Welcome to Sunset Dental!! This letter is to acquaint our new patients with our general office policies to help avoid any misunderstandings. Our responsibilities are to you as our patient. We practice preventive dentistry and stress the importance of regular care to help you in your goal to achieve and maintain excellent dental health.

Insurance Patients: If you have dental insurance, it is your responsibility to bring a current insurance card to your appointment. We will file insurance claims as a courtesy to our patient. Remember that your insurance contract is between you and your insurer. It is your responsibility to be aware of insurance available for each treatment, any specific clauses stated in your policy, and deductibles and waiting periods. Insured patients should be prepared to pay their co-pay and/or deductible at time of service. If your insurance company pays only part of your bill or rejects your claim, you are financially responsible for the balance and the balance will be due upon receipt of your statement. It is also your responsibility to make sure that we are a listed provider with your insurance company.

Patients with no Insurance: Patients with no insurance are required to pay for their treatment in full at the time of service, unless other prior arrangements are made.

Payment: We honor Visa, MasterCard, Cash and Personal Checks with proper identification. Checks written with insufficient amount will have accounts billed $50.00 for each bad check. Statements will be sent out on a monthly basis.

Delinquent Accounts: Any fees, such as Attorney's fees, collection agency fees and court costs incurred as a result of overdue accounts will be the patient's complete financial responsibility.

We try to see our patients as promptly as possible. However, there are times when emergencies and/or surgeries may arise causing unavoidable delays.

We ask that our patients please give us at least 24-hour notice when canceling an appointment. These times are reserved for you. Failure to give notice on multiple occasions will result in a broken appointment charge.

Our goal is to make your appointment as comfortable, safe and pleasant as possible. If you should have any questions or suggestions, please feel free to discuss them with our doctor and staff.

By signing on the line below I am stating that I have read or have had it read to me and I understand my responsibilities listed in the above policies.

_____ _____

Patient or Guardian's Signature Date

Patient Information (confidential)

Patient ID #_____
SS# _____
Date _____

Name _____ Birthdate _____ Home Phone _____

Address _____ City _____ State _____ Zip _____

Email _____ Work Phone_____ Cell Phone _____

Check Appropriate Boxes: ☐Male ☐Female ☐Minor ☐ Single ☐ Married ☐Divorced ☐ Separated

If Student, Name of School/College_____ City _____ ☐part-time ☐full-time

Patient's or Guardian's Employer _____ Work Phone _____
Business Address _____ City _____ State _____ Zip _____

Spouse or Guardian's Name _____ Employer _____ Work Phone_____

Whom May We Thank for Referring You? _____

Person to contact in case of emergency _____ Phone _____

is this person currently patient in our office? ☐ *Yes* ☐ *No*

Responsible Party

Name of Person Responsible for this account _____ Relation to Patient _____

Address_____ Home Phone _____

Email _____ Cell Phone _____

Driver's License # _____ Birthdate _____

Employer _____ Work Phone _____ SS#_____

Dental Insurance Information

Name of Insured _____ Relation to Patient _____

Birthdate _____ SS# _____ Email _____

Name of Employer _____ Work Phone _____

Address of Employer _____ City _____ State _____ Zip _____

Insurance Company _____ Group# _____ ID#_____

Ins. Co. Address _____ City _____ State _____ Zip _____

Patient Medical History

Physician _____
Office Phone _____
Date of Last Exam _____

	YES	NO
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation/serious illness within the last 5 years?	☐	☐
If yes, please explain _____		
3. Are you taking any medication(s) including non-prescription medicine?	☐	☐
If yes, what medication(s) are you taking? _____		
4. Have you ever taken Fen-Phen/Redux?	☐	☐
5. Do you use tobacco?	☐	☐
6. Do you use controlled substances?	☐	☐
7. Are you wearing contact lenses?	☐	☐
8. Are your under the care of a psychiatrist?	☐	☐

	Yes	No		Yes	No		Yes	No
Heart Attack	☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐
Rheumatic Fever	☐	☐	Frequently Tired	☐	☐	Hay Fever/Allergies	☐	☐
Swollen Ankles	☐	☐	Anemia	☐	☐	Tuberculosis	☐	☐
Fainting/Seizures	☐	☐	Emphysema	☐	☐	Radiation Therapy	☐	☐
Asthma	☐	☐	Cancer	☐	☐	Glaucoma	☐	☐
Low Blood Pressure	☐	☐	Arthritis	☐	☐	Recent Weight Loss	☐	☐
Epilepsy/Convulsions	☐	☐	Joint Replacement/Implant	☐	☐	Liver Disease	☐	☐
Leukemia	☐	☐	Hepatitis/Jaundice	☐	☐	Heart Trouble	☐	☐
Pacemaker	☐	☐	High Blood Pressure	☐	☐	Snoring	☐	☐
Kidney Disease	☐	☐	Stomach Troubles/Ulcers	☐	☐	Thyroid Problem	☐	☐
AIDS or HIV Infection	☐	☐	Osteoporosis	☐	☐	Heart Disease	☐	☐
Obstructive Sleep Apnea	☐	☐	Chest Pains/Angina	☐	☐	Bleeding Disorder	☐	☐
Cardiac Arrhythmias/ Irregular Heart Rhythm	☐	☐	Mitral Valve Prolapse/ Leaky Heart Valve	☐	☐	Diabetes	☐	☐
						Other _____	☐	☐

