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

Referred By

Previous Dentist

Emergency Contact

Emergency Contact #

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:

Mid Town Smiles
DENTAL CARE
107 Windel Dr., Ste. 101, Raleigh, NC 27609
919-787-5599 www.MidTown-Smiles.com

Office Financial Policy:

The quality of your needed or desired dental care should never be dictated by your dental insurance. We work hard to maximize your insurance benefits and make any balance due easily affordable.

Payment is due at the time services are rendered unless previously discussed in office.

We gladly file your claim for you if you bring your dental insurance card and all required employer information. You will be expected to pay for services rendered if the office is unable to verify your insurance information before treatment.

Insurance is not a guarantee of payment; insurance companies will not pay for all of your dental needs. We are happy to file your dental insurance claim for you with the following understanding:
Insurance benefits are determined by the dental policy between you and your employer – not by this office or the dentist. Any deductible and or estimated co-pay is due at the time of treatment. Insurance companies use their own fee schedules, not ours, and your portion is estimated based on the information they provide and cannot be guaranteed. There may be a balance due upon the final insurance payment even after co-pays and deductibles have been paid. Our fees are reasonable and customary for this area and reflect the quality materials, highly trained doctors and staff required to provide you with comprehensive care. Insurance company fee schedules can be based on zip codes and older data that does not reflect current technological and clinical costs incurred to provide your care.

If payment for services already rendered has not been paid in full within 45 days, either by you or your insurance company, the remaining balance for treatment is considered due and collectible.

Reservation Policy

Because our doctors and staff devote a great deal of time and effort preparing for the appointment reserved specifically for you, for appointments over one hour in length we reserve the right to require a deposit of half of the amount estimated due for the scheduled services or $75 per hour (or portion of hour) whichever is greater. **(Waved for first time "New Patient" appointments)**

We reserve the right to charge and collect $50 (operative) $100 (crown and bridge) per hour fee for broken appointments-appointments that are cancelled or broken without 48 hours advance notice. Appointments are reserved exclusively for you. It is your responsibility to remember your scheduled appointment.

A Returned Check Fee of $35 will be charged and is payable immediately and will be collectable.

For your convenience we accept cash, Visa, MasterCard, Discover, American Express and personal checks. Payment plans, financial arrangements and third party financing including CareCredit are available for comprehensive dental treatment and will be discussed at your treatment consultation.

Account balances not paid are subject to collection through the general district court/collection agency and you are responsible for any and all court/collection agency costs.

I have read and understand this financial policy.

Client's printed name: _____ Date:_____

Client's Signature: _____

MidTown Smiles

MidTown Smiles Medical History Form

Patient Name: Birth Date: Date Created:

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 you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	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
Are you on a special diet?	Yes No	
Do you use tobacco?	Yes No	

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics

Do you use controlled substances?	Yes No	If yes
Other?	☐	If yes

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

AIDS/HIV Positive	Yes No	Cortisone Medicine	Yes No	Hemophilia	Yes No	Radiation Treatments	Yes No
Alzheimer's Disease	Yes No	Diabetes	Yes No	Hepatitis A	Yes No	Recent Weight Loss	Yes No
Anaphylaxis	Yes No	Drug Addiction	Yes No	Hepatitis B or C	Yes No	Renal Dialysis	Yes No
Anemia	Yes No	Easily Winded	Yes No	Herpes	Yes No	Rheumatic Fever	Yes No
Angina	Yes No	Emphysema	Yes No	High Blood Pressure	Yes No	Rheumatism	Yes No
Arthritis/Gout	Yes No	Epilepsy or Seizures	Yes No	High Cholesterol	Yes No	Scarlet Fever	Yes No
Artificial Heart Valve	Yes No	Excessive Bleeding	Yes No	Hives or Rash	Yes No	Shingles	Yes No
Artificial Joint	Yes No	Excessive Thirst	Yes No	Hypoglycemia	Yes No	Sickle Cell Disease	Yes No
Asthma	Yes No	Fainting Spells/Dizziness	Yes No	Irregular Heartbeat	Yes No	Sinus Trouble	Yes No
Blood Disease	Yes No	Frequent Cough	Yes No	Kidney Problems	Yes No	Spina Bifida	Yes No
Blood Transfusion	Yes No	Frequent Diarrhea	Yes No	Leukemia	Yes No	Stomach/Intestinal Disease	Yes No
Breathing Problems	Yes No	Frequent Headaches	Yes No	Liver Disease	Yes No	Stroke	Yes No
Bruise Easily	Yes No	Genital Herpes	Yes No	Low Blood Pressure	Yes No	Swelling of Limbs	Yes No
Cancer	Yes No	Glaucoma	Yes No	Lung Disease	Yes No	Thyroid Disease	Yes No
Chemotherapy	Yes No	Hay Fever	Yes No	Mitral Valve Prolapse	Yes No	Tonsillitis	Yes No
Chest Pains	Yes No	Heart Attack/Failure	Yes No	Osteoporosis	Yes No	Tuberculosis	Yes No
Cold Sores/Fever Blisters	Yes No	Heart Murmur	Yes No	Pain in Jaw Joints	Yes No	Tumors or Growths	Yes No
Congenital Heart Disorder	Yes No	Heart Pacemaker	Yes No	Parathyroid Disease	Yes No	Ulcers	Yes No
Convulsions	Yes No	Heart Trouble/Disease	Yes No	Psychiatric Care	Yes No	Venereal Disease	Yes No
Yellow Jaundice	Yes No						

