WELCOME!
Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all of your dental healthcare needs, please fill out these forms completely using black ink. If you have any questions or need assistance, please ask us—we will be happy to help you.

PATIENT INFORMATION (CONFIDENTIAL) Date _____

Name (Last) _____ (First) _____ (Middle) _____

Address (mailing) _____ City _____ State _____ Zip _____

(physical) _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Social Security No. _____ DOB _____

E-mail Address_____ NCDL#_____

Please list the contact number at which we may contact you to confirm your appointments_____

Please Check Appropriate Response: Minor ___ Single ___ Married ___ Divorced ___ Widowed ___

If Student, Name of School/College _____

Patient's Employer _____ Work Phone _____

Employer's Address _____ City _____ State _____ Zip _____

Spouse's Name _____ Children's names and ages _____

Person to Contact in Case of Emergency _____ Phone _____

Relationship to Patient _____

Whom May We Thank for Referring You to Our Office? _____

If the patient is a minor (less than 18 years old), please complete the following information:

Name of Patient's Father _____ Name of Patient's Mother _____

If the minor's parents are married and both reside at the address previously listed, please skip to the next section. If the minor's parents are divorced, please complete the following information and indicate which parent has legal custody of the minor. If both parents share custody please indicate so by writing the word "Joint" in the appropriate space below.

Father's Mailing Address: _____
Father's Physical Address: _____
Father's Employer and Address: _____
Father's Employer's Phone #: _____ Father's DOB: _____ SS# _____

Mother's Mailing Address: _____
Mother's Physical Address: _____
Mother's Employer and Address: _____
Mother's Employer's Phone #: _____ Mother's DOB: _____ SS# _____

Which parent has legal custody of the patient/minor? _____

(Please complete other side)

RESPONSIBLE PARTY

Name of person responsible for this Account _____ DOB _____

Address (mailing) _____ City _____ State ____ Zip _____

(physical) _____ City _____ State ____ Zip _____

County in which you live_____

Phone # _____ Relationship to Patient _____ NCDL# _____

Employer _____ Work Phone _____ SSN _____

INSURANCE

We will be happy to file your insurance for payment as a courtesy to you. We are not a participating provider with any insurance plan and, therefore, would be considered an out-of-network provider for purposes of determining your benefits by your insurance carrier. Each patient or patient's parent/legal guardian (if the patient is a minor) is responsible for paying his/her deductible plus all coinsurance due at the time treatment is completed, including all fees not paid by the insurance carrier. Please assist us with the handling of your insurance by completing the following information.

PRIMARY INSURANCE:
Policyholder: _____
Policyholder DOB: _____
Policyholder SSN: _____
Group #: _____
Employer: _____
Employer Phone #: _____

SECONDARY INSURANCE:
Policyholder: _____
Policyholder DOB: _____
Policyholder SSN: _____
Group #: _____
Employer: _____
Employer Phone #: _____

NOTE: If you are over age 18 and are a full-time college student and have insurance coverage under your parent's insurance please indicate so by placing an "X" in the space provided. _____

APPOINTMENTS

Please make your scheduled appointments a priority. Rescheduling and failing to keep your appointments unnecessarily delays your much needed treatment and takes appointment time that other patients need to complete their treatment. Multiple last-minute cancellations and no-shows will not be tolerated and may result in dismissal from the practice. In order for us to assist you with scheduling appointments that are compatible with your work schedule and other commitments please provide the days of the week and times of day that you **CAN** schedule your dental appointments by checking the available days below. Please indicate any time restrictions on the line provided by the corresponding day. (Examples: Monday, Tuesday, and Thursday after 10:00 AM or Tuesday and Wednesday from 8:00-12:00 PM, etc.)

