WNC DENTAL

AUTHORIZATION TO RELEASE INFORMATION

Purpose: This form is used to obtain authorization to release information regarding you, covered under the Privacy Act to people other than yourself.

I, _____ authorize the following person(s) to have access to information covered under the Privacy Act regarding myself.

_____

(Please Print Name) Relationship

_____

(Please Print Name) Relationship

_____

(Please Print Name) Relationship

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 the acknowledgement
- ☐ Other (Please Specify) _____

Time 1:50 PM

WNC Dental

WNCDental Health History2.4.14c

Date 6/20/2018

Patient Name:

Birth Date:

Date Created:

Required Health History

Many health condition or medications can affect your oral health or dental treatment safety. Please answer all the questions to the best of your knowledge.

Are you in poor health? (If yes, any changes to your health in the past year and if you are under the care of a physician.)	◯ 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? Please list them:	◯ Yes ◯ No	If yes
Do you take, or have you taken, Phen-Fen or Redux? (weight loss drugs)	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? (e.g. for	◯ Yes ◯ No	If yes
Are you on a special diet?	◯ Yes ◯ No	If yes
Do you use tobacco?	◯ Yes ◯ No	If yes
Do you have any artificial joints such as a knee, hip, etc? If yes, what year were they placed?	◯ Yes ◯ No	If yes
Do you have any (circle) Artificial Heart Valve, damaged Heart Transplant, previous Endocarditis, Congenital Heart Disease	◯ Yes ◯ No	
Do you take aspirin daily or other prescription blood thinners?	◯ Yes ◯ No	If yes
Do you use controlled substances?	◯ Yes ◯ No	If yes

Women: Are you...

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

Females Note: Certain antibiotics can affect the efficacy of oral contraceptives. Additional precautions to avoid pregnancy

ARE YOU ALLERGIC to any medicine, drug, food, material or any environmental substance? If yes, Please list:	◯ Yes ◯ No	If yes
Have you ever had any serious illness not listed above?	◯ Yes ◯ No	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	Recent Weight Loss	◯ Yes ◯ No	Anaphylaxis	◯ Yes ◯ No
Drug Addiction	◯ Yes ◯ No	Hepatitis A, B or C	◯ Yes ◯ No	Renal Dialysis	◯ Yes ◯ No	Anemia	◯ Yes ◯ No
Easily Winded	◯ 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	Excessive Bleeding	◯ Yes ◯ No	Hives or Rash	◯ Yes ◯ No
Shingles	◯ 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	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
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	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
Yellow Jaundice	◯ Yes ◯ No	Alcoholism	◯ Yes ◯ No	Lupus	◯ Yes ◯ No	Hearing Problems	◯ Yes ◯ No

Dental History

Do you have concerns about your mouth or teeth?	◯ Yes ◯ No	If yes
Has it been a while since your last dental checkup?	◯ Yes ◯ No	If yes
Have you ever had any bad reactions to dental anesthetics (numbing)?	◯ Yes ◯ No	If yes

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist or his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form and I will inform the doctor and staff immediately of any changes to my health or medications.

Signature of Patient, Parent or Guardian:

X_____ Date:_____

Dentist Signature

Dentist's Authorized Medical History Review Electronic Signature In Comment Box: Comment

WNC Dental
Westmoreland, Ludwig and Associates, DMD, PLLC
3 1 79 Sweeten Creek Rd
Asheville, NC 28803
828-684-1288

Patient Name _____
First Middle Last "I like to be called"

Address_____City_____State____Zip_____

Date of Birth_____Social Security Number_____

Home Phone_____Work_____Cell_____Email_____

Height Weight____sex M F Married Single Occupation_____

Guardian or Emergency contact: Name_____Phone_____Relationship_____

Method of Payment: Cash Visa/MC check____Dental Insurance____

Dental Insurance Company_____Card Holder's Employer_____

How did you hear about us?_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

"YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT"

I_____ have received a copy of this office's Notice of Privacy Practices.

Print Name:_____

Sign:_____

Date:_____

WNC Dental
Westmoreland, Ludwig and Associates, DMD, PLLC

Consent for Treatment

I hereby authorize the staff and dentists of WNC Dental, Westmoreland, Ludwig and Associates, DMD, PLLC to perform all indicated and agreed upon dental examinations and treatments that have been presented to me. I have been provided with adequate information, in a way I can understand, to make a well-informed and confident decision regarding my proposed treatment. I further understand that I may ask any questions I wish, before, during, and after my treatments.

I am aware dentistry (like medicine), is not an exact science and acknowledge that no guarantees have been made as to the result of any examinations, procedures, or treatments. I further acknowledge that such examinations, procedures or treatments may have unforeseen or unexpected consequences that may result in less than ideal outcomes including complications that produce increased pain, disability, loss of function, morbidity and mortality.

In addition, I understand that in compliance with Federal OSHA (Occupational and Safety Health Administration) procedures, in the event of any exposure to the dentist, staff or patient of blood or other potentially infectious materials, the parties involved shall be deemed to have consented to testing for infectious pathogens to include but not be limited to HIV and Hepatitis and that appropriate follow up will be advised.

