



CAROLINAS

DENTAL CENTER

WELCOME TO OUR PRACTICE

On behalf of the entire team at Carolinas Dental Center, let us welcome you to our practice. We are grateful that you have chosen us to meet your dental needs, and trust that you will find your experience in our office to be pleasant, professional, and extraordinary. You may discover that we are different from the average dental practice. When you visit our office, you will find a unique and relaxing environment. Our team is friendly and attentive. All of our treatment is designed to be comfortable, to be long lasting, and to exceed all your expectations. We use the latest technology and techniques our profession has to offer. Our greatest strength lies in the unequalled advanced training in cosmetic and reconstructive dentistry we have received.

In order to better serve you, we are enclosing in this Welcome Packet several important documents that will assist us in making your transition to our office as smooth as possible. Please read each one carefully so that you can become familiar with our practice philosophy and policies. We are happy to answer questions you may have at any time.

Please find the enclosed Personal Information Sheet and Medical and Dental History questionnaire that should be filled out prior to your first appointment with us.

Be sure to visit our website at www.CarolinasDentalCenter.com. We look forward to serving all your dental needs for you and your family.

Yours truly for better dental health,

Christopher Phelps, DMD

Christopher Phelps, DMD



CAROLINAS DENTAL CENTER

PATIENT REGISTRATION

Welcome to Carolinas Dental Center. Would you please be kind enough to answer the following questions? Thank you so much for being our guest!

_____ M F S M D W
Name (Last) (First) (Middle) Date of Birth Sex Marital Status Social Security Number

_____ Email Address Cell Phone Number
How would you like to be addressed?

_____ (City) (State) (ZIP Code) Home Phone Number
Home Address (Street)

_____ Occupation Driver's License Number
Name of Employer

_____ (City) (State) (ZIP Code) Business Phone Number
Business Address (Street)

PERSON RESPONSIBLE FOR ACCOUNT

Who is responsible for account? self spouse parent/guardian other
(Please fill in the following information if the person responsible is different from self.)

_____ Social Security Number
Name (Last) (First) (Middle)

_____ (City) (State) (ZIP Code) Home Phone Number
Home Address (Street)

_____ Occupation Business Phone Number
Name of Employer

INSURANCE INFORMATION

_____ Relationship SSN Date of Birth
Insured Member (Last) (First) (Middle)

_____ Occupation Business Phone Number
Name of Employer

_____ (City) (State) (ZIP Code) Dental Insurance Co.
Business Address (Street)

_____ ID Number _____
Group Number

If patient was assisted with this form, enter name of person assisting:

_____ Date
Print name Sign name

_____ Date
Signature of patient

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry that you will be receiving. Thank you for answering the following questions.

General health (please check): EXCELLENT GOOD FAIR POOR Name of physician _____
Physician's Address _____ Telephone Number _____ Date of Last Physical _____

Are you now under care of a physician? Yes No

Are you pregnant or think you may be pregnant? Yes No If yes, expected delivery date: _____

Are you nursing? Yes No

Are you taking birth control pills? Yes No

Do you smoke? Yes No If yes, how much? _____

Are you taking any medication now? Yes No If yes, names of medications and problems for which they are taken:

Medication 1) _____ Taken for _____ 3) _____ Taken For _____
2) _____ Taken for _____ 4) _____ Taken For _____

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

Have you ever taken Fen-Phen or Redux? Yes No

Have you ever required a blood transfusion?....Yes No

Are you wearing contact lenses?.....Yes No

Do you or have you used controlled substances? Yes No

Do you bruise easily?.....Yes No

Have you ever had (please check-mark appropriate boxes):

Heart diseaseYes No

CancerYes No

Rheumatic feverYes No

Mitral valve prolapseYes No

Abnormal blood pressureHigh Low No

Night sweatsYes No

UlcersYes No

Heart murmur.....Yes No

Tuberculosis or lung disease.....Yes No

JaundiceYes No

DiabetesYes No

Drastic weight lossYes No

Epilepsy.....Yes No

Asthma or hay feverYes No

AnemiaYes No

Sinus troubleYes No

Congenital heart lesionsYes No

HepatitisYes No

ArthritisYes No

X-ray treatments for cancerYes No

Lymph node enlargement (swollen glands).....Yes No

GlaucomaYes No

Common coldYes No

Persistent diarrheaYes No

Kidney troubleYes No

StrokeYes No

Prolonged bleeding.....Yes No

Fainting spellsYes No

Excessive urination and/or thirstYes No

Swollen anklesYes No

Sexually transmitted disease.....Yes No

PacemakerYes No

Epilepsy/SeizuresYes No

Heart surgeryYes No

Mental health care.....Yes No

AIDS/HIV.....Yes No

Back problemsYes No

Thyroid problemYes No

Chemical dependencyYes No

AllergiesYes No

Cold sores/Fever blistersYes No

Joint replacement or implantYes No

Eating disordersYes No

If you have entered "yes" to any of the above, please explain: _____

Are you allergic to or have you had reactions to:

Local anesthetics like NovocaineYes No

AspirinYes No

Penicillin or other antibioticsYes No

IodineYes No

Sulfa drugsYes No

Any metal (e.g. gold, nickel, etc.).....Yes No

Barbiturates, sedatives, or sleeping pillsYes No

Latex/RubberYes No

Other (please list) _____

*Your signature indicates you have received a copy of the HIPAA law and Dental Materials forms and release Carolinas Dental Center to utilize any dental photographs for lecturing and educational purposes.