Monday____ Times Available_____
Tuesday____ Times Available_____
Wednesday ___ _ Times Available_____
Thursday_____ Times Available_____
Friday_____ Times Available_____

MEDICAL HISTORY QUESTIONNAIRE

Patient Name _____ DOB _____

1. Please list the name and phone # of all the doctors that you see or have seen, beginning with your regular family physician: _____
_____
_____

2. Are you under medical treatment now? Yes No If yes, for what condition(s)? _____

3. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? Yes No
If yes, please explain: _____

4. Please list all medication that you take, including non-prescription medication.
_____
_____
_____

5. Do you smoke or use chewing tobacco? Yes No If Yes, how many years? _____
Have you ever tried to quit before? Yes No Are you interested in quitting at this time? Yes No

6. Do you drink alcohol? Yes No

7. Do you use controlled substances or illegal drugs? Yes No

8. Do you have or have you had any of the following?

High Blood Pressure	Yes No	Heart Disease	Yes No	Chest Pains	Yes No
Cardiac Pacemaker	Yes No	Heart Attack	Yes No	Easily Winded	Yes No
Rheumatic Fever	**Yes** No	**Heart Murmur**	**Yes** No	Stroke	Yes No
Swollen Ankles	Yes No	Angina	Yes No	Anemia	Yes No
Hay Fever/Allergies	Yes No	Tuberculosis	Yes No	Asthma	Yes No
Fainting/Seizures	Yes No	Emphysema	Yes No	Glaucoma	Yes No
Radiation Therapy	Yes No	Low Blood Pressure	Yes No	Frequently Tired	Yes No
Recent Weight Loss	Yes No	Leukemia	Yes No	Liver Disease	Yes No
Epilepsy/Convulsions	Yes No	Cancer	Yes No	Arthritis	Yes No
Mitral Valve Prolapse	Yes No	Diabetes	Yes No	Heart Trouble	Yes No
Respiratory Problems	Yes No	**Artificial Joints**	**Yes** No	Thyroid Problems	Yes No
Sexually Transmitted Disease	Yes No	**Joint Replacement**	**Yes** No	Kidney Disease	Yes No
Stomach Problems/Ulcers	Yes No	AIDS/HIV Infection	Yes No	Hepatitis/Jaundice	Yes No
Low Blood Sugar	Yes No	Other_____			

DOCTOR/STAFF NOTES: _____
_____
_____

9. Are you allergic to or have you had any reactions to any of the following?

Local Anesthetics	Yes No	Sulfa Drugs	Yes No	Penicillin or other Antibiotics	Yes No
Latex Rubber	Yes No	Sedatives	Yes No	Codeine, hydrocodone, oxycodone	Yes No
Aspirin	Yes No	Iodine	Yes No	Any Metals (nickel, mercury, etc.)	Yes No
Barbiturates	Yes No	Other (please list) _____			

DOCTOR/STAFF NOTES: _____

10. WOMEN ONLY: A) Are you pregnant or think you may be pregnant? Yes No How many months? ____
B) Are you nursing? Yes No
C) Are you taking oral contraceptives (birth control)? Yes No

(Complete Other Side)

DENTAL HISTORY QUESTIONNAIRE

Name of Previous Dentist _____ Date of Last Exam _____
How long has it been since you had X-rays taken? _____

1. Do your gums bleed while brushing or flossing? Yes No
   A) How many times each day do you brush your teeth? _____
   B) How often do you floss your teeth? _____ How often do you use mouthrinse? _____

2. Are your teeth sensitive to cold, hot, or sweet foods and/or liquids? Yes No

3. Do you feel pain in any of your teeth? Yes No 4. **Do you ever get "cold sores/fever blisters"? Yes** No

5. Do you have any sores or lumps in or around your mouth? Yes No

6. Have you had any head, neck, or jaw injuries? If yes, please explain. Yes No
   _____

7. **Is your home drinking water supplied by the city, county, or a private well? City County Well**

8. **Do you participate in any sports or recreational activities? If yes, please list. Yes** No
   _____

9. Have you ever experienced any of the following problems in your jaw?
   (a) Clicking Yes No
   (b) Pain (joint, ear, side of face) Yes No
   (c) Difficulty in opening or closing Yes No
   (d) Difficulty in chewing Yes No

10. **Do you clench or grind your teeth? Yes** No 11. Do you have frequent headaches? Yes No

12. **Do you snore or have you been told that you snore? Yes** No

13. Have you ever had any prolonged bleeding or complications following extractions? Yes No

14. Have you had any orthodontic treatment? If yes, when and by which orthodontist? Yes No
    _____

15. Do you wear dentures or partials? If yes, when did you have them made? _____ Yes No
    Are you satisfied with the fit and appearance of your denture/partial? Yes No

