SEVEN LAKES
FAMILY DENTISTRY
JENNIFER S. MASSEY, DDS

# Patient Information

Full Name_____ Preferred Name _____ Birth Date ___ / ____ / ____ Age ____ Today's Date _____

Mailing Address_____ Street Address _____

Home Phone (____)_____ Cell Phone (____)_____ Email _____

Check Appropriate Box: Minor Single Married Divorced Separated Social Security #: _____

Patient's or Parent's Employer_____Occupation_____ Work Phone(____)_____

Spouse or Parent's Name_____ Employer_____ Work Phone_____

If Patient is a Student, Name of School/College_____ City_____ State_____

Name of person responsible for this account: _____Relation to Patient _____

Whom May We Thank for Referring You?_____

Person to Contact in Case of an Emergency_____ Phone_____

# Insurance Information

Name of Insured_____ Relation to Patient_____

Birth Date_____ Social Security #_____ Employer _____

Employer Address_____ Work Phone _____

Insurance Company_____ Group #_____

Insurance Address_____

If Additional Insurance Policy, Name of Insured _____ Relation to Patient _____

Birth Date_____ Social Security # _____Employer _____

Employer Address _____ Work Phone_____

Insurance Company _____ Group # _____

Insurance Address _____

# Dental History

Reason for Today's Visit_____

Former Dentist_____ Date of Last Dental Visit_____ Date of Last X-Ray_____

Check if you have had any of the following:

| | | |
|---|---|---|
| Bleeding gums | Loose teeth | Sensitivity to cold |
| Clicking or locking jaw | Missing teeth | Thumb or tongue habit |
| Food collection | Periodontal treatment | Trauma to your teeth or jaws |
| Grinding teeth | Sensitivity to heat | Cheek biting habit |

How often do you floss?_____ How often do you brush?_____

# Medical History

Physician's Name_____ Date of Last Physical_____

Are you under the care of a physician? ☐ Yes ☐ No For what conditions? _____

If patient is a child, what is his/her weight? _____

(Women) Are you pregnant? Yes No Nursing? Yes No Taking birth control pills? Yes No

Check if you have had any of the following:

- Allergies
- Arthritis, Rheumatism
- Artificial Heart Valve
- Asthma
- Back Problems
- Blood Disease
- Headaches
- Psychiatric Care
- Respiratory Disease
- Cortisone Treatments
- Cough, Persistent
- HIV/AID
- Epilepsy
- Fainting
- Mitral Valve Prolapse
- Pacemaker
- Tuberculosis
- Hemophilia
- Hepatitis
- High Blood Pressure
- Artificial Joint
- Kidney Disease
- Liver Disease
- Tobacco Habit
- Cancer
- Chemical Dependency
- Rheumatic Fever
- Scarlet Fever
- Sinus Problems
- Diabetes
- Swollen Neck Glands
- Thyroid Problems
- Bleeding Abnormalities
- Heart Murmur
- Heart Problems
- Venereal Disease

Medications Currently Taking:

_____

Allergies to Medications:

_____

# Authorization and Release

I have read and answered the above questions to the best of my knowledge. I understand that I am financially responsible for all charges whether or nc paid by insurance. I understand that after a history of 3 broken appointments, I will be charged $25 for all future appointments for which I do not show cancel within 24 hours of appointment time. Payment is due in full at the time of treatment. If you have insurance, we will gladly process your claim b your estimated portion is due at the time services are rendered.

_____ _____

Signature of patient or parent if minor. Date

# Informed Consent

I hereby consent for Dr. Massey to perform such dental procedures deemed necessary on myself or my dependent as have been discussed with the doctor. I understand that any evidence of dental disease or abnormality if left untreated will worsen in time. I have been informed of possible alternative treatments, if any exist.

Risks and complications associated with general dental treatment include (but are not limited to): swelling; sensitivity; bleeding; bruising; pain; infection; injury to a nerve resulting in numbness or tingling sensation in the lip, tongue, chin, gums, cheeks, and teeth that may persist for weeks, months, or in remote instances, permanently; changes in occlusion (biting); jaw muscle cramps and spasms; referred pain to ear, neck, and head; nausea; vomiting; allergic reactions; delayed healing; temporomandibular (jaw) difficulty; and treatment failure.

Additional risks and complications associated with oral surgery and extractions include (but are not limited to): Post operative discomfort, bleeding, bruising, and swelling that may require several days of recuperation; dry socket; swallowing or aspiration of the tooth; injury to adjacent teeth, crowns, or fillings; post operative infection requiring further treatment; decision to leave a small piece of root in the jaw when its removal would require additional surgery; opening of the maxillary sinus that may require additional surgery; restricted opening of the mouth for several days or weeks, with possible dislocation of the temporomandibular (jaw) joint or fracture of the jaw.

I understand that during the course of dental treatment something unexpected may arise that may necessitate procedures in addition to or different from those planned. I request and authorize the doctor to do whatever deemed advisable to correct the condition. I acknowledge that no guarantees have been made concerning the results of the treatment that I will receive. I agree to cooperate with the doctor and follow post-operative instructions to the best of my ability. I have had an opportunity to discuss with the doctor my medical and health history, as well as my dental condition, the planned procedure and treatment, and the risks and benefits to be reasonably expected from this treatment, compared with alternative approaches and/or no treatment.

