Reservation/Cancellation Policy

Our practice is sensitive to busy schedules. We strive to provide high quality dental care in the most efficient manner possible. Because we value your time, we reserve a place for you to see the hygienist and doctor. Your reservation helps us ensure we utilize your time most effectively and ensures that other patients receive the same quality care that you receive. Your reservation ensures that the time reserved is of supreme quality with our highly credentialed hygienist and doctor. We ask that you review our reservation/cancellation policy and acknowledge this policy with your signature below.

- With your permission, the practice will communicate reservation reminders via text messaging and telephone calls.
- We ask that all new patients arrive several minutes (e.g. 15) prior to your reservation time in order to allow for completion of necessary new patient forms.
- We ask that reservation cancellations be made at least 48 hours ahead of the scheduled reservation time.
- The practice understands that emergencies can sometimes arise. Therefore, Lumber River Dental will work with you to reschedule your reservation if you must cancel less than 24 hours prior.
- A reservation cancellation less than 24 hours prior can disrupt the quality time that other patients receive. Therefore, a second reservation cancellation under 24 hours prior will result in you having to pay a $50 deposit for future reservations. This deposit reservation fee must be paid at least 4 days in advance. The deposit will be applied toward the dental care you receive.
- A broken reservation without any notification also results in a $50 deposit paid 4 days in advance of future reservations. The deposited funds will be applied toward the dental care you receive.
- The practice reserves the right to modify this policy at any time in the future.

_____ _____

Patient Date

_____ _____

Lumber River Dental Representative Date

Financial Policy

We understand that dental care can be expensive which is why Lumber River Dental strives to be innovative with payment options. Our goal is to remove financial barriers so that you and your family can receive dental care at our practice. We ask that you take a moment to review this policy and acknowledge it with your signature.

- Payment for dental care is expected at the time of service.
- We will strive to verify your insurance benefits prior to treatment. However, you dental carrier only provides us an estimate of benefits. Any remaining balance becomes your financial responsibility.
- We will file a claim on your behalf if the practice is in network with your dental insurance provider.
- Law requires that this practice collect your copay for dental care received.
- It's important to us that our patients have options to pay for their dental care. Our practice provides financing options so that you can pay for your care on a monthly basis. Please ask our team member for questions about details.
- We accept cash, check, Visa, MasterCard, and Discover.
- Retuned checks are subject to a $30 fee.
- Account balances greater than 90 days are subject to being forwarded to a collection agency.
- The practice reserves the right to modify this policy at any time in the future.

_____ _____

Patient Date

_____ _____

Lumber River Dental Representative Date

Primary Dental Insurance Information

Name of Insured: (Last) _____ (First) _____ (MI) _____

Insured's Birth Date: _____ ID# _____ Group#: _____

Insured's Address: _____

(City) _____ (State) _____ (Zip) _____

Insured's Employer Name: _____

Employer's Address: _____

(City) _____ (State) _____ (Zip) _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance Plan Name: _____

Insurance Address: _____

(City) _____ (State) _____ (Zip) _____

Please let us know if you have secondary dental insurance.

Consent for Services

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the cost incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will accept assignment of benefits from most insurance companies, however, the patient is always responsible for any balance their insurance company does not cover.

I understand that any fee estimate for this dental care can only be extended for a period of ninety days from the date of the patient's examination.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment. I further agree to pay all costs and reasonable attorney fees if account goes into collection.

☐ I have read the above conditions of treatment and payment and agree to their consent.

Signature: _____ Date: _____

Relationship to the Patient: _____

LUMBER RIVER Dental

Medical & Dental History

Today's Date_____/_____/_____

Name (Last) _____ (First) _____ (MI) _____

Have you had dental x-rays within the last 12 months? _____ If so, please bring copies of the x-rays to your dental appointment. If you choose not to obtain those x-rays, we will need to take a new series of x-rays which consist of a panorex and bitewing x-rays.

What is the reason for your visit today? _____

Have you had hip/knee replacement surgery or any heart surgery within the last two years? _____ If yes, please let us know so that we may determine whether you may need an antibiotic prior to your appointment.

Would you consider yourself to be in fairly good health?
☐ Yes ☐ No
Within the past year, have there been any changes in your general health?
☐ Yes ☐ No

What is the date (or approximate date) of your last medical and dental exam?

_____

Your Primary Care Physician's name, address & phone number? _____

_____

Do you have or have you ever had any of the following?