Have you ever had any serious illness not listed	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:_____

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

MidTown Smiles
Zombek, & Associates D.D.S., P.A.
107 Windel Dr. Suite 101, Raleigh, NC 27609
919-787-5599 Contact person: Stacy J. Keifer Snell

Know Your Rights

Your decision to sign this Authorization is voluntary. MidTown Smiles will not refuse treatment to you if you refuse to sign this Authorization.

When your protected health information is released as provided by this Authorization, please be aware that the named recipient (above) may not be legally obligated (under HIPAA) to obtain an authorization for subsequent re-disclosure of your protected health information.

Patient Signature

I have read the contents of this Authorization, and I confirm that the contents are consistent with my directions. I understand that by signing this Authorization, I am permitting MidTown Smiles to release, use or disclose my protected health information.

Signature	Date
Print Name	Witness (Optional)

Representative Signature

I affirm that I am the personal representative of the patient noted above and that I have the authority to authorize the release, use or disclosure of the patient's protected health information on his/her behalf. I have read the contents of this Authorization, and I confirm that the contents are consistent with my directions. I understand that by signing this form, I am authorizing, on behalf of the patient, the release, use or disclosure the patient's protected health information.

Signature	Date
Print Name	Relationship to Patient

☐ Parent ☐ Guardian ☐ Power of Attorney

FOR OFFICE USE ONLY

Date Received	By	Patient ID

Authorization for the Release of Protected Health Information

Zombek, & Associates D.D.S., P.A.
107 Windel Dr. Suite 101, Raleigh, NC 27609
919-787-5599 Contact person: Stacy J. Keifer Snell

PLEASE PRINT CLEARLY

Patient Name _____ Today's Date _____

Address _____ Date of Birth _____

City, State ZIP _____ Email _____

Phone _____ Fax _____

Patient Authorization

I, _____, hereby authorize MidTown Smiles to release, use and/or disclose my protected health information as directed below.

Health Information

This Authorization pertains to the following types of protected health information about me:

- ☐ All dental records received or created by MidTown Smiles
- ☐ Dental report(s) (please specify) _____
- ☐ Dental image(s) (please specify) _____
- ☐ All dental records relating to (specify injury or condition) _____
- ☐ Other (please describe) _____

Release Information

Please release my health information to:

Organization _____ Phone _____

Contact _____ Email _____

Address _____ Fax _____

City, State ZIP _____ Handling Notes _____

I understand that, per my voluntary request, this Authorization permits MidTown Smiles to release, use or disclose my protected health information for purposes other than payment, treatment, or healthcare operations as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its corresponding regulations. I further understand that I may revoke this Authorization at any time by providing written notification to MidTown Smiles. Revocation of this Authorization will be effective on the date notice is received and processed by MidTown Smiles except to the extent that action has already been taken in reliance upon this Authorization.

Authorization Expiration

This Authorization will expire one (1) year from the date that I sign it, unless I indicate an alternative expiration date below:

Enter Alternative Expiration Date: _____ , 20_____

SLEEP HEALTH/WELLNESS ASSESSMENT

Zombek and Associates DDS, PA
107 Windel Dr Suite 101, Raleigh NC 27609
919-787-5599
www.MidTown-Smiles.com

Have you ever been told you snore? ____yes ____no

Have you ever awakened yourself by snoring or gasping for breath? ____yes ____no

Do you feel tired in the mornings and take a while to "get going"? ____yes ____no

Do you feel sleepy during the day on most days? ____yes ____no

Has anyone ever told you that you stop breathing when you sleep? ____yes ____no

Do you have high blood pressure? ____yes ____no

Do you move a lot while asleep? ____yes ____no

How many times do you typically wake up? ___never ___once ___twice ___more than twice

Do you have a deviated septum? ____yes ____no

Name_____

DOB _____ DATE _____