TIME 12:34 PM

DATE 7/9/2020

PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name:

Responsible Party (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Soc Sec: Drivers Lic:

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: Address 2:

City: State / Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: Age: Soc Sec: Drivers Lic:

E-mail: ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg:

Section 3

Insuance/verified:

Primary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Secondary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Time 12:33 PM

Uptown Premier Dental

Medical History USE!

Date 7/9/2020

Patient Name:

Birth Date:

Date Created:

Although Dr. Vu primarily treats 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

Are you under a physician's care now? (Primary Care and/or Specialist)	Yes No	If yes
Have you ever been hospitalized or had a major operation?	Yes No	If yes
Have you ever had a serious head or neck injury?	Yes No	If yes
Are you taking any medications, pills, or drugs?	Yes No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	Yes No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes No	If yes
Do you use tobacco?	Yes No	
Do you use controlled substances?	Yes No	If yes

Females ONLY:

If the following questions pertain to you please indicate:

Pregnant / Trying to Conceive	Yes No
Nursing	Yes No
Taking Oral Contraceptives	Yes No

If you are pregnant please complete the following:
OBGYN Doctors Name and Practice Name: _____

Doctors Phone Number: _____
Due Date: _____

Are you allergic to any of the following?

Aspirin	Penicillin	Codeine	Acrylic
Metal	Latex	Sulfa Drugs	Local Anesthetics

No known DRUG allergies: Yes No

* If YES, please indicate what your drug allergy is. _____

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

AIDS/HIV Positive	Yes No	Hemophilia	Yes No	Radiation Treatments	Yes No	Diabetes	Yes No
Hepatitis A	Yes No	Anaphylaxis	Yes No	Drug Addiction	Yes No	Hepatitis B or C	Yes No
Emphysema	Yes No	High Blood Pressure	Yes No	Epilepsy or Seizures	Yes No	High Cholesterol	Yes No
Artificial Heart Valve	Yes No	Excessive Bleeding	Yes No	Artificial Joint	Yes No	Asthma	Yes No
Fainting Spells/Dizziness	Yes No	Kidney Problems	Yes No	Leukemia	Yes No	Breathing Problems	Yes No
Liver Disease	Yes No	Stroke	Yes No	Cancer	Yes No	Glaucoma	Yes No
Lung Disease	Yes No	Thyroid Disease	Yes No	Chemotherapy	Yes No	Hay Fever	Yes No
Chest Pains	Yes No	Osteoporosis	Yes No	Tuberculosis	Yes No	Parathyroid Disease	Yes No
Convulsions	Yes No	Heart Trouble/Disease	Yes No	Psychiatric Care	Yes No	Blood Thinners	Yes No

Have you ever had any serious illness not listed above? Yes No If yes

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 patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X_____ Date:_____

Uptown Premier Dental

400 S. Tryon Street – Suite M4, Charlotte, NC. 28285

Authorization to Release Private Health Information

The notice contains a patient's rights section describing your rights under the law. Your ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. A revocation cannot be retroactive and/or will remain active until revoked by the patient or guardian.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

Phone Number we may text: _____

May we leave a message on your answering machine at home or your cell? YES NO

Phone Number we can leave a message on: _____

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

Family Member (Name/Relationship)	Phone Number

This consent was completed by: _____ (PRINT Patient's Name)

Signature: _____ Date: _____

Uptown Premier Dental

400 S. Tryon Street – Suite M4, Charlotte, NC. 28285

CONSENT FORM FOR GENERAL DENTAL PROCEDURES

You have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment.

It is very important that you provide your dentist with accurate information before, during and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialists, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor and/or failed outcome.

Certain heart conditions may create a risk of serious or fatal complications. If you (or a minor patient) have a heart condition or heart murmur, advise your dentist immediately so he/she can consult with your physician if necessary.

The patient is an important part of the treatment team. In addition to complying with instructions given to you by this office, it is important to report any problems or complications you experience so they can be addressed by your dentist immediately.

If you are a female on birth control medication, you should be aware that antibiotics might make oral birth control less effective. Please consult with you physician before relying on oral birth control medication if your dentist prescribes antibiotics. Do not consent to treatment until you discuss potential benefits, risks, and complications with your dentist and all of your questions are answered.