Yes	No	Yes	No
☐	☐ Abnormal Bleeding	☐	☐ Alcohol/Drug Abuse
☐	☐ Anemia	☐	☐ Arthritis
☐	☐ Artificial bones/joints	☐	☐ Asthma
☐	☐ Blood Disease/Transfusion	☐	☐ Cancer
☐	☐ Colitis	☐	☐ Diabetes
☐	☐ Emphysema	☐	☐ Epilepsy
☐	☐ Fainting	☐	☐ Frequent Headaches
☐	☐ Glaucoma	☐	☐ Hayfever/Seasonal Allergies
☐	☐ Heart Disease	☐	☐ Heart Murmur/Mitral Valve Prolapse
☐	☐ Hepatitis	☐	☐ Fever Blister/Herpes
☐	☐ High Blood Pressure	☐	☐ HIV
☐	☐ Jaundice	☐	☐ Kidney Disease
☐	☐ Liver Disease	☐	☐ Mental Disorders
☐	☐ Nervous Disorders	☐	☐ Pacemaker
☐	☐ Premedication needed	☐	☐ Pregnancy
☐	☐ Psychiatric Problems	☐	☐ Radiation Treatment
☐	☐ Rheumatic Fever	☐	☐ Sinus Problems
☐	☐ Stroke	☐	☐ Thyroid Problems
☐	☐ Tuberculosis/TB	☐	☐ Tumors
☐	☐ Ulcers	☐	☐ Venereal Disease/VD

WOMEN ONLY: Are you pregnant?
☐ Yes ☐ No If yes, due date? _____

Are you allergic to any of the following?

Yes	No		Yes	No
☐	☐ Penicillin		☐	☐ Codeine
☐	☐ Novocaine		☐	☐ Aspirin
☐	☐ Sulfa Drugs		☐	☐ Latex
☐	☐ Amoxicillin		☐	☐ Other

☐ Yes ☐ No Have you ever had complications following dental treatment?
☐ Yes ☐ No Are you currently under the care of a physician due to a specific condition?
☐ Yes ☐ No Have you been hospitalized within the last 5 years due to a surgery or illness?
☐ Yes ☐ No Do you use tobacco products (smoking or chewing)?
☐ Yes ☐ No Do you require the use of corrective lenses (contacts or glasses)?
☐ Yes ☐ No Do you have any conditions, diseases, etc., not listed above?

Please list any medications (prescription and non-prescription) that you are taking?

_____

_____

How frequently do you brush your teeth? ☐ 3+/day ☐ 2 X per day ☐ 1 X/day ☐ Weekly

How frequently do you floss your teeth? ☐ 1+/day ☐ 2-6 weekly ☐ 1-6 monthly ☐ Never

☐ Yes ☐ No Do your gums bleed when you brush or floss?
☐ Yes ☐ No Do your teeth experience sensitivity to cold or hot temperatures?
☐ Yes ☐ No Are any of your teeth currently causing you pain?
☐ Yes ☐ No Do you grind your teeth (either consciously or during sleep)?
☐ Yes ☐ No Are any of your teeth loose, or are you concerned about any teeth loosening?
☐ Yes ☐ No Do you currently have any dental implants, dentures or partials?
☐ Yes ☐ No Do you snore?
☐ Yes ☐ No Would you like your teeth whiter?

Authorization

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential to being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare providers. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

_____

Patient/Parent or guardian

_____

Doctors Signature

LUMBER RIVER Dental

Patient Information

Please take a moment to enter or update your information to help us ensure the quality of your care is excellent.

Name (Last) _____ (First) _____ (MI) _____

Title:_____ Preferred Name :_____

Gender: ☐ Male ☐ Female Family Status: ☐ Married ☐ Single ☐ Child ☐ Other

Date of Birth:_____ Email Address: _____

Address: _____

(City) _____ (State)_____ (Zip)_____

Phone: (home) _____ (work) _____ (mobile) _____

Emergency Contact Name and Phone Number: _____

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

Responsible Party Information

Name (Last) _____ (First) _____ (MI) _____

Title:_____ Gender: ☐ Male ☐ Female Family Status: ☐ Married ☐ Single ☐ Other

Date of Birth:_____ Social Security #: _____

Phone: (home) _____ (work) _____ (mobile) _____

Address: _____

(City) _____ (State)_____ (Zip)_____

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Phone: _____

Address: _____

(City) _____ (State)_____ (Zip)_____

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 _____
☐ Spouse (provide name and phone number) _____	☐ Financial ☐ Medical
☐ Parent (provide name and phone number) _____	☐ Financial ☐ Medical
☐ Email communication-Provide email address* _____ *In order for email communication to occur, please accept the disclosure below:	☐ Financial ☐ Medical ☐ Breach notification
☐ For email communication I understand that if email is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email communication.	
☐ Communication about treatment alternatives even if this office is being compensated for making the communication.	

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.

The information is released at the patient's request and 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)

Revised August 2013

Authorization to Release Health Information

Patient Information:

Name of Patient _____ Date of Birth _____

Address _____

City, State, Zip _____ Phone _____

At my request the following information may be released:

☐ Entire record ☐ Financial records ☐ Office visit notes
☐ Marketing* ☐ On site record review by the patient
☐ Psychotherapy notes – if this box is checked only psychotherapy notes may be released.
☐ Diagnostic studies (list):

☐ Other as listed

*Financial compensation is received for this communication.

Entity or person who will receive the information:

Name Lumber River Dental

Address 3718 Hillcrest Drive

City, State, Zip Lumberton NC 28358 Phone (910)474-2587

This authorization shall be in effect until the information has been forwarded as requested or until the course of treatment is complete.

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.

I understand that released information may include a communicable disease diagnosis such as HIV.

_____ Date _____
Signature of Patient or Personal Representative

Revised August 2013