Signature: _____ Date: _____

DENTAL HEALTH AND APPEARANCE

Reason for visit: _____ Approximate date of last dental visit: _____

What is your primary concern that you would like us to address first? _____

When would you like us to start treatment? _____

Have you ever had any serious problem associated with previous dental treatment or any dental emergencies?..... Yes No

If so, explain: _____

What, if anything, has happened in previous experiences at the dentist that was reason not to return? _____

Do you have missing teeth?_____ If yes, have you had them replaced?_____

If you have had missing teeth replaced, are you happy with the results? _____

If not, would you like to learn about your options to replace them? _____

Do you ever feel (or have you ever been told) that you don't have fresh breath? _____

How often do you brush your teeth?_____ How often do you floss? _____ What type of brush do you use? Manual Powered

Do you avoid brushing any part of your mouth because of pain? Yes No If yes, what part? _____

Which foods cause you twinges of pain: hot cold sweet sour none Do you lose fillings or break fillings?..... Yes No

Do you chew on only one side of your mouth?.....Yes No If yes, explain: _____

Do your gums feel tender or swollen?.....Yes No Do you usually have many cavities?.....Yes No

Do you clench or grind your jaws while sleeping or during the day?.....Yes No Do your jaws ever feel tired?.....Yes No

We respect your right to choose the level of care that fits *your* needs. We've found that many adults are unaware that problems even exist. There are rarely symptoms (pain, bleeding) associated with the aging and deterioration of teeth and gums – until it is far too late. According to the ADA, more than 80% of adult Americans have some level of gum disease. With your permission we would like to explain the choices available to achieve long-term health and beauty for your existing natural teeth. Please check all that apply:

- I desire to keep my own teeth for life, if possible. I want my teeth to look good, feel good, and last for a long time.
- Spreading payments out over time may help me to achieve the excellent results I desire.
- Phasing treatment, by priority, over a few years may make it feasible for me to achieve the excellent results I desire.
- I am interested in a plan for long-term dental health. However, I am currently unable to pursue this, and would appreciate help with emergencies and cleanings for now.
- Although I am not interested in a plan for long-term dental health, I do desire an office who will treat teeth in need of immediate/emergency attention, as well as keep me up to date on cleanings.

COSMETIC/ESTHETIC EVALUATION

Are you delighted with your smile? _____ Please rate your smile from 1 to 10 (1 = I hate my smile, 10 = awesome)_____

Would you like to have whiter teeth? Yes No

If you had a magic wand, what, if anything, would you change about your smile?_____

What (if any) personal or professional benefit might you gain if you had a gorgeous smile? _____

Do you have any special occasions coming up? _____

Through state-of-the-art technology of cosmetic dentistry, we have the ability to help you achieve a world-class smile, often overnight... Using Computer Assisted Dental Imaging and High Resolution Video Photography, we can simulate very closely how YOU would look after the improvements, PRIOR to any treatment! Imaging can be performed as part of your exam visit (at NO additional charge). Would you like to see what YOU would look like with a new and improved smile? Yes No If yes, please check off all that apply:

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Lighten all front teeth showing | <input type="checkbox"/> Rebuild fracture(s) | <input type="checkbox"/> Straighten rotation | <input type="checkbox"/> Eliminate dark or stained fillings |
| <input type="checkbox"/> Lighten single tooth | <input type="checkbox"/> Lengthen | <input type="checkbox"/> Straighten angulation | <input type="checkbox"/> Reduce gum showing in smile |
| <input type="checkbox"/> Close spaces between teeth | <input type="checkbox"/> Shorten | <input type="checkbox"/> Eliminate crowding | <input type="checkbox"/> Repair uneven edges |

Please add anything you feel is important: _____

At Carolinas Dental Center, though our focus is on appearance-related dentistry, our team also delivers routine general dental care. With flexible payment plans as well as phasing treatment over time, you and your family can achieve spectacular long-term results. Thank you so much for the opportunity to be of service.



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APPOINTMENT AGREEMENT

At Carolinas Dental Center, we understand that your time is very valuable. We are constantly striving to make your experience here more pleasant than any other place you have previously been. Trying to accommodate every patient's individual needs and work schedule can be challenging. We make every effort to stay on time so that our patients will not have to wait unnecessarily.

