Patient Information

Patient Name: _____ Date:_____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other_____

Social Security #: _____-_____-_____ Birth Date:____/___/_____ Driver's License: _____
State Issued Number

Phone (Home): _____ (Work): _____ Ext_____ (Cell): _____

Email Address_____@_____

Mailing Address:_____
Street or PO Box Apartment #

_____
City State Zip Code

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

Have you ever had any of the following? (Answer Yes or No to all)

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	AIDS	☐	☐	Glaucoma	☐	☐	Liver Disease	☐	☐	Rheumatism
☐	☐	Anemia	☐	☐	Growths	☐	☐	Mental Disorders	☐	☐	Sinus Problems
☐	☐	Arthritis	☐	☐	Hay Fever	☐	☐	Nervous Disorders	☐	☐	Stomach Ulcers
☐	☐	Artificial Joints	☐	☐	Head Injuries	☐	☐	Pacemaker	☐	☐	Stroke
☐	☐	Asthma	☐	☐	Heart Disease	Date Placed:_____			☐	☐	Tuberculosis
☐	☐	Blood Disease	☐	☐	Heart Murmur	☐	☐	Penicillin Allergy	☐	☐	Tumors
☐	☐	Cancer	☐	☐	Hepatitis	☐	☐	Radiation Treatment	☐	☐	TMJ
☐	☐	Codeine Allergy	☐	☐	High Blood Pressure	☐	☐	Respiratory Problems	☐	☐	Venereal Disease
☐	☐	Diabetes	☐	☐	Hip Replacement	☐	☐	Rheumatic Fever	OTHER:		
☐	☐	Dizziness	☐	☐	Jaundice				_____		
☐	☐	Epilepsy	☐	☐	Kidney Disease				_____		
☐	☐	Excessive Bleeding	☐	☐	Knee Replacement						
☐	☐	Fainting	☐	☐	Latex Allergy						

- Are you currently pregnant? ☐ Yes ☐ No If yes, what is your due date? _____
- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Primary Care Physician: _____
  Address: _____ Phone:_____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
  Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain:_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date:_____
Signature of patient, parent or guardian

Responsible Party Information

☐ Self (Skip to next section) ☐ Parent/Guardian ☐ Spouse

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext:_____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment Occupation:_____

☐ Retired ☐ Disabled ☐ Student ☐ Homemaker ☐ Other _____(Please specify)

Employer Name: _____ Work Phone: _____

Address: _____
Street City State Zip Code

Who May We Talk to About Your Treatment?

Is there someone that we may have permission to talk to about your dental treatment? A spouse, an adult child, anyone that may help you with health related issues, etc.?

1. _____ _____
Name Relationship to You Phone Number

2. _____ _____
Name Relationship to You Phone Number

3. _____ _____
Name Relationship to You Phone Number

Emergency Contact Information

Name: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Phone (Home) _____ (Work)_____Ext_____ (Cell)_____

Relationship to you:_____

How did you hear about our office?

- ☐ Yellow Pages
- ☐ TV
- ☐ Internet
- ☐ Dr. _____Name of Office _____
- ☐ Friend or Family Member

If Friend or Family Member, who may we thank for your referral?_____

Medication Form 1

Patient Name: _____

Are you allergic to any medications? ☐ **Yes** ☐ **No** If yes, please list:

_____

Do you take Aspirin or other blood thinners? ☐ **Yes** ☐ **No**

Do you take Coumadin? ☐ **Yes** ☐ **No**

If Yes, you are taking Coumadin, then what is the date of the last INR you had taken?

_____ What was that INR value? _____

Do you OR have you ever taken Bisphosphonate drugs? ☐ **Yes** ☐ **No**
These drugs are used to treat osteopenia or osteoporosis.
Some of these drug names are:
Pamidronate (APD, Aredia)
Neridronate
Olpadronate
Alendronate (Fosamax)
Ibandronate (Boniva)
Risedronate (Actonel)
Zoledronate (Zometa, Aclasta)

Do you have a history of abuse **OR** are you currently using alcohol, tobacco, **AND/OR** drugs? ☐ **Yes** ☐ **No**

If Yes, please explain:

_____

_____

_____ _____

Patient Signature **Date**

Medication Form 2

Are you currently taking any medications or supplements? Over the Counter **OR** Prescription? ☐ **Yes** ☐ **No**

We ask that you please list **ALL** medications, supplements or prescriptions you are currently taking, **OR** have quit taking within the last 30 days. This includes any prescription medicines, over-the-counter medicines, or herbal supplements. Please include any that are taken on an "as needed" (PRN) basis:

Name of Medication	Dosage	Reason You are taking this medication

By signing below, I am stating I have disclosed **ALL** medications that I am taking. I understand that this is for my benefit and will aid the doctor should I be in need of medication.

_____ _____

Patient Signature **Date**

Upwards Dental
J. Eric Dollinger, DDS, PA

NOTICE OF PATIENT INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO INFORMATION. PLEASE REVIEW IT CAREFULLY.

