UNION FAMILY DENTAL

PATIENT NAME: ______ SEX: ______ DATE OF BIRTH: ______ S.S.# ______ INSURANCE ID# ______

PREFFERED NAME: ______ PHONE NO: (HOME): ______ (CELL): ______ (WORK): ______

ADDRESS: ______ APT/UNIT NO: ______ CITY: ______ STATE: ______ ZIPCODE: ______

PARENT/SPOUSE'S NAME: ______ DOB: ______ E-MAIL ADDRESS: ______

IN CASE OF EMERGENCY, WHO SHOULD BE NOTIFIED, BESIDES PERSON LISTED ABOVE? ______ PHONE NUMBER: ______

WHOM MAY WE THANK FOR REFERRING YOU? ______

FEMALES: ARE YOU PREGNANT OR TRYING TO GET PREGNANT? ______ IF SO, DUE DATE: ______ ARE YOU NURSING? ______

NAME OF OB/GYN: ______ PHONE NO: ______ ARE YOU TAKING ORAL CONTRACEPTIVES? ______

LIST ANY MEDICATIONS, NOTING REASON, DOSEAGE & FREQUENCY (USE SEPARATE PAGE IF TOO MANY TO LIST): ______

______

HAVE YOU HAD MAJOR SURGERY OR BEEN HOSPITALIZED IN THE PAST FIVE YEARS? ______ REASON/ DATE: ______

HAVE YOU EVER HAD A SERIOUS HEAD OR NECK INJURY? ______

ARE YOU UNDER A PHYSICIAN'S CARE NOW: ______ IF SO, PLEASE EXPLAIN: ______

PHYSICIAN'S NAME/PHONE NUMBER: ______ DATE OF LAST PHYSICAL EXAM: ______

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING? ASPIRIN: ______ PENICILLIN: ______ CODEINE: ______ LATEX: ______