Your appointment is a commitment of time between you and our office. We ask that you make every effort to keep that commitment. We do provide a courtesy reminder call one to two days prior to your appointment.

If you find that you cannot keep your appointment, we do require a minimum notice of 24 hours so we are able to assist other patients with their dental needs. If our office is not notified within the 24 hours, you will be subject to a \$50 late cancellation charge.

We truly appreciate your understanding. Our goal at Carolinas Dental Center is to be your partner in health and to assist you in keeping your teeth for a lifetime.

By signing below, I agree to fulfill my obligation as a patient at Carolinas Dental Center and agree to the "broken appointment" fee should I not give proper notification.

Signature of patient or responsible party

Date



CAROLINAS DENTAL CENTER

Here at Carolinas Dental Center, our office policy regarding financing is as follows: As a condition of the treatment performed by the providers of the office, financial arrangements must be made in advance for the full cost of proposed treatment. The practice's vitality depends upon payment for services as rendered and it is the responsibility of the patient/patient's parent/guardian to satisfy the costs incurred in dental care. Financial arrangements on the part of each individual must be determined prior to treatment completion.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are rendered. Additionally, a discount can be extended, at the management's discretion, for payments in full with cash or money order. (Inquire for more details.)

Individuals who carry dental insurance understand that all dental services furnished are charged directly to the patient and that said patient is personally responsible for payment of all dental services provided, regardless of dental insurance reimbursement. As a customer courtesy, this office will help prepare and submit patients' insurance forms as well as assist in making collections from insurance companies. We will credit any such collections to the appropriate account. However, this dental office cannot render services on the assumption that our charges will be paid in part or in full by an insurance company. (Please understand that the amount to be paid by your particular policy is pre-determined and agreed to by your employer and the insurance company. If you have any questions about the amount the plan will pay or the treatments your plan will cover, you should refer these questions to your employer.) Additionally, there may be a deductible, a co-insurance factor, and a yearly maximum to be considered. Most policies cover what they consider a "usual and customary fee." However, the insurance company sets these fees, and they are not always the same as the fees that may be charged in this or any office. All these factors may combine to reduce the benefits you will ultimately receive. We will do our best to see that you receive your full benefits within the structure of your particular dental plan.

A service charge of 2% per month (24% per annum) on any unpaid balance will be charged on all accounts exceeding 60 days from date of service, unless previously written financial arrangements are agreed upon and satisfied. I understand that the fee estimate listed for any proposed dental care can only be extended for a period of six months from the date of diagnosis and/or examination. I further acknowledge that the proposed treatment plan can shift and/or change from the diagnosed treatment plan once treatment is begun due to unforeseen circumstances beyond the doctors' control.

In consideration for the professional services rendered to me by the doctor, at the provider's recommendation, or at my own request, I agree to pay the reasonable 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 reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time allotted 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 Carolinas Dental Center and/or Carolinas Dental Center's financial coordinator to telephone me at home or at my place of business to discuss matters related to this form.

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

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party



CAROLINAS DENTAL CENTER

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ Social Security # _____

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. We encourage you to read it carefully and completely before signing this Consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting our office at (704) 243-8920 or by mailing us at 2514 Cuthbertson Road, Suite A, Waxhaw, NC 28173.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the address above. Please understand that revocation of this Consent will not affect any action we took before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that by signing this Consent form I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____ Relationship: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.



CAROLINAS DENTAL CENTER

NOTICE OF PRIVACY PRACTICES THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes:

- *Treatment* means providing, coordinating, or managing health care and related services by one or more health care providers. Examples would be teeth cleaning services, extraction letters, and periodontal or endodontic referrals.
- *Payment* means such activities as obtaining reimbursement for services, confirming coverage, and obtaining specific benefit information such as benefit maximums and deductibles met, etc., billing or collection activities, and utilization review.
- *Health care operations* include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individual identifiable information. 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. Any other uses and 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 uses 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 inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain—and we have the obligation to provide—a paper copy of this notice from us at your first delivery of services date.
- The right to provide—and we are obligated to receive—a written acknowledgement that you have received a copy of our Notice of Privacy Protection Practices.

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.

This notice is effective as of April 2003 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 our 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 their provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

By signing this form, I agree to allow the use and disclosure of my medical record information for the purposes described above. A copy of this authorization (consent) form will be given to me.

Signature: _____ Date: _____

Please contact us for more information:
Carolinan Dental Center
2514 Cuthbertson Road, Suite A
Waxhaw, NC 28173
(704) 243-8920
www.CarolinanDentalCenter.com

For more information about HIPAA or to file a complaint:
The U. S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, SW
Washington, DC 20201
202-619-0257
Toll Free: 1-877-696-6775