Acrylic  Metals  Other:_________________________________________

7. **Are you taking or have you ever taken any of the following medications (please circle if yes):**
   Fosamax  Actonel  Boniva  **For how long?** ____________________________
   Aredia  Reclast  Zometa  **When did you stop?** ____________________________

8. **Please list other medications you are taking:**
   _____________________________________________________________________________________________
   _____________________________________________________________________________________________

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## Have you ever had any of the following?

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chest Pains</td>
<td></td>
<td></td>
<td>Shortness of Breath</td>
<td></td>
<td></td>
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<tr>
<td>Heart Failure</td>
<td></td>
<td></td>
<td>Ulcers</td>
<td></td>
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<tr>
<td>Heart Disease</td>
<td></td>
<td></td>
<td>Mental Health Issues</td>
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<tr>
<td>Heart Attack</td>
<td></td>
<td></td>
<td>Emphysema</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart Problems</td>
<td></td>
<td></td>
<td>Fainting/Dizziness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Angina Pectoris</td>
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<td></td>
<td>Eating Disorder</td>
<td></td>
<td></td>
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<tr>
<td>Heart Surgery</td>
<td></td>
<td></td>
<td>Epilepsy/Seizures</td>
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<td></td>
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<tr>
<td>Liver Disease</td>
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<td></td>
<td>Persistent Cough</td>
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<tr>
<td>Hypertension</td>
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<td></td>
<td>Tuberculosis</td>
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<td>Heart Murmur</td>
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<td></td>
<td>Asthma</td>
<td></td>
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<tr>
<td>Rheumatic Fever</td>
<td></td>
<td></td>
<td>Hepatitis A</td>
<td></td>
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<tr>
<td>Psychiatric Treatment</td>
<td></td>
<td></td>
<td>Hepatitis B</td>
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<td></td>
<td></td>
<td></td>
<td>Tobacco Products</td>
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</tr>
</tbody>
</table>

**Alliance Dentistry NC Adult Medical History**
### Dental History

1. Date of last dental exam: ____________________ Date of last dental x-rays: ____________________
2. Previous dentist’s name / location: _______________________________________________________
3. Are you having tooth or gum pain at this time? Yes No
4. Do you feel nervous about having dental treatment? Yes No
5. Have you ever had a bad experience in a dental office? Yes No
6. Do your gums bleed when brushing / flossing? Yes No
7. Have you ever seen a periodontist? Yes No
8. Have you ever had a “deep cleaning” (Scaling and Root Planing)? Yes No
9. Is there anything you would like to speak with the Doctor about in private? Yes No
10. Would you be interested in discussing ways to improve your smile? Yes No

If yes, please explain: ________________________________________________________________

**Do you have any of the following dental concerns:**

<table>
<thead>
<tr>
<th>Concern</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clicking in jaw joint</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Pain in or around your ears</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Difficulty opening or closing</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Difficulty chewing</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>History of trauma to jaw or face</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Diagnosis of TMJ/TMD</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Sensitivity to: Hot, Cold, Sweets, Biting</td>
<td></td>
<td></td>
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<tr>
<td>Swelling</td>
<td></td>
<td></td>
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<tr>
<td>Bad Taste</td>
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<tr>
<td>Food Catching</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clenching</td>
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<td></td>
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<tr>
<td>Other:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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I understand the importance of a truthful health history and realize that incomplete information may have an adverse effect on my treatment. To the best of my knowledge, the information above is complete and accurate.

Signature: ___________________________________________ Date ____________________________

Doctor’s Signature ________________________________________________________________

Doctor’s Notes:
Financial Guidelines

Payment for treatment is due and payable the day services are rendered. It is our goal, however, to assist all of our patients in obtaining the dental treatment they deserve. Therefore, we are pleased to offer several payment options. Please read the following carefully. Our financial coordinator will answer any questions you may have, and assist you in selecting the appropriate financial plan for your needs.

For your convenience, we offer the following financial options:

1. In addition to personal checks and cash, we also accept payment through MasterCard/Visa, American Express, and Discover.

2. We offer extended payment plans for amounts up to $25,000 upon approved credit. This plan has the following features:
   - No down payment
   - Extended terms with low monthly payments.
   - No prepayment penalty.
   - No interest up to 12 months.

3. Dental Insurance

We are happy to file insurance claims and assist you in obtaining the maximum benefits specified in your contract. However, please keep the following in mind:

   - Your insurance is a contract between you, your employer, and your insurance company. We are not a party to that contract. We will do our best to ESTIMATE your coverage, and file your insurance on your behalf. Not all dental services are necessarily covered under your dental insurance plan. It is essential that you read and understand your coverage and pay special attention to any preauthorization requirements, exclusions and waiting periods.

   - Our office policy states that you are totally responsible for your bill. The ESTIMATED patient portion of the fee is due at the time of service. If a balance remains after we receive payment from your insurance carrier within 30 days we will notify you. Failure of your insurance carrier to reimburse our office within 30 days will result in our billing you directly for the remaining balance.

   - We are committed to providing the highest quality of care. Our treatment recommendations and the dental services we provide are in the best interest of the patient’s health. The patient is responsible for payment in full regardless of an insurance company's arbitrary determination of treatment necessity.

   - Our participation in a Preferred Provider Organization (PPO) is a contract between this office and the organization to provide dental services for the negotiated network fee schedule. Individual coverage and benefits will vary within the organization and are dependent on the contract between you, your employer and the insurance company. While we guarantee our fees will not exceed the network fee schedule, we cannot be responsible for variances in coverage and benefits within the PPO.
If your coverage changes for any reason, please notify the office immediately.

By signing this form, you have read and understand our policy. Any denials or insurance payments less than estimated will be your responsibility. Payment will be due upon our billing cycle. All estimated out of pocket fees and deductibles are due the day of treatment. Ask our office regarding our financial options before your visit, or if you have any questions regarding your insurance and our policy.

Usual and Customary Fees

Our practice is committed to providing the best treatment for our patients, and we charge what is usual and customary for our area and experience. You are responsible for payment regardless of any insurance company's arbitrary determination for usual and customary fees. **All accounts not paid within 60 days will accrue a finance charge of 1.5% (18% APR).**

I have read the Financial Policy. I understand and agree to this Policy.

________________________________________________________     ____________________
Signature of Patient or Responsible Party                  Date
Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: ________________________________

State and federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with a Notice of Privacy Practices. Our Notice is available online. If you prefer a paper copy, please ask a team member for a copy of our Notice.

I acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

_______________________________________________________________________

___________________

Signature

Date

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FOR OFFICE USE ONLY-------------------

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communication barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining the acknowledgement

☐ Other (Please Specify)
Authorization for Release of Information to Family and/or Friends

Name of Patient________________________________ Date of Birth___________

Alliance Dentistry is authorized to discuss my dental care and may release my confidential health information to the following:

____________________________________ __________________________
                        Name                      Relationship

____________________________________ __________________________
                        Name                      Relationship

Rights of the Patient

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 by sending a written notification to Alliance Dentistry, 202 Davis Grove Circle Ste 102, Cary, NC 27519. 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 conditioned on signing this authorization.

This authorization shall be in force and effective until revoked by the patient or representative signing the authorization.

____________________________________ Date______________________
Signature of Patient or Personal Representative

____________________________________
Description of Personal Representative’s Authority (attach necessary documentation)