Understanding the reasonable benefits and risks to the proposed treatments I hereby elect to consent to treatment and release, WNC Dental, Westmoreland, Ludwig and Associates, DMD, PLLC from any unwarranted liability and waive any and all current or future unwarranted claims against WNC Dental, Westmoreland, Ludwig and Associates, DMD, PLLC and staff concerning my dental treatments.

_____ _____ _____

X Patient Signature (or Guardian) Print Name Date

For Parents/ Guardians: Do you want to authorize any other adult to participate in your child's treatment?

No Yes If so, I authorize the adult individuals listed below to bring my minor child

(Print child's name)_____

to dental appointments and have the authority to share my child's protected health information and grant them permissions to alter treatment plans as necessary (act on my behalf). Minors will only be seen if accompanied by their parent, legal guardian, or authorized adult persons listed below:

I Authorize: (name)_____

_____ _____ _____

Sign Patient/Guardian Print Name Date

WNC DENTAL

MISSED APPOINTMENT POLICY

WNC Dental is dedicated to your quality care and is pleased to reserve your appointment time exclusively for you. We attempt to schedule appointments that are most convenient for you and that fit your personal schedule.

We respect our patients time and make every effort to remain on schedule. Some visits are more complicated than initially anticipated, and emergencies may arise that could possibly delay us. In such a case, every effort will be made to notify you beforehand.

Because we reserve time exclusively for each patient, we ask that you make every effort to not change your reserved dental appointment. If you find that you cannot keep your scheduled appointment, we require a minimum 24-hour notification. This allows your reserved time to be made available for other patients in need of treatment. To notify us of any change, please call our office during business hours.

We understand that there are unforeseen circumstances that cause reserved appointments to be missed without 24 hours' notice; we certainly want to make provisions for this within our policy. In order to make this provision, as well as to maintain the most efficient schedule for all our patients, our Appointment Policy is as follows:

- As a courtesy, our staff attempts to confirm appointments before the scheduled date and time by the methods of text and email. If we do not hear from you, we will call you two days before the reserved time. If we do not hear back from you within 24 hours of your appointment, the reserved time might be cancelled and given to the next patient in need of treatment.

- Late arrivals cause schedule delays for those patients who arrive promptly at their appointment time. Late arrivals will be worked into the schedule if time allows or re-appointed to another day.

- Patients who don't show up for their appointment or reschedule without the required 24 hours' notice will be required to supply us with a credit card to secure their rescheduled appointment. WNC Dental will not place any charges on the credit card, so long as the rescheduled appointment is honored or rescheduled within the 24 hours prior to the new appointment day.

- Should the next appointment be broken without following the above guidelines, WNC Dental reserves the right to charge a $50 missed appointment fee per half hour scheduled. To avoid raising our dental fees and allow for all of our patients to reserve appointment times when desired, we find it necessary to implement this policy. Thank you for understanding and respecting our time policy!

Patient Signature_____ Date_____

WNC DENTAL

Westmoreland, Ludwig and Associates, DMD, PLLC

OFFICE INSURANCE AND FINANCIAL POLICIES

Insurance Policies

If we have received all of your insurance information on the day of the appointment, we will be happy to file your claim for you. You must be familiar with your insurance benefits, as we will collect from you the estimated amount insurance is not expected to pay. By law your insurance company is required to pay each claim within 30 days of receipt. You are responsible for any balance on your account after 30 days, whether insurance has paid or not. We will be glad to send a refund to you once insurance has paid us.

PLEASE UNDERSTAND that we file dental insurance as a courtesy to our patients. We do not have a contract with your insurance company, only you do. We are not responsible for how your insurance company handles its claims or for what benefits they pay on a claim. We can only assist you in estimating your portion of the cost of treatment; we at no time guarantee what your insurance will or will not do with each claim. We also are not responsible for any errors in filing your insurance; once again we file claims as a courtesy to you.

Fact 1 – NO INSURANCE PAYS 100% OF ALL PROCEDURES

Dental insurance is meant to be an aid in receiving dental care. Many patients think that their insurance pays 90-100% of all dental fees. This is not true! Most plans only pay between 50%-80% of the average total fee. Some pay more, some pay less. The percentage paid is usually determined by how much you or your employer has paid for coverage or the type of contract your employer has set up with the insurance company.

Fact 2 – BENEFITS ARE NOT DETERMINED BY OUR OFFICE

You may have noticed that sometimes your dental insurer reimburses you or the dentist at a lower rate than the dentist's actual fee. Frequently, insurance companies state that the reimbursement was reduced because your dentist's fee exceeded the usual, customary, or reasonable fee ("UCR") used by the company. A statement such as this gives the impression that and fee greater than the amount paid by the insurance company is unreasonable or well above what most dentists in the area charge for a certain service. This can be very misleading and simply is not accurate. Insurance companies set their own schedules and each company uses a different set of fees they consider allowable. These allowable fees may vary widely because each company collects fee information from claims it processes. The insurance company then takes this data and arbitrarily choose a level they call the "allowable" UCR Fee. Frequently this data can be three to five years old and these "allowable" fees are set by the insurance company so they can make a net 20%-30% profit. Unfortunately, insurance companies imply that your dentist is "overcharging" rather than say that they are "underpaying" or that their benefits are low. In general, the less expensive insurance policy will use a lower usual, customary, or reasonable (UCR) figure.

Patient Signature_____ Date_____