By consenting to treatment you signal your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

Patient Name (printed): _____

_____ _____

Patient Signature **Date**

CONSENT FOR ANESTHETICS (LOCAL ANESTHETIC)

I hereby authorize Dr. Athena Vu DDS, to administer anesthetics to myself. I have been informed of the side effects, as well as, informed of the advantages and disadvantages of anesthetics. I understand the risk of my body having reactions, such as but not limited too - redness, swelling, pain, itching, vomiting, anaphylactic shock and/or permanent nerve damage or other unforeseeable complications which may result from the administration of anesthetics. I realize that in spite of the possible complications, the use of local anesthesia is necessary and desired by me.

_____ _____

Patient Signature **Date**

In an effort to control the increasing cost of dental care, any claims or disputes against this office shall be resolved by "binding arbitration". By signing this agreement, the patient agrees with the office of Dr. Athena Vu, that any dispute relating to dental or medical care services rendered for any condition, including any services rendered prior to the date this agreement was signed, and any dispute arising out of the diagnosis, treatment, or care of the patient, including the scope of this arbitration clause and the arbitrability of any claim or dispute, against whenever made, (including to the full extent permitted by applicable law third parties who are not signatories to this agreement including associates)shall be resolved by binding arbitration, by the National Arbitration Forum, under the Code of Procedure then in effect. The patient understands that the result of this arbitration agreement is that claims, including malpractice claims he/she may have against the doctor, cannot be brought as a lawsuit in court before a judge, and agrees that all such claims will be resolved as described in this section.

Uptown Premier Dental

400 S. Tryon Street – Suite M4, Charlotte, NC. 28285

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name:_____ **Date of Birth:** _____

Patient Address:_____

I have received a copy of the Notice of Privacy Practices for Uptown Premier Dentistry:

Signature of Patient:_____ **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 mail.
- Unable to communicate with the patient for the following reasons: : _____
- Other:_____

Prepared By:

Signature:

Date: _____

Uptown Premier Dental

400 S. Tryon Street – Suite M4, Charlotte, NC. 28285

OFFICE FINANCIAL POLICY

PATIENTS WITH INSURANCE

We will provide you with an *estimate* of the total fee expected. Your estimated portion is due in full on the day of treatment. As a courtesy, we will file your insurance. **If after 40 days we have not received payment from your insurance company, the balance becomes your responsibility.** We will bill you and allow you 30 days to settle your account.

When estimating insurance coverage, we stress the word ***estimate*** as dental benefits are determined by each patient's dental contract. Insurance is a contract between **you** and **your insurance company**. We are not a party to that contract. We will not become involved in disputes about charges; secondary insurance, usual and customary charges etc. other than to supply factual information as necessary.

Initial_____

CANCELLATION AND TARDY POLICY - 24-HOUR CANCELLATION POLICY

We recognize that unexpected situations may arise, but as a courtesy to our patients and Dr. Vu, we require that you give a **minimum of 24 business hours notice** when cancelling or rescheduling a scheduled appointment. Unless an emergency occurs, leaving a message after hours on our voice mail does not allow us enough time to fill your reserved spot.

Please note that we charge a $50.00 *late cancellation* or *no show* fee. **Initial** _____

In addition, if something unforeseen arises and you are going to be **more than ten minutes late for your appointment** we may ask you to reschedule and a late fee may be applied. While we do understand late cancellations can happen, if your account is reflective of 2 or more late cancellations or no shows within a 12 month period, it may be necessary to bill your account 25% of the original scheduled appointment charge. This amount will be billed to your account and a statement will generate and we will allow 30 days to pay the balance. This amount will be non-refundable and cannot be applied as a credit to any future treatment.

Our goal is to be respectful of all our patients' time and their needs. We appreciate your cooperation with our policies.

PAYMENT OPTIONS

For your convenience, we offer the following payment options:

- **Cash**
- **Check** ($30 charge for all returned checks)
- **Visa, Master Card, Discover, American Express**
- **Monthly Payments** (Short-term and long-term financing through **Care Credit** a dental payment plan with no interest plans for up to 12 months*)

Patient Name (printed): _____

Signature of Patient/Guardian _____ **Date** _____