

# WELCOME

Date \_\_\_\_\_

## Patient Information

\_\_\_\_\_  
Last Name                                      First Name                                      Initial                                      Preferred Name

\_\_\_\_\_  
Street                                      Town                                      State                                      Zip Code

\_\_\_\_\_  
Social Security #                                      Date of Birth                                      Email Address

\_\_\_\_\_  
Home Phone #                                      Work Phone #                                      Cell Phone #

Whom may we thank for referring you to our practice? \_\_\_\_\_

Person to Contact in Case of Emergency \_\_\_\_\_ Phone \_\_\_\_\_

Check Appropriate Box: Single Married Divorced Student

Patient's or Parent's Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Employer's Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_

## Responsible Party

If Patient is a Minor, Person Responsible \_\_\_\_\_ Phone # \_\_\_\_\_

## Insurance Information

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Date of Birth \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_

Name of Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Insurance Company \_\_\_\_\_

Group # \_\_\_\_\_ Subscriber ID# \_\_\_\_\_

# Patient Medical History

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Today's Date \_\_\_\_\_

Primary Care Physician (M.D.) \_\_\_\_\_ Office Phone \_\_\_\_\_

## 1. Please LIST all current medications.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Are you a SMOKER? .....  Yes (#Packs/day? \_\_\_\_\_)  No

3. Do you use chewing tobacco? .....  Yes  No

## 4. Are you ALLERGIC to or have you had any reactions to the following?

- Local anesthetics with EPINEPHRINE .....  Yes  No  
Penicillin or Amoxicillin .....  Yes  No  
Tylenol .....  Yes  No  
Ibuprofen .....  Yes  No  
Aspirin .....  Yes  No  
Hydrocodone .....  Yes  No  
Any Metals (eg. Nickel, mercury, etc.) .....  Yes  No  
Latex .....  Yes  No  
Other Allergies (list) \_\_\_\_\_

## 5. Any significant events related to your health in the past?

- Heart Attack .....  Yes (When? \_\_\_\_\_)  No  
Stroke .....  Yes (When? \_\_\_\_\_)  No  
Joint Replacement .....  Yes (When? \_\_\_\_\_)  No  
Tuberculosis .....  Yes (When? \_\_\_\_\_)  No  
Asthma .....  Yes (Last Attack? \_\_\_\_\_)  No  
Hepatitis .....  Yes (Type? \_\_\_\_\_)  No  
Cancer .....  Yes (When? \_\_\_\_\_ Type? \_\_\_\_\_)  No

## 6. Do you have or have you ever had any of the following?

- |                            |                                                          |                            |                                                          |
|----------------------------|----------------------------------------------------------|----------------------------|----------------------------------------------------------|
| High Blood Pressure.....   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes.....              | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart Disease.....         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Dysfunction.....    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Angina.....                | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Dysfunction.....     | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cardiac Pacemaker.....     | <input type="checkbox"/> Yes <input type="checkbox"/> No | AIDS or HIV Infection..... | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart Murmur.....          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Dysfunction.....   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Mitral Valve Prolapse..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma.....              | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Fainting/Syncope.....      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Arthritis.....             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Epilepsy/Seizures.....     | <input type="checkbox"/> Yes <input type="checkbox"/> No | Gastric Reflux/Ulcers..... | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Emphysema.....             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Anemia.....                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| COPD.....                  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Frequent Headaches.....    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Other _____                |                                                          |                            |                                                          |

## 7. Women Only:

- a. Are you pregnant or think you may be pregnant? .....  Yes  No  
b. Are you nursing? .....  Yes  No  
c. Are you taking birth control pills? .....  Yes  No

# Patient Dental History

Name of Previous Dentist and Location \_\_\_\_\_

Date of Last Exam \_\_\_\_\_

*In an effort to serve you best, please fill out the following so that we can custom tailor your future dental treatment to your specific needs.*

1. How have your relationships been with dental offices in the past?  Good  Satisfactory  Poor

2. Do dental procedures make you nervous? .....  Yes  No  
If yes, anything specific? \_\_\_\_\_

3. How frequently were you being seen for checkups/cleanings in the past?  Every 6 months  
 Every 3-4 months  
 Once per year  
 Never regularly

4. Have you ever had a problem with gum disease in the past? .....  Yes  No

5. Have you ever been referred to or treated by a Periodontist (Gum Specialist)?  Yes  No

6. Do you have crowded/crooked teeth, or gaps that you want corrected? .....  Yes  No

7. Do you wear dentures or partials? .....  Yes  No  
If yes, do they fit well / are they comfortable?  Yes  No

8. Are you missing any teeth that you would like to have replaced? .....  Yes  No

9. Would you like your teeth to be WHITER? .....  Yes  No

10. Do you clench or grind your teeth? .....  Yes  No

11. Have you had any problems with your jaw joints in the past? .....  Yes  No

12. Do you have any problems with tooth sensitivity? .....  Yes  No

## Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental Care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents' behalf.

