KILDAIRE
FAMILY DENTAL

3420 Ten-Ten Rd, #310 ▪ Cary, NC 27518 ▪ Phone (919) 342-8509 ▪ Fax (919) 882-8455 ▪ team@kildairefamilydental.com

Patient Agreement

v1.21.16

Last Name: **First Name:** **DOB:**

Thank you for choosing Kildaire Family Dental! Our practice strives for open and honest communication with our patients in order to serve you well. We put forth our best efforts toward patient care and strive to continually develop our clinical skills and office operations to make your experience better. To better serve all of our patients we have developed the following policies.

Attendance Policy

Kildaire Family Dental strives to provide all of our patients with quality care in their scheduled time slots. When you schedule an appointment, that time is reserved with your provider especially for you, so that we may be dedicated to your care. We ask that you arrive on time and notify us 2 *business* days in advance of any needed changes to your appointment. If you need to reschedule a Monday appointment please let us by Thursday so that we may offer that time slot to other patients.

Late Arrival for Appointments – If you are 15 minutes late, we may need to reschedule your appointment so that we may provide scheduled patients with the care that they deserve. If you are late for two appointments, you will be charged a broken appointment fee of $45.00 and all future appointments must be paid in advance.

Missed Appointment - If you fail to appear for an appointment, your account will be charged a $45.00 broken appointment fee that must be paid if you wish to reschedule.

Change of Appointments – If you cancel/change your appointment without proper notice (48 hours) twice, it will be necessary for you to pay a broken appointment fee of $45.00 and pre-payment for all future appointments will be required.

Insurance

As a service to our patients, Kildaire Family Dental is in-network with a number of insurance plans. We work closely with many insurances to make claim filing easier for our patients. We are happy to help you fill out claim forms, and provide the insurance company with any information they need to process your claim.

In-network insurance – Our staff will file with your insurance provider who will pay Kildaire Family Dental directly based on your benefits at our negotiated rate. You will be responsible for estimated co-pays at time of service and will be responsible for any additional balances or receive a refund based on claim payment.

Out-of-network insurance – Payment will be due at the time the service is rendered. In most cases your insurance company will reimburse you instead of paying Kildaire Family Dental. Our staff can help you file your claim with your insurance company. In some cases we can still file with your insurance company, please talk to our team to see if we work directly with your insurance company.

Payment

Methods of Payment – We accept Cash, Personal Check, Credit card (Visa®, MasterCard®, American Express®, or Discover®), and CareCredit® financing. Please ask our team about financing options if you have any questions.
Returned payment - Kildaire Family Dental charges $25 for returned checks and other returned payments.
If your account becomes **past due over 60 days**, there will be a finance charge of **2%** added monthly **(24%APR).**
If you are scheduled for an **emergency visit,** 100% is due at the time of service.

Ultimately, you are responsible for payment of all fees for dental care rendered by our office.

☐ By checking here you verify that you have read and understand the financial and attendance policies of Kildaire Family Dental.

_____ _____

Signature of Patient, Parent or Guardian Date

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GENERAL INFORMATION

v1.21.16b

Title: ___ First Name: _____ MI: _____ Last Name: _____

Preferred Name: _____ Gender: ❑ Male ❑ Female Married: ❑ Yes ❑ No

Home: _____ Work: _____ Cell: _____ Can we text you? ❑ Yes ❑ No

Email Address: _____ DOB: _____ SS#:_____

Email opt in: *I authorize Kildaire Family Dental to send emails that may contain protected health information such as treatment information, appointment times, etc. as requested by me to the email address listed above.* ❑ Yes ❑ No

Preferred Contact Method: ❑Work Phone ❑Home Phone ❑Cell Phone ❑Text ❑Email ❑Mail

Preferred Contact Method for appt reminders: ❑Work Phone ❑Home Phone ❑Cell Phone ❑Text ❑Email ❑Mail

Preferred Contact Method for cleaning reminders: ❑Work Phone ❑Home Phone ❑Cell Phone ❑Text ❑Email ❑Mail

Address: _____ Address 2:_____

City: _____ State: _____ Zip: _____

Is address same for the entire family? ❑ Yes ❑ No

Emergency Contact: _____ Relationship: _____Ph#_____

FINANCIAL INFORMATION

❑ Dental Insurance ❑ No Insurance ❑ Kildaire Family Plan

Dental Insurance:

Subscriber's Full Name: _____ Relationship to subscriber: ❑ Self ❑Spouse ❑Child

Subscriber's Employer: _____ Insurance Company: _____

Group number: _____ Subscriber ID: _____

Subscriber's DOB: _____ Subscriber's SS#:_____ Phone # on back of Card: _____

Secondary Dental Insurance:

Subscriber's Full Name: _____ Relationship to subscriber: ❑ Self ❑Spouse ❑Child

Subscriber's Employer: _____ Insurance Company: _____

Group number: _____ Subscriber ID: _____

Subscriber's DOB: _____ Subscriber's SS#:_____ Phone # on back of Card: _____

Responsible Party if not Patient:

First Name: _____ MI: _____ Last Name: _____

Address: _____ Phone: #:_____

How did you hear about our office? Please mark all that apply.

❑ Drive/Walk by	❑ Flyer	❑ Promotional bag	❑ Local Event	❑ Sign
❑ Google search	❑ Facebook	❑ Yelp	❑ Healthgrades	❑ Grocery Cart
❑ Insurance Company	❑ Other _____		❑ Referral: _____	

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DENTAL HISTORY

Last Name: **First Name:** **DOB:**

Why are you changing dentists?

❑ Change of residence ❑ Your office is closer ❑ Unhappy ❑ You were recommended
❑ Change of dental plan ❑ My dentist retired/closed ❑ Too expensive ❑ Other

Please explain:

How long since your last visit to dentist?

❑ 1 month ❑ 6 months ❑ 2 years ❑ I've never seen a dentist
❑ 3 months ❑ 1 year ❑ 3 or more years

Reason for your visit? ❑ Check-up ❑ Cleaning ❑ Pain ❑ Other
Please provide details:

Have you ever had a bad experience at the dentist? ❑ Yes ❑ No
If yes please explain:

Have you had any complications following dental treatment? ❑ Yes ❑ No
If yes please explain:

Dental Health Questions

□ Y □ N Are you experiencing any discomfort?
□ Y □ N Do you snore?
□ Y □ N Do you have bleeding gums?
□ Y □ N Do you have bad breath?
□ Y □ N Do you grind your teeth?
□ Y □ N Do you play sports?
□ Y □ N Are you sensitive to □ hot, □ cold or □ sweets?
□ Y □ N Have you ever received Periodontal (Gum) Therapy?
□ Y □ N Do you use a fluoride supplement?
□ Y □ N Do you use tobacco?
□ Y □ N Do you drink coffee or tea?
□ Y □ N Are you interested in having whiter/brighter teeth?
□ Y □ N Do you have difficulty brushing your teeth?
□ Y □ N Do you have difficulty flossing your teeth?

How would you rate your smile on a scale from 1 to 10, with 10 being the highest? 1 2 3 4 5 6 7 8 9 10

What would you change about your smile if you could? _____

Denture/Partial Patients

□ Y □ N Do you wear a denture or partial? How old is your denture or partial? _____
□ Y □ N Does your denture or partial cause irritation?
□ Y □ N Are your dentures loose?

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MEDICAL HISTORY

Last Name: **First Name:** **DOB:**

Primary Care Physician: _____ **Physician's Phone:** _____

□ Y □ N Are you under a physician's care?

□ Y □ N Have you ever had a serious head or neck injury?

□ Y □ N Do you use tobacco products?

□ Y □ N Have you been admitted to hospital in last 2 years?

□ Y □ N Are you pregnant, trying to get pregnant or nursing?

□ Y □ N Have you ever taken medications for osteoporosis?

If you answered yes to any of the above questions, please explain:

Are you allergic or do you react adversely to any of the following?

□ Y □ N Aspirin
□ Y □ N Acrylic
□ Y □ N Sulfa drugs
□ Y □ N Penicillin or other antibiotics
Which ones?_____

□ Y □ N Tetracycline
□ Y □ N Metal
□ Y □ N Codeine
□ Y □ N Barbiturates, sedatives or sleeping pills

□ Y □ N Latex
□ Y □ N Local anesthetics (Novacaine-like medication)
□ Y □ N Milk protein

Other: _____

Please check any conditions that you currently or previously have had:

- ❑ AIDS/HIV Positive
- ❑ Alzheimer's Disease
- ❑ Anaphylaxis
- ❑ Anemia
- ❑ Angina
- ❑ Arthritis/Gout
- ❑ Artificial Heart Valve*
- ❑ Artificial Joint*
- ❑ Asthma
- ❑ Blood Disease
- ❑ Blood Transfusion
- ❑ Breathing Problems
- ❑ Bruise Easily
- ❑ Cancer
- ❑ Chemotherapy
- ❑ Chest Pains
- ❑ Cold Sores/Fever Blisters
- ❑ Congenital Heart Disorder
- ❑ Convulsions
- ❑ Cortisone Medicine
- ❑ Diabetes
- ❑ Drug Addiction
- ❑ Easily Winded
- ❑ Emphysema
- ❑ Endocarditis
- ❑ Epilepsy or Seizures
- ❑ Excessive Bleeding
- ❑ Excessive thirst
- ❑ Fainting Spells/Dizziness
- ❑ Frequent Cough
- ❑ Frequent Diarrhea
- ❑ Frequent Headaches
- ❑ Glaucoma
- ❑ Hay Fever
- ❑ Heart Attack/Failure
- ❑ Heart Murmur*
- ❑ Heart Pacemaker*
- ❑ Heart Trouble/Disease
- ❑ Hemophilia
- ❑ Hepatitis A
- ❑ Hepatitis B or C
- ❑ Herpes
- ❑ High Blood Pressure
- ❑ Hives or Rash
- ❑ Hypoglycemia
- ❑ Irregular Heartbeat
- ❑ Kidney Problems
- ❑ Leukemia
- ❑ Liver Disease
- ❑ Leukemia
- ❑ Lung Disease
- ❑ Mitral Valve Prolapse*
- ❑ Osteoporosis
- ❑ Pain in Jaw Joints
- ❑ Parathyroid Disease
- ❑ Parkinson's Disease
- ❑ Pins, Rods, Stints or Shunts
- ❑ Psychiatric Care
- ❑ Radiation Treatments
- ❑ Recent Weight Loss
- ❑ Renal Dialysis
- ❑ Rheumatic Fever
- ❑ Rheumatism
- ❑ Scarlet Fever
- ❑ Shingles
- ❑ Sickle Cell Disease
- ❑ Sinus Problem
- ❑ Spina Bifida
- ❑ Stomach/Intestinal Disease
- ❑ Stroke
- ❑ Swelling of Limbs
- ❑ Thyroid Disease
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Tumors or Growths
- ❑ Ulcers
- ❑ Venereal Disease
- ❑ Yellow Jaundice
- ❑ None

Please list any other conditions you have had or currently have:

MEDICAL HISTORY (cont)		
Last Name:	**First Name:**	**DOB:**
Please check any medications and/or supplements taken in the past 12 months:		
❑ Antibiotics or sulfa drug ❑ Tranquilizer ❑ Anticoagulants (e.g. Coumadin, blood thinners) ❑ Aspirin (daily) ❑ Contraceptives ❑ Heart medications	❑ Radiation / Chemotherapy ❑ Insulin or diabetes medication ❑ Bisphosphonates (used to treat osteoporosis, such as Fosamax, Boniva, Actonel and Zometa)	❑ Herbal supplements ❑ Phen-Fen or Redux ❑ High blood pressure medication ❑ Nitroglycerin (Please bring with you) ❑ Inhaler/Asthma/COPD (Please bring with you)
List all medications/supplements you are currently taking:		

I have answered all questions to the best of my knowledge. I will notify Kildaire Family Dental of any change in my health or medication at each visit.

I authorize Kildaire Family Dental to use the necessary local/topical anesthetic to perform my treatment in a safe, effective manner, during this visit and any future visits. I understand that my failure to provide information on previous adverse reactions may cause unforeseen negative reactions. I release Kildaire Family Dental of all liability regarding undisclosed medical history information.

_____ _____ _____

Print Name of Client or Guardian **Date** **If authorized guardian, relationship to client**

_____ _____

Signature of Client or Guardian **Date**

(If filling out online signature will be captured later)

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NOTICE OF PRIVACY PRACTICES v1.21.16

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED, DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

Federal and state law requires us to maintain the privacy of your health information. That law also requires us 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 we describe in this notice while it is in effect. This notice takes effect May 1, 2015, 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 any time, provided such applicable law permits the changes. We reserve the right to make the changes in our privacy practices 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 practices, 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.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and health care operations. For example:

Treatment: We may use your health information for treatment or disclose it to a dentist, physician or other health care provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you. We may also disclose your health information to another health care provider or entity that is subject to the federal Privacy Rules for its payment activities.