SULFA DRUGS: ______ LOCAL ANESTHESIA: ______ ACRYLIC: ______ FOOD/OTHER ALLERGY: <explain> ______

DOES PATIENT HAVE, OR HAS EVER HAD, ANY OF THE FOLLOWING? DOES PATIENT USE TOBACCO PRODUCTS? ☐ YES ☐ NO

	YES	NO		YES	NO		YES	NO		YES	NO
AIDS/HIV POSITIVE	☐	☐	CORTISONE MEDICINE	☐	☐	HEMOPHELIA	☐	☐	RADIATION TREATMENTS	☐	☐
ALZHEIMER'S	☐	☐	DIABETES	☐	☐	HEPATITIS A	☐	☐	RECENT WEIGHT LOSS	☐	☐
ANAPHYLAX	☐	☐	DRUG ADDICTION	☐	☐	HEPATITIS B or C	☐	☐	RENAL DIALYSIS	☐	☐
ANEMIA	☐	☐	EASILY WINDED	☐	☐	HERPES	☐	☐	RHEUMATIC FEVER	☐	☐
ANGINA	☐	☐	EMPHYSEMA	☐	☐	HIGH BLOOD PRESSURE	☐	☐	RHEUMATISM	☐	☐
ARTHRITIS/GOUT	☐	☐	EPILEPSY OR SEIZURES	☐	☐	HIGH CHOLESTEROL	☐	☐	SCARLET FEVER	☐	☐
ART.HEART VALVE	☐	☐	EXCESSIVE BLEEDING	☐	☐	HIVES OR RASH	☐	☐	SHINGLES	☐	☐
ARTIFICIAL JOINT	☐	☐	EXCESSIVE THIRST	☐	☐	HYPOGLYCEMIA	☐	☐	SICKLE CELL DISEASE	☐	☐
ASTHMA	☐	☐	FAINTING /DIZZINESS	☐	☐	IRREGULAR HEARTBEAT	☐	☐	SINUS TROUBLE	☐	☐
BLOOD DISEASE	☐	☐	FREQUENT COUGH	☐	☐	KIDNEY PROBLEMS	☐	☐	SPINA BIFADA	☐	☐
BLOOD TRANS	☐	☐	FREQUENT DIARRHEA	☐	☐	LEUKEMIA	☐	☐	STOMACH/INTEST DISEASE	☐	☐
BREATHING PROBLEMS	☐	☐	FREQUENT HEADACHE	☐	☐	LIVER DISEASE	☐	☐	STROKE	☐	☐
BRUISE EASILY	☐	☐	GENITAL HERPES	☐	☐	LOW BLOOD PRESSURE	☐	☐	SWELLING OF LIMBS	☐	☐
CANCER	☐	☐	GLAUCOMA	☐	☐	LUNG DISEASE	☐	☐	THYROID DISEASE	☐	☐
CHEMOTHERAPY	☐	☐	HAY FEVER	☐	☐	MITRAL VALVE PROL	☐	☐	TONSILLITIS	☐	☐
CHEST PAINS	☐	☐	HEART ATTACK/FAILURE	☐	☐	OSTEOPOROSIS	☐	☐	TUBERCULOSIS	☐	☐
COLD SORE/FEVER BLISTERS	☐	☐	HEART MURMUR	☐	☐	PAIN IN JAW JOINTS	☐	☐	TUMORS OR GROWTHS	☐	☐
CONG.HEART DISORDER	☐	☐	HEART PACEMAKER	☐	☐	PARATHYROID DISEASE	☐	☐	ULCERS	☐	☐
CONVULSIONS	☐	☐	HEART TROUBLE/DISEASE	☐	☐	PSYCHIATRIC CARE	☐	☐	VENEREAL DISEASE	☐	☐
									YELLOW JAUNDICE	☐	☐

HAS THE PATIENT EVER HAD OR HAS ANY SERIOUS ILLNESS OR CONDITIONS NOT LISTED ABOVE? ☐ YES ☐ NO

IF "YES", PLEASE LIST: ______

ADDITIONAL INFORMATION/COMMENTS: ______

TO THE BEST OF MY KNOWLEDGE, THE QUESTIONS ON THIS FORM HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY (OR THE PATIENT'S) HEALTH: IT IS MY RESPONSIBLITY TO INFORM THE DENTAL OFFICE OF ANY CHANGES IN MEDICAL STATUS.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN: ______ DATE: ______

PATIENT APPOINTMENT POLICIES

We at Union Family Dental Clinic (UFDC) believe that the best relationships are based on mutual respect. We believe both your time and our time is valuable and should be respected. We strive to keep our schedule organized and on time in order to minimize wait time, while maximizing your time here. We therefore ask that you read and acknowledge the below patient appointment policies.

CANCELLATIONS

UFDC requires 24-hour notice for cancellations of reserved appointments. Cancellations without 24-hour notice will be considered failures. We are aware and understand that emergencies do arise and will review on a "case by case" basis.

Patients who do not come for up to 3 reserved appointments, have multiple late arrivals, *or* abuse scheduled appointment times, will no longer be appointed for dental care with the providers of East Charlotte Dental, resulting in dismissal from the practice.

FAILURES

Listed below is UFDC's appointment failure policy:

First & Second Failed Appointments (within a 12-month period)

Appointments will be rescheduled.

Third Failed Appointment (within a 12-month period)

Appointment will be rescheduled; however, you will be seen on a "STANDBY BASIS". You can still be seen at UFDC, but you will not be given a guaranteed appointment slot. After three kept "STANDBY" appointments, you will be permitted to schedule regular appointments with a guaranteed appointment.

APPOINTMENT TIMES - RESERVED APPOINTMENTS

Our patients are scheduled according to their dental needs, allowing our doctors the time they need to provide the quality of care you expect from UFDC. Arriving late to your scheduled appointment time could be disruptive to the next patient's care.