X \_\_\_\_\_ Date \_\_\_\_\_

Signature of patient (or parent if minor)

## NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that any medical records disclosed in any form, whether written, electronically, or orally, are kept confidential. This Act gives the patient rights to control how health information is used. At our office we are committed to health information privacy. Your private health information (PHI) may be used in the following ways:

- ♣ Treatment means providing or coordinating health care and related services in our office as well as in other specialists' offices where treatment is referred.
- ♣ Payment means obtaining reimbursement for services, confirming insurance coverage, billing, or collection activities.
- ♣ Health care operations include the business aspects of running our practice, such as quality assessment activities and financial analysis reviews.

We may, without prior consent, disclose health information to carry out treatment, payment, or health care operations in the following situations:

- ♣ If we are required by law to treat you, and we are unable to obtain such consent; or
- ♣ If substantial barriers prevent communications and we are unable to obtain consent, but in our professional judgment, consent for treatment is inferred from the circumstances, or
- If requested by HHS when it is undertaking a compliance investigation, review or enforcement action.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

If you do not want this information left on an answering machine or mailed to your home Address you must inform us in writing.

Any other disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- ♣ The right to request restrictions on certain used and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

- ♣ The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
  - ♣ The right to update your protected health information.
- \* The right to amend information in your PHI
  - ♣ The right to receive an accounting of disclosures of protected health information.
  - ♣ The right to obtain a paper copy of this notice from us upon request.
- \* The right to obtain a copy of your PHI records.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of November 14<sup>th</sup>, 2002 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

By signing below I acknowledge that I have reviewed this policy and understand my rights provided in it.

Patient Signature (or Guardian) \_\_\_\_\_

Date \_\_\_\_\_

Please contact us for more information or file a complaint:

Jonathan S. Ludwig , DMD, PA  
 Attn: Jennifer Ludwig, Privacy Officer  
 1014 Grandiflora Drive  
 Suite B  
 Leland, NC 28451  
 (910)371-5965

For more information about HIPAA or to file a complaint:

US Dept. of Health & Human Services  
 Office of Civil Rights  
 200 Independence Ave. SW  
 Washington, DC 20201  
 (877)696-6775

**Jonathan S. Ludwig, DMD, PA**  
**1014-B Grandiflora Drive - Leland, NC 28451**  
**phone (910)371-5965 / fax (910)371-5959**

## **FINANCIAL OPTIONS**

### **METHODS OF PAYMENT**

- Cash, check or credit card (VISA, MasterCard)
- Dental Insurance (described below)
- Care Credit Payment Plans

If you do not have dental insurance, we require the full amount be paid at the time of service. The office staff will be glad to assist you in estimating what your fee will be before your appointment, but please remember it is only an estimate! Please note there will be a \$35 fee on all returned checks.

### **DENTAL INSURANCE**

Our office will file your primary insurance for you as a courtesy. However, your insurance contract is between you, your employer, and the insurance company, not our dental office. All such insurance plans carry differing benefits, and I understand that my social security number will be cross-referenced with my insurance company in order for an estimate of my dental benefits to be made. *Please understand that, regardless of what your insurance company pays, you are ultimately responsible for your dental bill.*

We will need you to bring us a copy of your benefit booklet if you would like help interpreting your benefits. However, it is your responsibility to read and know your insurance booklet. **The insurance co-payment is an estimate of what your insurance may pay. IT IS NOT A GUARANTEE!!** Not all services are a covered benefit in all insurance contracts. Alternative treatment clauses and reasonable and customary allowances are a factor in what your insurance company may pay.

Your estimated co-payment and deductible are due at the time services are rendered. We cannot use a "wait and see" policy with insurance benefits as that it is the law that we collect your portion when services are rendered. Delay in collections only increases your cost of care with additional costs of billing. Insurance companies take from 30 to 60 days to pay a claim and often require further information from our office or from you before they will process your claim. If the insurance company does not pay your claim within 60 days, you will be billed for the full cost of treatment incurred and reimbursed when the insurance check comes in.

### **APPOINTMENT PHILOSOPHY**

Your appointment time has been reserved exclusively for you. A 24-hour notice is needed for any changes in your appointment as this affects other patient scheduling; when we are unable to fill an appointment due to last-minute cancellations, everyone pays the price in that cost of care must increase to cover such losses. For this reason, patients who repeatedly cancel or do not show up for their appointments may be asked to seek treatment elsewhere.

Please be advised that all accounts will be cross-referenced for outstanding medical debts utilizing the patient's (or guardian's) social security number through docWatch, an independent medical credit reporting agency. The information obtained will be used solely for informational purposes and will not be reported to the patient's (or guardian's) credit history.

I have read and understand the above information. I have had a chance to ask any questions and have them answered to my satisfaction. I understand that I am responsible for any charges incurred from services rendered.

Signature \_\_\_\_\_ Date \_\_\_\_\_