	YES	NO
10. Have you ever had difficulties with general anesthesia or sedation?	☐	☐
11. Are you allergic to or have you had any reactions to the following?	☐	☐
Local Anesthetics (e.g. Novocain)	☐	☐
Penicillin or other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (e.g. nickel, mercury, etc.)	☐	☐
Latex (rubber)	☐	☐
Other (please list) _____	☐	☐
12. Have you ever taken or are you currently taking any medications for Osteoporosis?	☐	☐
13. Women only: a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking oral contraceptives?	☐	☐

Patient Dental History

Name of Previous Dentist _____
Office Phone or Location _____
Date of Last Exam _____

	YES	NO
1. Do your gums bleed while brushing or flossing?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?		
7. Have you ever experienced any of the following problems in your jaw?		
a. Clicking?	☐	☐
b. Pain (joint, ear or side of face)?	☐	☐
c. Difficulty in opening or closing?	☐	☐
d. Difficulty in chewing?	☐	☐
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you ever had any difficult extractions in the past?	☐	☐
12. Have you ever had any prolonged bleeding following extractions?	☐	☐
13. Have you had an orthodontic treatment?	☐	☐
If yes, what was the date of placement? _____	☐	☐
15. Do you like your smile?	☐	☐

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any such collections to the patients account. However, this dental office cannot render services on the assumption that our charges will be paid by the insurance companies. I understand that the fee estimated listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me or at my request, by the doctor, I agree to pay therefore the value of said services to said doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the value of said services shall be as billed unless objected to by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or work to discuss matters related to this form. I have read the above conditions of treatment and payment and agree to their content.

_____ _____ _____
Signature of patient/guardian Date Relationship to patient

_____ _____ _____
Signature of responsible party/guarantor Date Relationship to patient

Financial Policy

All patients please read the following...

Payment is expected for all services at the time the service is provided. If treatment requires multiple appointments, payment may be divided over the number of appointments. Cash, personal checks, MasterCard and Visa are accepted. If an extended payment is desired, please ask us about the Care Credit program.

I understand and agree that all services rendered to me, my dependents, or others assigned by me to my account are charged directly to me. I further understand I am personally responsible for payment. If I suspend or terminate care and treatment, any fees for services rendered will be immediately due and payable. Should the fees for the professional services not be paid in accordance with the provisions herein, reasonable attorney's fees, plus applicable financial charges and disbursements, allowances, and cost provided by law shall be included in the computation of the amount due.

Finance charges may be applied to all past due amounts at the rate of 1.5% per month (18% annual rate). If the account is in default and turned over for collection, a collection fee will be added.

If you have dental insurance...

As a courtesy, we will file your claim for you. We may accept direct payment from most insurance companies. We will estimate your deductible and the portion not covered by your insurance, which is due at the time of treatment. Our estimates may be different than your insurance company's calculations; therefore, the amount due to our office may be adjusted accordingly. All services rendered are charged directly to the patient, and the patient is ultimately responsible for the account regardless of the insurance coverage. Any insurance claims denied or remaining unpaid after 60 days will automatically become the responsibility of the patient.

We do not accept Medicaid or NC Choice

_____

Patient / Guardian Signature

_____

Date

SUNSET DENTAL

688 SUNSET BLVD N

SUNSET BEACH NC 28468

910-575-6300 (PHONE) 910-575-6311 (FAX)

PATIENT RECORD RELEASE FORM

Name of Person Whose Records Are Requested:_____

DOB: _____

Phone Number: _____

PLEASE PROVIDE A COPY OF RECORD MARKED BELOW

_____ **XRAYS**

_____ **A SPECIFIC DENTAL RECORD IF AVAILABLE**

PLEASE EMAIL RECORDS TO : SUNSETDENTAL@ATMC.NET

Previous Dentist Information:

Name of Previous Dentist:_____

Address: _____

Phone:_____ Fax: _____

Email:_____

_____ _____

SIGNATURE OF PATIENT DATE

HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGE OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/LIMITED AUTHORIZATION AND RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.

Date: _____

This undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed dated document shall be effective as the original. **MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OF RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR OR FACILITIES IN THE FUTURE.**

_____ _____

Please PRINT name of PATIENT | Please SIGN for Patient/Guardian of Patient

_____ _____

Legal Representative/Guardian | Relationship of Legal Representative/Guardian

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Please list any other parties who can have access to your health information: (this includes step-parents, grandparents and caretakers who can have access to patient's records)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO CONFIRM MY APPOINTMENTS, TREATMENT AND BILLING INFORMATION VIA:

- ☐ Cell Phone Confirmation
- ☐ Home Phone Confirmation
- ☐ Work Phone Confirmation
- ☐ Text Message to my Cell Phone
- ☐ Email Confirmation
- ☐ **Any of the Above**

I AUTHORIZE INFORMATION ABOUT MY CHILD'S HEALTH BE CONVEYED VIA:

- ☐ Cell Phone Confirmation
- ☐ Home Phone Confirmation
- ☐ Work Phone Confirmation
- ☐ Text Message to my Cell Phone
- ☐ Email Confirmation
- ☐ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS OR NEW HEALTH INFORMATION ON BEHALF OF THIS HEALTHCARE FACILITY VIA:

- ☐ Cell Phone Confirmation
- ☐ Home Phone Confirmation
- ☐ Work Phone Confirmation
- ☐ Text Message to my Cell Phone
- ☐ Email Confirmation
- ☐ **Any of the Above**

In signing this HIPAA Patient Acknowledgement Form you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration form these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As Employee, I attempted to obtain the patients (or representatives) signature on this Acknowledgement but did not because:

- It was emergency treatment ☐
- I could not communicate with the patient ☐
- The patient refused to sign ☐
- The patient was unable to sign because ☐
- Other (please describe) ☐

_____

Signature of Employee