FAYETTEVILLE

DENTAL STUDIO

Dr. Subodh Gurung D.M.D.

Welcome Packet

FAYETTEVILLE
DENTAL STUDIO
Dr. Subodh Gurung D.M.D.

Patient Information

Name: _____ Today's Date: _____
DOB: _____ Age: _____ Gender: _____ SSN: _____
Address: _____
City: _____ State: _____ Zip: _____
Cell Phone: _____ Work: _____ Alt Phone: _____
Email_____ Primary Language: _____

Emergency Contact: Name: _____ Phone: _____ Relationship: _____

What is the reason for your visit/ Chief Complaints?

_____

How did you hear about us? _____

Primary Insurance Information

Insurance Company: _____ Employer: _____
Policy's Holders Name: _____ Policy Holder DOB: _____
Policy Holder's SSN: _____ Patient Relationship to Subscriber: _____
Member ID: _____ Group Number: _____

Secondary Insurance Information

Insurance Company: _____ Employer: _____
Policy's Holders Name: _____ Policy Holder DOB: _____
Policy Holder's SSN: _____ Patient Relationship to Subscriber: _____
Member ID: _____ Group Number: _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with the above-named Insurance Company and assign directly to Fayetteville Dental Studio all insurance benefits, if any for services rendered. I understand that I am financially responsible for all charges whether paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named medical facility may use my healthcare information and may disclose such information to the above-named insurance company (ies) and their agents for the purpose for obtaining payment for services and determining insurance benefits or benefits payable to related services. This consent will stay in effect as long as I am patient with above-name medical facility.

Signature: _____ **Print:** _____

Date: _____ **Relationship to Patient:** _____

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Preferred Pharmacy Information

Pharmacy Name: _____ Phone: _____

Dental History and Oral Health

IF A NEW PATIENT, please answer the following question

Date of last dental visit: _____ Date of last Xray: _____

Have you ever been treated for periodontal disease? ☐ Yes ☐ No

On a scale 1 (not happy) to 10 (very happy), how happy are you with your smile? _____

Checks check any dental conditions that apply to you:

☐ Pain in Jaw ☐ Teeth Grinding/Clenching ☐ Use Toacco Products ☐ Swollen. Bleeding Gums
☐ Mouth Sores ☐ Broken/Loose Tooth ☐ Sensitive Teeth ☐ Crooked/Space Teeth
☐ Tooth Color/Appearance ☐ Difficulty Chewing/Swallowing

Do you currently have any tooth/jaw pain? ☐ Yes or ☐ No

Do you experience any fears or anxieties related to dental treatment? ☐ Yes or ☐ No

If yes, please explain: _____

Medical History

Primary Care Provider(Name and Phone): _____

Date of last physcial: _____

*Are you currently taking any birth control? ☐ Yes or ☐ No ☐ Not Applicable

*Are you currently prengant or nursing ☐ Yes or ☐ No

Estimated due date, if applicable: _____

Please list any prior hospitalizations or sugeries, including dates:

_____

_____

Is the patient currently using alcohol or drugs ☐ Yes or ☐ No

If yes, Type: _____ Frequency: _____ Amount: _____

Do you require antibiotics prior to dental procedures? ☐ Yes or ☐ No

Are you allergic to any medications? ☐ Yes or ☐ No

If yes, please write out known allergies:

_____

_____

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Please list any current prescribed medications or supplements you are taking, or have used over a long period of time:

Prescription/Supplement Name	Dosage/Frequency	Dates

□ None
□ Anemia
□ Asthma
□ Breathing Problems
□ Dementia
□ Epilepsy
□ Hearing Loss
□ Heart Trouble
□ Kidney disease
□ Lung Disease / COPD
□ Mobility Impairment
□ Radiation Therapy
□ Sexually Transmitted Disease
□ Stroke
□ Ulcers
□ Other Disease / Illness: _____

□ Alcoholism
□ Arthritis
□ Blood Thinners
□ Cancer
□ Diabetes
□ Excessive Bleeding
□ Heart Murmur
□ Hepatitis
□ Liver Disease
□ Lupus
□ Pacemaker
□ Rheumatic Fever
□ Sinus Problems
□ Thyroid Disease
□ Visual Impairment

□ Allergies or Hives
□ Artificial Joints
□ Blood Transfusion
□ Chemotherapy
□ Drug Addiction
□ Fainting / Dizziness
□ Heart Surgery
□ High Blood Pressure
□ Low Blood Pressure
□ Mitral Valve Prolapse
□ Psychiatric Care
□ Seizures
□ Stomach Problems
□ Tuberculosis (TB)

_____ _____

Patient Signature **Date**

_____

Printed

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FINANCIAL POLICY AND TREATMENT ESTIMATE

At Fayetteville Dental Studio we strongly believe that a good doctor/patient relationship depends upon good communication and understanding. Our goal is to avoid any confusion concerning payment by providing you with our office Financial Policy and estimate of your treatment costs calculated and based on information provided to us by your benefits company prior to your treatment.

As a courtesy to you we file claims directly to your carrier, but all estimates provided to you prior to treatment are **estimates** only. Final payment is determined by your carrier when the claim is received. Your benefits are a contract between you and your carrier. At times you may need to contact your carrier personally to resolve problems and we will notify you if this is the case. All payments are contingent upon satisfied deductibles, available benefits, and patient eligibility.

A predetermination of benefits will only be filed when requested by the patient.

While we always do our best to help you in filing your claims and collecting insurance payment, the patient/responsible party is ultimately responsible for the total cost of treatment rendered. We estimate your cost as close as possible, but we cannot guarantee payment from your insurance carrier.

Your estimated portion is always due at time of service.

INSURANCE CHECKS: If an insurance payment is sent to you directly, it must be endorsed to our office and brought to/mailed to 997 S. McPherson Church Rd. Fayetteville, NC 28303.

You will receive a statement for any remaining balance after your benefits pay and will **be due within 30 days**. Please allow up to 45 days from receiving final payment from your benefits company to receive a statement from our office. It is also possible that treatment plans may change as treatment is rendered. Unexpected treatment may become necessary, and a revised estimate will be provided.

Our office accepts payment by Cash, Check, and major Credit Cards.

By signing below, you are agreeing to the above terms.

_____ _____

Signature of patient or guardian **Date**

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NOTICE OF CONSENT

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g., my insurance company)
- The day-to-day healthcare operations of your practice.

I have been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

- I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for the delivery of proper dental care.
- I authorize release of any information concerning my (or my child's) healthcare, for the advice and treatment provided for purpose of evaluation and administering claims for insurance benefits.
- I authorize release of any information concerning my (or my child's) healthcare, for the advice and treatment to another dentist, or another healthcare professional and their staff

_____ _____

Signature of patient/guardian **Date**

_____

Printed Name