16. Have you ever received oral hygiene instructions regarding the care of your teeth and gums? Yes No

17. Are you happy with the appearance of your teeth? Yes No
    If no, what would you like to change about your teeth? (BE SPECIFIC)
    _____
    _____

AUTHORIZATION AND RELEASE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such dental care to third party payors and/or health practitioners. I understand that payment for services rendered is due in full at the time of service for patients with no dental insurance coverage. For those patients with dental insurance coverage the deductible, if not already satisfied, plus the patient's coinsurance will be due at the time of service as specified in their specific insurance policy. I understand that my dental insurance carrier may pay less than the actual charges for services rendered and I agree to be responsible for payment of all services rendered on my behalf or my dependants.

Patient/Parent Signature_____ Date_____

ACKNOWLEDGMENT OF RECEIPT

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. It also provides information about your rights as a patient of our practice and whom you may contact at our office to ask any questions about our privacy practices.
By signing this form, you agree that you have been offered our Notice of Privacy Practices.

I have received/been offered a copy of the Notice of Privacy Practices for the office of Marty E. Heesch, DDS.

_____ _____
Patient Name (Please Print) DOB

Address_____

_____ _____
Signature of Patient or Patient's Representative 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_____

  _____

Prepared By _____

Signature _____

Date _____

(Please complete the other side)

PATIENT AUTHORIZATION TO DISCLOSE INFORMATION

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (CHECK ALL THAT APPLY):

- o Home Telephone (Please list the #: _____)
- o O.K. to leave message with detailed information
- o Leave message with call-back number only

- o Written Communication
- o O.K. to mail to home address
- o O.K. to mail to my work/office address
- o O.K. to fax to number indicated (Fax #: _____)

- o Work Telephone (Please list the #: _____)
- o O.K. to leave message with detailed information at work number
- o Leave message with call-back number only at work number

- o Mobile/Cell Phone (Please list the #: _____)

- ❖ Please list the best number at which we may contact you to confirm your appointments_____

I hereby authorize the office of Marty E. Heesch, DDS and his associates to disclose individually identifiable health information, including financial and billing information as described below, to persons listed below. I am providing authorization under my own free will**. I UNDERSTAND THAT ANY PERSONS LISTED BELOW ARE THE ONLY INDIVIDUALS THAT CAN HAVE HEALTH INFORMATION REGARDING THE PATIENT REFERENCED ON THIS RECORD OF DISCLOSURE FORM. IF SOMEONE CONTACTS OUR OFFICE THAT IS NOT ON THIS FORM THEY CANNOT BE GIVEN ANY INFORMATION ABOUT THE HEALTH INFORMATION OF THE PATIENT ON THIS RECORD OF DISCLOSURE FORM.**

Authorized Persons: _____

_____

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 Patient's Representative

(Revised September 2010)

FINANCIAL OPTIONS AND DISCLOSURES FORM

Marty E. Heesch, DDS
1093 13th Street, SE
Hickory, NC 28602
(828)324-7056

Patient Name_____
Responsible Party _____
Address _____
City _____ State _____ Zip Code_____
Home # _____ Work # _____ Mobile_____
E-mail address_____

Accepted Methods of Payment: Please select the methods of payment that you will be using to pay for your treatment.

____ Cash
____ Personal Check
____ Master Card/ VISA/Discover/Debit card
____ Dental Insurance
____ Third-party financing through Care Credit

____ **PATIENTS WITHOUT INSURANCE PLEASE NOTE**: Payment in full is due prior to services being rendered. We do not "bill you" for any treatment completed. For treatment involving laboratory fees and/or multiple appointments you will be required to pay 25% of the treatment fee when the appointment is scheduled, 50% the day that your treatment is started, and the remaining 25% prior to your treatment being completed. Any appointment not involving a laboratory fee or multiple visits to complete and requiring 1 ½ hours or more to complete must be reserved with a 25% deposit at the time the appointment is scheduled. The remaining 75% of the treatment fee is due the day of treatment. This 25% deposit will be non-refundable if you fail to show for the appointment on the day that it is scheduled or do not provide at least 24 hours notice in the event that you need to change your appointment.