We will allow a 10-minute maximum grace period to arrive at your appointment. AFTER 10 MINUTES, your appointment may be rescheduled, based on the appointment times available and the reason for the delay. Please contact us at your earliest convenience to advise us if you think you will not arrive on time. Please note however that failure to arrive on time without notice will constitute an appointment failure.

APPOINTMENT CONFIRMATION

In order for us to provide quality care to all of our patients, we must maintain our schedule in an efficient manner. UFDC requires our patients to confirm their intent to keep their scheduled appointment times no later than 2pm on the business day prior to their reserved appointment. The office will make two (2) attempts within a 48-hour period to reach you. Unfortunately, if we do not receive a response OR if unable to reach you, we will be required to move the appointment to standby status.

We can be reached by calling (704) 776 – 4157 to confirm your scheduled appointment. Please feel free to leave a message if the office is closed or if our phone lines are busy.

By signing this agreement, you acknowledge receipt of our *Patient Appointment Policy* and will in good faith abide by this agreement.

______________________________ ____________________

Patient Name (*printed*) Date

____

Signature

HIPAA OMNIBUS RULE

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

(You may refuse to sign this acknowledgement & authorization. In refusing, please note that we may not be permitted to process your insurance claims)

Date: ______________________________

The undersigned acknowledges receipt of Union Family Dental's currently effective *Notice of Privacy Practices*. A copy of this signed, dated document shall be as effective as the original.

MY SIGNATURE SERVES AS A RELEASE FOR PROTECTED HEALTH INFORMATION (PHI) DOCUMENTS, SHOULD I REQUEST TREATMENT, RADIOGRAPHS OR ANY OTHER RECORDS BE SENT TO ANOTHER ATTENDING DOCTOR / FACILITY IN THE FUTURE.

______________________________ ______________________________

Patient First & Last Name (*printed*) Patient Signature

______________________________ ______________________________

Patient Legal Representative/Guardian Name (*printed*) Representative/Guardian Relationship to Patient

Comments regarding Acknowledgement / Consent (*optional*): ______________________________

____

HOW SHOULD THE PATIENT BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:

- ☐ First Name Only
- ☐ Proper Surname
- ☐ Other: ______________________

PLEASE LIST ANY OTHER PARTIES WHO MAY BE GIVEN ACCESS TO THE PATIENT'S HEALTH INFORMATION:
(Such as stepparents, grandparents or other caregivers who may be given access to the patient's records, or who may accompany the patient to appointments)

First & Last Name (*printed*): ______________________ Relationship to Patient: ______________________

First & Last Name (*printed*): ______________________ Relationship to Patient: ______________________

I AUTHORIZE CONTACT FROM THIS FACILITY TO **CONFIRM PATIENT APPOINTMENTS** 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 PATIENT HEALTH, TREATMENT & BILLING** BE CONVEYED VIA:

- ☐ Cell Phone Confirmation
- ☐ Home Phone Confirmation
- ☐ Work Phone Confirmation
- ☐ Email Confirmation
- ☐ **Any of the Above**

I AUTHORIZE CONTACT REGARDING **SPECIAL SERVICES, EVENTS, FUNDRAISING EFFORTS or NEW HEALTHCARE INFORMATION** ON BEHALF OF THIS FACILITY VIA:

- ☐ Cell Phone Confirmation
- ☐ Home Phone Confirmation
- ☐ Work Phone Confirmation
- ☐ Text Message to my Cell Phone
- ☐ Email Confirmation
- ☐ **Any of the Above**
- ☐ **None of the Above** (*opt out*)

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

Office Use Only

As Privacy Officer of this facility, attempts to obtain the patient (or representative) signature on this Acknowledgement were unsuccessful because:

- ☐ Emergency Treatment
- ☐ Unable to communicate with patient
- ☐ Patient Refusal
- ☐ Patient Unable to Sign (please describe): ______________________
- ☐ Other (please describe): ______________________

Signature of Privacy Officer:

____