Health Care Operations: We may use and disclose your health information for our health care operations. Health care operations include quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities. We may disclose your health information to another health care provider or organization that is subject to the federal privacy rules and that has a relationship with you to support some of their health care operations. We may disclose your information to help these organizations conduct quality assessment and improvement activities, review the competence or qualifications of health care professionals, or detect or prevent health care fraud and abuse.

On Your Authorization: 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 uses 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 may disclose your health information to a family member, friend or other person to the extent necessary to help with your health care or with payment for your health care. Before we disclose your health information to these people, we will provide you with an opportunity to object to our use or disclosure. If you are not present, or in the event of your incapacity or an emergency, we will disclose your medical information based on our professional judgment of whether the disclosure would be in your best interest. We may 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. We may use or disclose information about you to notify or assist in notifying a person involved in your care, of your location and general condition.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, texts, or letters.)

(continued)

Disaster Relief: We may use or disclose your health information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

Public Benefit: We may use or disclose your medical information as authorized by law for the following purposes deemed to be in the public interest or benefit:

- as required by law;
- for public health activities, including disease and vital statistic reporting, child abuse reporting, FDA oversight, and to employers regarding work-related illness or injury;
- to report adult abuse, neglect, or domestic violence;
- to health oversight agencies;
- in response to court and administrative orders and other lawful processes;
- to law enforcement officials pursuant to subpoenas and other lawful processes, concerning crime victims, suspicious deaths, crimes on our premises, reporting crimes in emergencies, and for purposes of identifying or locating a suspect or other person;
- to coroners, medical examiners, and funeral directors;
- to an organ procurement organizations;
- to avert a serious threat to health or safety;
- in connection with certain research activities;
- to the military and to federal officials for lawful intelligence, counterintelligence, and national security activities;
- to correctional institutions regarding inmates; and
- as authorized by state worker's compensation laws.

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 request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge you a reasonable cost-based fee that may include labor, copying costs, and postage. 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 may—but are not required to—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 more information about fees.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information over the last 6 years (but not before June 1, 2015). That list will not include disclosures for treatment, payment, health care operations, as authorized by you, and for certain other activities. 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. Contact us using the information listed at the end of this notice for more information about fees.

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). Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. Your request is not binding unless our agreement is in writing.

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. You must specify in your request the alternative means or location, and provide satisfactory explanation how you will handle payment 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 we should amend the information. We may deny your request under certain circumstances.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us using the information listed at the end of this notice. Our staff will setup an appointment for you to talk with Dr. Ashley DeSaix regarding your concerns.

If you believe that:

- we may have violated your privacy rights,
- we made a decision about access to your health information incorrectly,
- our response to a request you made to amend or restrict the use or disclosure of your health information was incorrect, or
- we should communicate with you by alternative means or at alternative locations, you may contact us using the information listed below.

You also may submit a written complaint 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 upon request. 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.

Contact Information

Practice:	Ashley S. DeSaix DDS, PA dba "Kildaire Family Dental"	**Fax**:	(919) 882-8455
		Address:	3420 Ten-Ten Rd, Suite 310 Cary, NC 27518
Privacy Officer:	Ashley S. DeSaix, DDS		
Phone:	(919) 342-8509	**Email**:	contact@kildairefamilydental.com

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES v1.21.16

Last Name: **First Name:** **DOB:**

"YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT"

Kildaire Family Dental is required by applicable federal and state laws to maintain the privacy of your health information. We are also required to give you information about our privacy practices.

☐ **By checking this box or signing below you are acknowledging you are familiar with HIPPA privacy practices and have received a copy of our privacy practices.**

I, _____, have received a copy of this office's Notice of Privacy Practices.
Please print your name

_____ _____
Date **Signature of Patient** (or parent, guardian, power of attorney)

Explicitly Permitted Disclosure

I allow you to give my clinical information to answer or to answer questions from:
Please list who you would allow to receive information on your behalf.

Name:_____ Relationship to you: _____ Contact Information: _____

Name: _____ Relationship to you: _____ Contact Information: _____

Name: _____ Relationship to you: _____ Contact Information: _____

Name: _____ Relationship to you: _____ Contact Information: _____

_____ _____
Signature of Patient (or parent, guardian, power of attorney) **Date**

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, 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) _____ Staff initials and date: _____