TRIANGLE FAMILY DENTISTRY

Welcome to our Practice!

Thank you for choosing our office for your dental care!

We are dedicated to providing you and your family with the highest quality of care, using state of the art treatment in a comfortable and professional environment. The following information is being provided to help familiarize you with our office guidelines and philosophy.

APPOINTMENTS:

Our appointment system is designed so that we may give the most efficient care in a pleasant and relaxed environment. We make every effort to honor all time commitments and expect that patients extend the same courtesy to us. We make every effort to call our patients as a reminder for an appointment. You will receive confirmation notifications prior to your appointment and a day before reminder.

CONFIRMATION IS REQUIRED:

Patients are required to confirm scheduled appointments at least forty-eight (48) business hours in advance. Appointments can be confirmed by responding within the electronic notification or by calling the office. Appointments that remain unconfirmed will be released to patients on our waitlist who need dental care. Any reservation deposit associated with the appointment will be forfeited and will not be applied to a future service.

LATE ARRIVALS:

To ensure that every patient receives the full benefit of their scheduled service and to maintain our commitment to prompt service for all guests, we have established the following for late arrivals:

Modified Services After 10 Minutes: If you arrive more than ten (10) minutes late, we will do our best to accommodate you. However, your service may be modified or shortened to ensure we remain on schedule for the next patient.

CANCELLATIONS & MISSED APPOINTMENTS:

We require forty-eight (48) business hours' advance notice of cancellation. Patients who do not provide forty-eight (48) business hours' notice of cancellation or do not present for a scheduled appointment will be charged a fee. This fee will vary depending on the length of time scheduled and procedure type and will not be less than $50.00. Any reservation deposit associated with the appointment will be forfeited and will not be applied to a future service. Patients who fail to present for two (2) appointments risk being dismissed from the practice.

AFTER HOURS EMERGENCY CARE:

Our practice provides 24-hour support for our patients of record. A patient of record has been seen and received treatment in the office within the last 18 months. If you are a patient of record in need of emergency dental care and it is after hours, you may call the office number and our answering service will contact our doctors.

CONTINUING CARE:

This practice is centered on prevention and optimum oral health. We discourage isolated, occasional treatment and recommend comprehensive treatment, continuing care and regular maintenance.

CHILDREN & ADOLESCENTS:

We provide children with the same care that our adult patients receive and prefer to care for them as individuals. Parents may accompany children in the operatories by invitation only. We require that parents remain in the building with minor children (under 18 years of age) for the entire appointment.

EDUCATION:

An abundance of educational material is available in the office and on our website, www.tfdsmiles.com for your review. We will provide specific information as it relates to your dental needs. We welcome your questions about any dental products, services, or technology.

TECHNOLOGY:

Digital radiography, intra-oral photography and Patient Education software are examples of the state-of-the-art technology used in our office for diagnosis and treatment planning. Our patients appreciate the efficiency and accuracy of this technology and like being involved in the decision-making process.

STERILIZATION:

Rest assured we follow all recommended sterilization procedures and are compliant with all OSHA regulations.

INVESTING IN YOUR DENTAL HEALTH:

New studies have shown that investing in your oral health, in terms of both prevention and treatment, is not only good for function and aesthetics, but for overall health as well. More recently, the bacteria that causes periodontitis has been linked to an increase in cardiovascular disease. We endeavor to provide our patients with the highest standard of care at an affordable price.

PAYMENTS & INSURANCE:

Fees for services are due at the time treatment is rendered. Payment may be made in cash, check, or by credit card. We also offer third party financing. As a courtesy to our patients with dental insurance, we will make a good faith estimate of your benefits and file the appropriate claim forms. We defer billing you for that amount up to 30 days.

Please ask questions if you do not understand any of these guidelines.

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***PATIENT'S NAME:** _____
(First) (MI) (Last)

Nickname/Preferred Name: _____

Street Address _____ City _____ State _____ Zip _____

Home# _____ Cell# _____ Work# _____

Email Address _____
required

How would you like our office to notify you of your appointment: ☐ Text ☐ Email ☐ Voice Mail

Social Security # _____ Drivers License # _____
required

Occupation _____ Employer _____

Date of Birth ____/____/____ Age _____ Gender: Male / Female
(Month/Day/Year) *(Please circle)*

In case of emergency contact: _____ *Phone: _____

How did you hear about us? *(please check all that apply)*

___TFD Sponsored Event ___Brochure ___New home package

___Drive by/Location ___Insurance ___Online _____
(Please specify website)

___Referred by _____ ___Other _____
(Please specify name) *(Please specify)*

***RESPONSIBLE PARTY:** *(if other than the patient)*

Name _____ Relationship _____
(First) (MI) (Last)

Street Address _____ City _____ State _____ Zip _____

Telephone: Home _____ Cell _____ Work _____

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*INSURANCE POLICY:

Name of Insured_____ Relationship_____
(First) (MI) (Last)

Date of Birth_____/_____/_____ Social Security#_____
(Month/Day/Year)

Employer_____ Insurance Company_____

Policy#_____ Group#_____ ID#_____

We are happy to file insurance claims and assist you in obtaining the maximum benefits specified in your contract.