**If any of the above risks concern you or you do not understand the terminology ask to speak to the doctor or one of the staff for clarification.**

**I CERTIFY THAT I HAVE READ AND UNDERSTOOD THE TERMS AND WORDS WITHIN THE ABOVE CONSENT.**

_____ _____

Patient, Parent, or Guardian Date

_____ _____

Witness Doctor

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Seven Lakes Family Dentistry is required by the Health Insurance Portability and Accountability (HIPPA) act of 1996 to inform its patients of their rights and duties regarding the privacy of their health information. This policy is available in the lobby area and is provided to patients at the time of their registration.

I acknowledge that I have received a copy of this notice regarding the use and disclosure of the patient's health information.

Print Name _____ Signature _____

Date _____

I authorize Seven Lakes Family Dentistry to leave messages on voicemail or answering machines at phone numbers I supply.

Yes_____ No _____

I specifically authorize Seven Lakes Family Dentistry to release medical information to the following:

| Name | Relationship | Phone number |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

I understand that I may change this consent at any time. I release Seven Lakes Family Dentistry, its employees and dentistry for any legal responsibilities or liabilities for disclosure of my medical information to the extent authorized here.

| Signature | Date | Relationship to patient |
|---|---|---|
| _____ | _____ | _____ |

For Office Use Only:

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practice and Consent for Use and Disclosure of Health Information, but acknowledgement could not be obtained because:

_____ Individual refused to sign
_____ Communication barriers prohibited obtaining the acknowledgement
_____ An emergency situation prevented us from obtaining acknowledgement
_____ Other (Please specify) _____

# INSURANCE AND FINANCIAL POLICY

**Jennifer S. Massey, DDS, PA**

We believe that you deserve the best care. That is why we always present you with the best dental solution possible to treat your personal situation. Each year we provide outstanding dental care to hundreds of patients. Some have dental benefits but some don't. If you have dental benefits, congratulations! You are very fortunate. Here are some important things you should know:

**Initial**

- _____ Your dental benefits are based upon a contract made between your employer and an insurance company. If you have any questions regarding your dental benefits, please contact your employer or insurance company directly. Dental benefit plans will never pay for completion of your dental care. It is only meant to assist you.

- _____ We currently accept all private care insurance plans (plans that do not require you to select a dentist from a list or require our office to accept a reduced fee for service). This means that we work with literally thousands of companies. Although we can maintain computerized histories of payment by a given company, they do change; therefore it is impossible to give you a guaranteed quote at the time of service. We estimate your portion based on the most up-to-date information we have, but it is ONLY AN ESTIMATE. If you would like to know your insurance benefit, we will be happy to file a "pre-treatment authorization" with your insurance company prior to treatment. Keep in mind this is not a guarantee of coverage. This does delay treatment but will give you the exact out of pocket figures you may require.

- _____ We will bill your insurance as a courtesy. If insurance does not pay within 90 days, we reserve the right to request payment in full for services from you and let you collect the insurance funds that are due to you. This is rare but it is important that you recognize that the insurance you have is a legal contract between YOU and your insurance company. Our office is not, and cannot be a part of that legal contract. Ultimately, you are responsible for all charges incurred in our office.

- _____ We require payment in full for your portion AT THE TIME OF SERVICE. We accept MasterCard, Visa, American Express, Discover, cash, and checks (for existing patients with established payment history). If you are in need of an extended finance option, we also work with CareCredit, who offers up to 1 year with no interest to meet your treatment plan needs on approved credit.

- _____ A specific amount of time is reserved especially for you and we strongly encourage all patients to keep their appointments. If you must change your appointment, we require at least 24 hour notice to avoid a $25 cancellation fee (cancellation fee starts after a history of 3 appointments which were broken or cancelled less than 24 hours).

- In the event of an emergency after regular business house a $60 emergency fee will be charged for established patients in addition to the necessary treatment fees. Patients who are not established in the practice will be charged a $125 after hours emergency fee.

**I agree with the above conditions.**

Print Name: Date:

Patient/Parent Signature: _____

# NOTICE OF PRIVACY POLICIES

# 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.

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**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 January 1, 2006, 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 anytime, provided such changes are permitted by applicable law. We reserve the right to make changes in our privacy practice 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 practice, 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.

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**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, or 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 disclosure. In the even 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).

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**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 $0.50 for each page, $20 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.

**Disclosing 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 payment 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.

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**ADENDUM TO NOTICE:** We will continue to use your Personal Health Information in some of these specific ways: by calling you by your first and last name from our waiting room, by verbally describing your treatment progress, by posting daily schedules in areas throughout our office and on computers, by mailing you a reminder appointment card with the stated reason for your visit, by calling to confirm appointments or to discuss billing issues and leaving a message if necessary, by using photographs, models or slides of study cases when authorized, by continuing to allow patients access to the front office area for use of the telephone or for scheduling and for a variety of reasonable daily activities wherein you personal health information is required to be used.

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**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 at the end of this Notice. You also may submit a written complain 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. 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.

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**CONTACT INFORMATION:**

Please address all inquiries, request, and complaints to:

Jennifer S. Massey, DDS, PA
Attn: Charles Massey
6513 Seven Lakes Drive
Seven Lakes, NC 27376
Phone (910)673-6030, fax (910)673-6031