TTH
FAMILY DENTISTRY

PATIENT REGISTRATION

Chart ID:

First Name: Last Name: Middle Initial:

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

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

Additional Comments:

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: .00 Rem. Deduct: .00

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: .00 Rem. Deduct: .00

HEALTH INFORMATION

1. Do you premedicate before a dental visit? Yes No
   If yes, for what reason: _____

   What do you premedicate with? _____

   Do you take anticoagulants (blood thinners) such as (Please circle):

   - Clopidogrel (Plavix)
   - Dipyridamole (Persantine)
   - Prasugrel (Effient)
   - Ticagrelor (Brilinta)
   - Vorapaxar (Zontivity)
   - Xarelto (Rivaroxabn)
   - Warfarin
   - Aspirin

2. Are you allergic to any medications? Yes No
   If yes, please list: _____

3. Are you currently taking any medications? Yes No
   If yes, please list: _____

4. Are you currently under the care of a physician? Yes No
   If yes, please explain: _____

5. Do you use any tobacco products? Yes No
   If yes, please explain: _____

6. Have you ever had any complications from dental treatment? Yes No
   If yes, please explain: _____

7. Do your gums bleed: Yes No

8. Have you been told you have gum disease? Yes No

9. Have you been told you have bad breath? Yes No

10. Have you ever had any pain in your jaw joints? (clicking/popping) Yes No

11. Are you happy with your smile? Yes No
    If no, please explain: _____

12. FEMALE PATIENTS: Are you pregnant? Yes No
    If yes, expected due date is : _____

13. Circle Yes or No to the following:

AIDS	Y	N	Prolonged Bleeding	Y	N
Diabetes	Y	N	Cancer	Y	N
Epilepsy	Y	N	Asthma	Y	N
Rheumatic Fever	Y	N	Fainting Spells	Y	N
Heart Disease	Y	N	Tuberculosis	Y	N
Mitral Valve Prolapse	Y	N	Anemia	Y	N
Heart Attack	Y	N	Stomach Ulcers	Y	N
Liver or Kidney Disease	Y	N	Thyroid Problems	Y	N
Heart Murmur	Y	N	Latex Allergy/Reaction	Y	N
Stroke	Y	N	Artificial Heart Valve	Y	N
Organ Transplant	Y	N	Chemotherapy	Y	N
Chest Pain/Angina	Y	N	Convulsions	Y	N
Sleep Apnea	Y	N	Pacemaker	Y	N
High Blood Pressure	Y	N	Hemophilia	Y	N
Hepatitis A, B or C	Y	N	Psychiatric Care	Y	N
Arthritis	Y	N			

Reason for this Visit : _____

Date of last dental visit: _____

Date of last xrays: _____

To the best of my knowledge, all the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

My signature authorizes treatment. _____

Signature of patient, parent or guardian

Date : _____

Office Policies and Financial Agreement
It is our desire to provide the highest quality dental care to everyone. The following is a statement of Dr. Tasha Hinton's Dental Office/Financial Policies. We ask that you please read, agree to, and sign before any treatment is rendered.

Regarding Insurance
Our goal is to maximize your insurance benefits. It is important to understand that the insurance contract is between the insurance company and you, the insured. Dental insurance was not designed to pay for all dental care. Treatment recommended by Dr. Tasha Hinton is never based on what your insurance company will pay. Due to pending claims and patient privacy issues, we do not always know how much an insurance company has already paid to another office or specialist, and the balance remaining on a yearly maximum.

Please be prepared to show your insurance card and driver's license at the time of your visit. It is the patient's/guarantor's responsibility to provide any new information regarding insurance. Our office will gladly submit your insurance claim to your insurance carrier, as a courtesy to you. At the time of treatment, the patient/guarantor is responsible for the estimated portion the insurance does not cover. If for some unforeseen reason your insurance carrier has denied or not made payment within 60 days, the patient/guarantor is responsible for the balance in full. If sent to collections you will be responsible for the cost of the collection charges.