1. Your insurance is a contract between you, your employer, and your insurance company. We are not a party to that contract. We will do our best to ESTIMATE your coverage and file your insurance on your behalf. Not all dental services are necessarily covered under your dental insurance plan. It is essential that you read and understand your coverage and pay special attention to any preauthorization requirements, exclusions and waiting periods.

2. Our office policy states that you are totally responsible for your bill. The ESTIMATED patient portion of the fee is due at the time of service. If a balance remains after we receive payment from your insurance carrier within 30 days we will notify you. Failure of your insurance carrier to reimburse our office within 30 days will result in our billing you directly for the remaining balance.

3. We are committed to providing the highest quality of care. Our treatment recommendations and the dental services we provide are in the best interest of the patient's health. The patient is responsible for payment in full regardless of an insurance company's arbitrary determination of treatment necessity.

4. Our participation in a Preferred Provider Organization (PPO) is a contract between this office and the organization to provide dental services for the negotiated network fee schedule. Individual coverage and benefits will vary within the organization and are dependent on the contract between you, your employer and the insurance company. While we guarantee our fees will not exceed the network fee schedule, we cannot be responsible for variances in coverage and benefits within the PPO.

5. If your coverage changes for any reason, please notify the office immediately.

By signing this form, you have read and understand our policy. Any denials or insurance payments less than estimated will be your responsibility. Payment will be due upon our billing cycle. All estimated out of pocket fees and deductibles are due the day of treatment. Ask our office regarding our financial options before your visit, or if you have any questions regarding your insurance and our policy.

X_____
(Signature) **(Date)**

* APPOINTMENT POLICY:

1. You will receive confirmation notifications prior to your appointment and a day before reminder. Patients are required to confirm their appointment at least forty-eight (48) business hours in advance. Appointments can be confirmed by responding within the electronic notification or by calling the office. Appointments that remain unconfirmed will be released to patients on our waitlist who need dental care. Any reservation deposit associated with the appointment will be forfeited and may not be applied to a future service.

Please Initial Here:_____

2. We require forty-eight (48) business hours advance notice of cancellation. Patients who do not provide forty-eight (48) business hours' notice of cancellation or do not present for a scheduled appointment will be charged a fee. This fee will vary depending on the length of time scheduled and procedure type and will not be less than $50.00. Any reservation deposit associated with the appointment will be forfeited and may not be applied to a future service.

Please Initial Here:_____

TRIANGLE FAMILY DENTISTRY

Credit Card on File Agreement

Triangle Family Dentistry is implementing a new credit card on file policy effective February 2023. Like many other dental and medical practices, we have adopted a similar policy. We kindly request our patient's guardian/guarantor provide a credit card which will be used to pay a balance. Co-pays are still due at the time of service. Your credit card information will be obtained and kept securely on file.

After your claim is paid, we will process your card on file for any balances less than $100.00 and send you a receipt for the charge. For balances over $100.00, you will receive an electronic statement, and your prompt payment is expected within 7 days. You may call our office if you have questions about your balance.

This "Card-on-File" policy simplifies payment for you, and it reduces paperwork, ultimately helping lower the cost of care. Our Guest Support team is always available to answer questions about the Credit Card on File payment method or any balances due.

By signing below, I authorize Triangle Family Dentistry to keep my signature and my credit card information securely on-file in my account. I authorize Triangle Family Dentistry to charge my credit card for any outstanding balances equal to or less than $100.00.

☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

Name on Card (Print):_____

Cardholder Relationship to Patient: _____

Last Four Digits of Credit Card (CC) Number: _____ Exp. Date:_____

Please be advised, if the credit card on file differs from the CC info provided above, we will use CC on file.

Please fill out information below for any person(s) you authorize this credit card for:

Patient Full Name (Print): _____ DOB: _____

Patient Full Name (Print): _____ DOB: _____

Patient Full Name (Print): _____ DOB: _____

Credit Card Holder's Signature: _____ Date: _____

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Patient Medical History

All information provided here is 100% confidential and any attempt to conceal pre- existing 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.

1. Please provide your primary care physician's name and phone number:

_____

Please check the correct response:

2. Have you ever been seriously ill? ☐ Yes ☐ No
3. Have there been any changes in your general health recently? ☐ Yes ☐ No

   If yes, please explain _____

   _____

4. Is a medical doctor currently treating you? ☐ Yes ☐ No

   Doctor's Name: _____

   Doctor's Contact #: _____

5. Please list any medication (Prescription or Over-the-Counter) that you take.

_____

_____

6. Have you ever had a major operation or been hospitalized? ☐ Yes ☐ No

   If yes, please explain _____

   _____

7. Do you have artificial joints, heart valves, or an organ transplant? ☐ Yes ☐ No
8. Do you have a serious congenital heart condition? ☐ Yes ☐ No

   If yes, please mark with an X those that apply:

   ☐ Unrepaired or incompletely repaired cyanotic congenital heart disease, including a palliative shunt or conduit

   ☐ Completely repaired congenital heart defect with prosthetic material or device, either placed by surgery or by catheter intervention, during the first six months after the procedure

   ☐ Any repaired congenital heart defect with residual defect at the site or adjacent to the site of a prosthetic patch or a prosthetic device

9. Have you had a cardiac transplant that developed a problem in a heart valve? ☐ Yes ☐ No
10. Do you have chest pains upon exertion? ☐ Yes ☐ No

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11. Are you allergic to, or have you had unusual reactions to any of the following?