____ **PATIENTS WITH INSURANCE PLEASE NOTE**: Our office is committed to helping you maximize your insurance benefits. Because insurance policies vary, we can only estimate your coverage in good faith but cannot guarantee coverage due to the complexities of insurance contracts. Your dental benefits are derived from a contract between **YOU, YOUR EMPLOYER, AND THE INSURANCE COMPANY**. Our fees generally are NOT fully covered by the maximum allowance (UCR) determined by your carrier, and all treatment that is needed may not be a covered benefit under your insurance plan. Your insurance benefits are based on percentages, and it is the insurance company that makes the final determination of your eligibility and benefits. The total amount of the patient's estimated portion, including any deductible, is due at the time services are rendered. Again, the patient's estimated portion is only an estimate; therefore, **ANY AND ALL fees not paid by your insurance company are your responsibility --- NO EXCEPTIONS**. On treatment involving laboratory fees and/or multiple appointments you will be required to pay 25% of the treatment fee when the appointment is scheduled with the remaining portion of your co-insurance being due on the day of your appointment prior to treatment being started. Any appointment not involving a laboratory fee or multiple visits to complete and requiring 1 ½ hours or more to complete must be reserved with a 25% deposit at the time the appointment is scheduled. Any remaining coinsurance is due on the day of your appointment prior to treatment being started. This 25% deposit will be non-refundable if you fail to show for the appointment on the day that it is scheduled or do not provide at least 24 hours notice in the event that you need to change your appointment.

____ **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 on the account, the finance charge (if any), and any payments or credits applied to your account during the month. Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is received, and is past due if not paid by the specified date on the statement. **(OVER)**

____ **FINANCE CHARGES**: A finance charge will be applied to each item on your account which has not been paid by the specified date on your billing statement and will continue to accrue every thirty (30) days that the balance is not paid and remains outstanding. The finance charge will be computed at the rate of one percent (1%) per month or an Annual Percentage Rate of twelve percent (12%). The finance charge on your account is computed by applying the periodic rate (1%) to the "overdue balance" on your account.

____ **CREDIT HISTORY**: You agree to give us permission to check your credit and employment history and to answer questions about your credit experience with us, including but not limited to American Credit Bureau, for the purpose of considering payment options and collecting on your account in the event that it becomes overdue. We reserve the right to report your account status to any credit reporting agency such as a credit bureau when attempting to collect on an overdue account.

____ **RETURNED CHECKS**: There is a $25.00 fee for any returned or stopped check.

____ **MISSED APPOINTMENT FEE**: Please make scheduled appointments a priority! We reserve the right to apply a fee to your account for any appointment that is missed or broken. Any appointment that is cancelled or changed the day of the scheduled appointment is considered a broken appointment and is subject to the aforementioned fee. Our office is closed on Friday, Saturday, and Sunday, so all messages left on the office answering machine regarding appointments shall be considered received on the following Monday. In order to avoid charges and fees due to missed and broken appointments we simply ask that you schedule your appointments at a time convenient for you that does not conflict with any other scheduled events and make a commitment to keeping the appointment time that has been reserved especially for you. Multiple missed and broken appointments will not be tolerated. Following the third missed/broken appointment you will be required to pay for any future appointments in full prior to scheduling the appointment, with the fee being non-refundable in the event that you fail to keep the appointment.

____ **PAST DUE ACCOUNTS**: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, credit bureau, or small claims court you agree to pay all of the costs which are incurred with this action. If we have to refer collection of the balance to an attorney, you agree to pay all attorneys' fees incurred plus all court costs.

____ **WAIVER OF CONFIDENTIALITY**: You understand that if this account is submitted to an attorney or collection 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.

____ **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 parents' responsibility to collect from the other parent.

____ **TRANSFERRING OF RECORDS**: You will need to request the transfer in writing by completing a Records Release Authorization and pay a reasonable copying fee ($10) if you want to have copies of your records sent to another doctor's office or organization. You authorize us to include all relevant information, including your payment history. If you are requesting your records to be transferred from another doctor's office or organization to us, you authorize us to receive all relevant information, including your payment history.

This is an agreement between the office of Marty E. Heesch, DDS and the Responsible Party named on this document. By executing this agreement you are agreeing to pay for all services that are received. 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.

Responsible Party Signature _____ Date _____