J. Eric Dollinger, DDS, PA's LEGAL DUTY

J. Eric Dollinger, DDS, PA is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

J. Eric Dollinger, DDS, PA uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example, J. Eric Dollinger, DDS, PA may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

J. Eric Dollinger, DDS, PA may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law.

In any other situation, J. Eric Dollinger, DDS, PA's policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

J. Eric Dollinger, DDS, PA may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and patient exam areas and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. J. Eric Dollinger, DDS, PA will consider all such requests on a case by case basis, but the practice is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that J. Eric Dollinger, DDS, PA may have violated your privacy rights or if you disagree with any decision we have made regarding access or disclosure of your personal health information, please contact our practice manager at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on J. Eric Dollinger, DDS, PA's health information practices or if you have a complaint, please contact the following person at the location you are seen at:

J. Eric Dollinger, DDS, PA
Upwards Dental- Hendersonville
777 S. Allen Rd.
Flat Rock, NC 28731
(828) 595-9177

Upwards Dental
J. Eric Dollinger, DDS, PA

PATIENT INFORMATION ACKNOWLEDGEMENT FORM

I have read and fully understand J. Eric Dollinger, DDS, PA's Notice of Information Privacy Practices and have had the opportunity to obtain a copy. I understand that J. Eric Dollinger, DDS, PA may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided any personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that Dr. Dollinger will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby acknowledge to the use and disclosure of my personal health information for purposes as noted in J. Eric Dollinger, DDS, PA's Notice of Information Practices. I understand that I retain the right to revoke this acknowledgement by notifying the practice in writing at any time.

_____
Patient Name

_____
Signature

_____
Date

Patient Name_____

Confirmation Call Back Policy Notice

I understand that Upwards Dental will contact me to remind me of my appointments. I understand if a message is left for me, either on my voicemail/answering machine or with a person at my number, it is my responsibility to give a confirmation call back or reply to text messages or emails to the office to confirm my appointments.

_____ _____

Patient Signature or Guardian Signature if patient is minor Date

Broken Appointment Policy Notice

I understand that Upwards Dental requires 24-hours advanced notice for any cancellations and re-scheduling of appointments. I understand that if less than 24-hours notice is given or if I "no call, no show" for an appointment, it is considered a broken appointment. I understand that Upwards Dental reserves the right to dismiss anyone from the practice for one or more broken appointments. I also understand that I may be charged a broken appointment fee of $75 or up to 75% of the cost of my scheduled appointment.

_____ _____

Patient Signature or Guardian Signature if patient is minor Date

Financial Policy

This is an agreement between Upwards Dental (Dr. J. Eric Dollinger, DDS, PA), as creditor, and the Patient/Debtor named on this form.
In this agreement the words "you", "your" and "yours" mean the Patient/Debtor. The word "account" means the account that you have established in your named to which charges are made and payments credited. The words "we," "us," and "our" refer to Dr. J. Eric Dollinger, DDS, PA.
By executing this agreement, you are agreeing to pay for all services that are received.

Monthly Statements: If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account, and any payments or credits applied to your account during the month.

Payments: Unless arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued and is past due if not paid by 10 days from the date of statement. Patient Portion of work rendered is due at the time of service and collected at check in. If you do not have insurance, payment in full, will be collected the day services are rendered. Payments are collected at check-in time of appointment.

Co-Payments/Required Payments: Any co-payment or required payment by an insurance company MUST be paid at the time of service. This is an insurance requirement.

Insurance: If you carry dental insurance, you understand that all dental services furnished are charged directly to the patient and that you are responsible for payment of all dental services. We will help prepare your insurance forms and assist in making collections from insurance companies and will credit such collections to your account. You authorize payment of insurance benefits to be paid directly to us, the provider. You understand that you are responsible for supplying correct insurance information to us. You understand that we, as a courtesy to you, will make every effort to bill all insurance companies for payment of your account. You understand benefits quoted by my insurance company is NOT a guarantee of payment. You understand that you are financially responsible for all non-covered charges or unpaid charges to your account within 30 days of date of services rendered. **You understand that we are not a member of any networks or PPOs.**

Payment Options:

1. You choose to pay by Cash, Check, Visa, Master Card, Discover and American Express on the day that treatment is rendered.
2. We offer third party financing through Care Credit, which offers 6 month-no interest, 12 month-no interest and 24 months with interest. Care Credit has a HIGH approval rating. To apply call 1-800-365-8295 or visit www.CareCredit.com

Treatment Plans/Estimates: Our office may provide you with a treatment plan/estimate for your dental care. You understand that the treatment plan/estimate can only be extended for six months from the date of patient examination. This is only an estimate.

Divorce: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Past Due Accounts: If you account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collections agency, you agree to pay all of the collection costs which are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyer's fees which we incur plus all court costs. In case of suit, you agree the venue shall be in the county the office is located.

Returned Checks: All personal checks that are received as payment will be converted to an electronic funds transfer (EFT) and your account will debited the amount of the transaction. In the event that the EFT is returned unpaid, a $25.00 fee will be charged to your account via draft or EFT by the bank.

_____Patient/Guardian Initials _____Date

Missed Appointment Fee: Patients who do not show up for an appointment, do not show up on time for an appointment, or cancel with less than 24 hours notice will be charged a $75.00 fee and/or up to 75% of the cost of your appointment. This fee must be paid before a new appointment is scheduled. Upwards Dental reserves the right to dismiss any patient who breaks an appointment.

Transferring of Records: You will need to sign a "Release of Records" form and may be required to pay a reasonable copying fee if you want to have your records sent to another doctor. You authorize us to include relevant information, including your payment history. If you are requesting your records to be transferred from another doctor to us, you authorize us to receive all relevant information, including your payment history.

Waiver of Confidentiality: You understand if this account is submitted to an attorney or collections agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

Contact Information: You agree to contact us when any of your contact information changes. You give us permission to contact you at home, at work, or on your cell to discuss matters related to this form.

I have read and understand Upwards Dental Financial Policy.

Patient Name: (Print)_____

Responsible Party
(If not the patient): (Print)_____

Signature:_____ Date:_____

A copy of this document will be provided to you upon your request.