Please check all that apply:

☐ Penicillin	☐ Codeine	☐ Sulfa Drugs	☐ Aspirin	☐ Latex	☐ Barbiturates
☐ Iodine	☐ Erythromycin	☐ Metals	☐ Ibuprofen	☐ Other	☐ No Known Allergies

If other, please explain: _____

_____

12. Are you currently using any recreational drugs such as cocaine? ☐ Yes ☐ No
13. Have you ever taken the drug Fen-Phen? ☐ Yes ☐ No
14. Have you ever taken a bisphosphonate such as Fosamax, Actonel, or Boniva? ☐ Yes ☐ No
15. Have you ever had a blood transfusion? ☐ Yes ☐ No
16. Have you experienced an unusual reaction to dental anesthetic? ☐ Yes ☐ No
17. Please check the box if you have ever had or been told you have any of the following:

Active Infection	☐	Hepatitis	☐
ADHD	☐	Herpes	☐
AIDS	☐	Hives/Skin Rash	☐
Anemia	☐	Infective Endocarditis	☐
Arthritis	☐	Jaundice	☐
Asthma	☐	Jaw Joint Pain	☐
Asperger's /Autism	☐	Kidney Disease	☐
Low Blood Pressure	☐	Osteoporosis	☐
High Blood Pressure	☐	Pacemaker	☐
Cancer	☐	Rheumatic Fever	☐
Depression	☐	Seizures	☐
Deviated Septum	☐	Sinus Trouble	☐
Diabetes	☐	Stroke	☐
Epilepsy	☐	Swollen Neck Glands	☐
Frequent Headaches	☐	Thyroid Problems	☐
Hay Fever	☐	Tuberculosis	☐
Heart Attack	☐	Venereal Disease	☐
Heart Defect	☐		

Other: ☐ Please explain: _____

_____

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18. Do you smoke or use tobacco? ☐ Yes ☐ No
19. Please list any foods that you are allergic to:

QUALITY OF SLEEP:

20. Have you been told you snore occasionally? ☐ Yes ☐ No
21. Do you wish you slept better and had more energy? ☐ Yes ☐ No
22. Have you been prescribed or do you use a CPAP? ☐ Yes ☐ No
23. Do you feel tired throughout the day? ☐ Yes ☐ No

FOR WOMEN ONLY:

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

24. Are you pregnant or suspect that you may be pregnant? ☐ Yes ☐ No
25. Are you taking oral contraceptives (birth control pills)? ☐ Yes ☐ No
26. If you use other types of birth control medications that are not pills (such as Depo shots), please list:

_____

FOR PARENTS:

Please list any physical, behavioral, sensory or developmental special needs or circumstances for your child. This information will help us better serve and accommodate you or your child's needs.

_____

_____

_____

I have read and understand the above questions. I have answered all of these questions truthfully to the best of my ability and knowledge. I consent to the diagnostic procedures and dentistry necessary for proper dental care.

Signature X _____ **Date** _____

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with a Notice of Privacy Practices. Our Notice is available on-line. If you do not have internet connectivity, please ask one of our staff for a copy of our Notice.

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

Signature X _____ **Date** _____

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Dental Questionnaire

MY DENTAL GOALS ARE:

- ☐ Whiter Teeth
- ☐ Pain Free
- ☐ Straighter Teeth
- ☐ Healthier Gums
- ☐ Replacing Missing Teeth
- ☐ Full Dentures
- ☐ Cavity Free
- ☐ Better Breath
- ☐ Less Bleeding
- ☐ Decrease Sensitivity
- ☐ Partials
- ☐ Better Chewing
- ☐ Sedation Dentistry
- ☐ Stop Snoring

1. Why did you leave your other dental practice? _____
2. What do you expect from our practice? _____
3. When was the last time you were seen by a Dentist? _____
4. May we take dental x-rays on you if they are needed? ☐ Yes ☐ No
5. Do you take fluoride supplements? ☐ Yes ☐ No
6. Have you ever had periodontal treatment (gum treatment)? ☐ Yes ☐ No
7. Do you floss regularly? ☐ Yes ☐ No
8. Do your gums bleed when you brush or floss? ☐ Yes ☐ No
9. If you had a magic wand, what would you change about your smile? _____

Thank you for taking the time to complete these new patient forms. We personalize your dental care based on the answers you've provided.