Payment Options
Cash, Check, MasterCard, Visa or American Express, Discover

With prior approval, we are pleased to offer a choice of No Interest or Extended Payment Plans to qualified applicants through Care Credit. If you would like to make extended payments for services provided at our office, please ask any of our administrative team for assistance in filling out an application form.

Additional Charges
A fee of $30 will be charged on all returned checks.

Cancellation Policy

If you are unable to keep an appointment, we ask that you kindly provide us with minimum 24 hour notice; otherwise there will be a **$75 broken appointment fee per hour.**
This courtesy on your part will make it possible to give your appointment to another patient who needs to see the dentist or hygienist.

Patient/Guardian
Name_____Date_____

Signature _____

TTH
FAMILY DENTISTRY

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Morrisville, NC 27560
(919) 388-3719
www.tthfamilydentistry.com

Insurance Authorization and Release

I,_____ understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform the office of any changes in my status with my dental insurance. I authorize the dental staff to perform the necessary dental services for my diagnosis, treatment and receive payments from my insurance company. However, this office cannot guarantee any estimated coverage. My insurance coverage is an agreement between my insurance company and me. It is the patient's responsibility to know his/her insurance benefits. I am responsible for all charges and if the insurance company does not pay in 45 days I must pay in full. Should this become a collection issue, I assume all costs of collection including but not limited to court costs, interest, and legal fees.

_____

Patient (Responsible Party) Signature Date

TTH 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 _____

Authorization for Release of Information – Compound Release

Name of Patient _____ Date of Birth _____

_____ is authorized to release protected health information about the above named patient in the following manner and to identified persons.

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	☐ Results of lab tests/x-rays ☐ Other_____
☐ Other person (s) (provide name and phone number)	☐ Financial ☐ Medical
☐ Email communication-Provide email address* _____ *For email communication to occur, please accept the disclosure below:	☐ Financial ☐ Medical ☐ Appointment reminders ☐ Breach notification
☐ Text communication – Provide number * _____ *For text communication to occur, accept the disclosure below:	☐ Appointment reminder ☐ Other: _____
☐ For **email and/or text 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 receive email and/or text communication as selected.	

Patient Rights:

- I have the right to revoke this authorization at any time.
- 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 have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

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

_____ Date _____

Signature of Patient or Personal Representative

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

_____

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TTH
FAMILY DENTISTRY

At TTH Family Dentistry, we stand behind every dental service we provide to our patients, from teeth whitening and family dentistry to more complex procedures.

We are confident in our quality of work and support it with a warranty, which very few dental offices offer. We will repair, replace, or provide a refund for the restorative dental treatment rendered based on the following guidelines and exclusions for five (5) years from the date of treatment. Failure to fulfill the following requirements will void the dental treatment warranty.

Terms & Conditions of Our Dental Warranty

- You must remain a client for 5 years after the procedure.
- You must maintain a schedule of regular recall appointments to include a minimum of an oral exam every 3-6 months, a cleaning every 3-6 months, bitewing x-rays every 12 months and comprehensive x-rays every 5 years.
- You must maintain a high standard of home dental care on all remaining natural teeth with a minimum of brushing and flossing two times per day.
- We will replace the restorative dental work at no additional cost for either materials or labor if there is a failure in the fabrication and if all limitations are met.
- The warranty is null and void if the failure of the restorative work is due to abuse or negligence due to any form of mistreatment of the piece. This includes but is not limited to, biting into metal objects, chewing ice, self-adjustments, etc.
- The warranty is null and void if the restorative work needs to be removed or is damaged due to a dental problem or repair with the supporting tooth/teeth including but not limited to root canals, recurrent decay, etc.
- The warranty does not include any cost associated with routine maintenance required over the course of its working life.

If the doctor determines a night guard/occlusal guard is necessary to maintain and protect your restorative work, the warranty will be null and void if you do not have one fabricated.

I have read and understand all the above information:

Patient Name

Patient Signature Date