Welcome To Our Practice

We would like to thank you for choosing us as your dental care provider. We are pleased to meet any dental needs you or your family have. We will always do our best to give you the most up to date and professional care available. To avoid any confusion, we have listed below some of our policies and procedures.

- **Regarding Payment**

Payment for services is due at the time services are rendered unless prior arrangements have been made with the practice manager.

We accept the following forms of payment: Cash, Check, Visa, Discover & MasterCard.

If any treatment involves sending your case to a dental laboratory (Crowns, Bridges, Invisalign, etc.), a 50% deposit will be required at the time of the first impression. The remaining balance is due at the completion of the procedure.

Checks that are returned to our office from your financial institution are subject to a $50.00 returned check fee. This fee covers the processing fees that are charge to our office.

You are responsible to pay the cost of collecting any debt owed on your account. This includes all attorney's fees, late fees and interest to be charged at 1.5% per month.

- **Regarding Insurance**

As a courtesy, we will file your dental insurance claim. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. In the event we do accept assignment of benefits and your insurance company has not paid your account in full within 60 days, the balance may be transferred to your account. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and customary under the terms of your insurance policy. Our practice is committed to providing the best treatment for our patients and we charge what is the usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Your complete insurance information must be presented at the time services are provided. Most benefits will be verified before your insurance company can be billed. All insurance co-pays and deductibles must be paid at the time of service.

- **Regarding Appointments**

Broken appointments are very costly and inconvenient. Please inform us at least forty-eight (48) hours in advance if you are unable to keep your appointment. Appointments that are cancelled with less than forty-eight hours notice are subject to a broken appointment fee of $50.00. Excessive broken appointments will lead to you and your family being dismissed from our practice.

If you are more than fifteen (15) minutes late for your appointment, you may be rescheduled for another day. This will be considered a broken appointment.

All patients under the age of eighteen (18) will not be seen or treated, in the absence of a parent or legal guardian, without a signed consent form.

I have read, understand and agree to the policies explained above.

_____

Patient Name (please print)

_____ _____

Signature of patient or Responsible Party **Date**

Date:_____

Patient Registration

Full Name:		
Nickname:		
Address:		
City:	State:	Zip:
Phone:	Work:	Cell:
Preferred Method of Contact (phone/email/text):		
SSN:	Driver's License Number:	
DOB:	Sex:	Marital Status:
Employer:	Occupation:	
Emergency Contact:	Phone:	
How Did Hear About Us? Website/Insurance/Google/Family/Friend		

DENTAL INSURANCE

Primary Insurance Company:
Group number:
Policy Number:
Subscriber's Name/DOB/SSN - if different from patient:
Secondary Dental Insurance
Insurance Company:
Group number:
Policy Number:
Subscriber's Name/DOB/SSN – if different from patient:

Signature of Patient or Responsible Party: _____

PATIENT MEDICAL HISTORY

All information provided here is 100% confidential and any attempt to conceal preexisting conditions or other relevant information could result in serious patient drug interactions or death. The following questions must be answered honestly so that our office can provide you with the best possible care. If we determine that questions have not been answered honestly you will be dismissed from our practice.

Physician/Practice Name:	**Phone:**
Current Medicine List:	

- **Please check to indicate if you have had any of the following diseases or problems:**

Abnormal Bleeding		Diabetes Type I		Kidney Problems	
Alcoholism		Diabetes Type II		Lupus	
Anemia		Eating Disorder		Mental Health Disorders	
Angina		Emphysema		Mitral Valve Prolapse	
Arteriosclerosis		Epilepsy		Osteoporosis	
Arthritis		Excessive Urination		Pacemaker	
Artificial Heart Valves		GE Reflux		Recreational Drug Use	
Asthma		Glaucoma		Rheumatic Fever	
Autoimmune Disease		Heart Attack		Rheumatoid Arthritis	
Blood Transfusion		Heart Murmur		Seizures	
Bronchitis		Heartburn		Sexually Transmitted Disease	
Cancer		Hemophilia		Sinus Trouble	
Cardiovascular Disease		Herpes		Sleep Apnea	
Chronic Pain		Hepatitis		Smoking	
Congenital Heart Defects		High Blood Pressure		Stroke	
Congestive Heart Failure		HIV/AIDS		Thyroid Problems	
Coronary Artery Disease		Joint Replacement		Tuberculosis	
Other:				Ulcers	

	Yes	No
Have you ever been hospitalized?		
Have you ever had a major operation?		
Have you had a physical exam in the last year?		
Do you bleed for a long time when you cut yourself?		
Would you consent to a blood test if the Doctor or staff member suffers a needle stick or puncture wound?		

- **For Women Only**

Are you pregnant?		
Are you taking oral contraceptives (birth control pills)?		

Women who take oral contraceptives (birth control pills) should take extra precautions when taking antibiotics. Antibiotics can cause failure of birth control pills which could result in pregnancy.

I have read and understand the above questions. I have answered all of these questions truthfully to the best of my ability and knowledge.

Signature: _____ Date:_____

ALLERGIES

- **Are you allergic to or have you had a reaction to:**

Local Anesthetics		Codeine or other Narcotics	
Latex		Seasonal	
Penicillin		Metals	
Sulfa Drugs		Animals	
Aspirin		Food	
Other:			

PATIENT DENTAL HISTORY

	Yes	No
When was the last time you visited the dentist? Where?		
When was the last time you had your teeth cleaned?		
Do you usually see a dentist every six (6) months?		
May we take dental x-rays if they are needed?		
Have you ever had to take antibiotics before having dental work?		
Have you ever experienced an unusual reaction to dental anesthetic?		
Have you ever had x-rays for a tumor, growth or any other condition?		
Do you have fluoride in your drinking water?		
Do you take a fluoride supplement?		
Have you ever had periodontal (gum) treatment?		
Have you ever had orthodontic treatment (braces)?		
Do you floss regularly?		
Do your gums bleed when you floss?		
Do you have frequent or severe headaches?		
Do you have sinus trouble?		
Do you have frequent cold sores or canker sores?		
Do you have frequent colds?		
Are you nervous?		
Do you use a soft toothbrush?		

I have read and understand the above questions. I have answered all of these questions truthfully to the best of my ability and knowledge.

Signature: _____ Date:_____

Authorization for Release of Information

Name of Patient _____ Date of Birth _____

Snisnki & Schmitt D.M.D., P.A. is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Entity to Receive Information. Check each person/entity that you approve to receive information.	**Description of information to be released.** Check each that can be given to person/entity on the left in the same section.
❑ Voice Mail	❑ Results of lab tests/x-rays ❑ Other:
❑ Spouse	❑ Financial ❑ Medical as follows:
❑ Parent (provide name):	❑ Financial ❑ Medical as follows:
❑ Other (provide name):	❑ Financial ❑ Medical as follows:

Patient Information

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

_____Date_____

Signature of Patient or Personal Representative

Description of Personal Representative's Authority (attach necessary documentation)

Sninski & Schmitt D.M.D., P.A
100 Ridgeview Dr Suite 103 Cary, NC 27511
919-467-2203

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: _____

Address: _____

_____

I have received a copy of the Notice of Privacy Practices for the above named practice.

_____ _____
Signature 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 return mail.
- ❑ Unable to communicate with the patient for the following reason:

  _____

- ❑ Other:_____

  _____

Staff
Member Signature: _____ Date: _____