Seamless
DENTISTRY
Where Healthy Meets Beautiful

Dear Patient,

It is with the greatest pleasure that we welcome you and your family to our dental practice here in Kannapolis! My name is Todd Hendrickson and I have been in dentistry for almost 10 years now. My family and I live nearby in Davidson and enjoy the outdoor life and the great neighbors! My dental team and I are very proud of the full line of dental services and products that we offer to make your visit with us an enjoyable one. It is our main priority to make this dental experience for you relaxing and help you get healthy, beautiful teeth for a lifetime.

At your first visit you get to meet me and all of my friendly staff. You will also get to take a tour of our beautiful rustic office that is right above Cabarrus Family Medicine. After my dental examination, we can thoroughly discuss the best treatment plan to meet your overall oral health goals. Feel free to bring the entire family! We love meeting new people and hope for a long lasting friendship along the way.

For your convenience, we have enclosed a number of documents for new patient registration, insurance, and other forms needed in our office. As always, your personal healthcare and financial information will be kept private and in accordance with HIPAA Privacy Regulations. Please complete these forms and along with a copy of your dental insurance card (front & back), you can email or fax them right to us. You may also bring them with you to your appointment if you do not have a computer.

We strive to stay on time and appreciate you to do the same. Should you have any questions or need help finding us, please call us at 704.699.3515 or send us an email at info@seamlessdentistry.com

We look forward to meeting you soon!

Sincerely,

Dr. Todd

Seamless Dentistry

We want to get to know you better so we can give you the best dental healthcare possible! Please fill out these forms completely and know your information is confidently saved in our system. To be seen in our office, it is mandatory that all forms are read and signed before being seen. If you need any help, please feel free to ask us!

Patient Information

Name ____ Date of Birth________________ Sex: Male/Female

SS# __________________________ Driver's License #__________________ Nickname _________________________

Status: Married, Single, Divorced, Widowed, Minor

Address ____ City ______________ State ______ Zip ______________

Cell Phone ______________________ Home Phone _______________________ Work Phone ________________________

Email ___________________________________

Employer Name ________________________________ (If minor, name of school)

Employer Address ______________________________ City _____________ State ______ Zip _________

Emergency Contact _____________________ Phone ____________________________

Please circle how you heard about our practice?

Flyer in Mail	Internet Search	Insurance Plan	Facebook	Exterior Sign	Newspaper Ad	School Sponsor Ad	Friend/Relative

If you were referred by a current patient, whom may we thank? ____________________________

Other: ________________

Responsible Party/Insurance Policy Holder

○ Please check here if this is same as above

Name of Policy Holder _____________________________________ Relationship to Patient _______________

Address __________________________________ City ______________ State _____ Zip ___________

Date of Birth ___________SSN _________________ Phone # _____________ Email __________________________

Employer Name ______________________________

Employer Address ___________________________City _____________State_____ Zip __________

Dental Insurance Company Name _______________________________ Group# _______________

Policy/Subscriber ID# __________________________

Insurance Address ______________________________ City ______________State ______ Zip ____________

I authorize release of any information required in the course of the examination and/or treatment. I permit payment of insurance benefits directly to the dentist for services rendered. I recognize and accept responsibility for payment of services not covered by insurance benefits.

Responsible Party's Signature ___________________________________ **Date** _________________

Dental History
We want to make you smile!

Are your teeth sensitive to hot/cold?............ Yes No
Are your teeth sensitive to sweet/sour?......... Yes No
Have any sores in/around mouth?.............. Yes No
Have you noticed any mouth odors?.............. Yes No
Do you have loose teeth?.............................. Yes No
Do you have pain in your teeth?.................... Yes No
Difficulty opening/closing mouth?................ Yes No
Difficulty chewing?.. Yes No
Ever had periodontal treatment?............ Yes No

Do you grind your teeth? Yes No
Have you ever had braces? Yes No
Difficult extractions in past? Yes No
Do you have frequent headaches? Yes No
Do your gums bleed when flossing? Yes No
Have you ever had head/neck injury? Yes No
Do you wear dentures? Yes No
If yes, date of placement: __________________

Do you have dental anxiety?...................... Yes No
If yes, would you be interested in sedation dentistry? ______________________

Do you want whiter teeth? Yes No (If yes, ask us how to get free whitening for life!)
Do you want straighter teeth? Yes No
Do you like your smile? Yes No
Would you change anything about the appearance of your teeth? ______________________

How often do you brush your teeth? ______________________

Do you own an electric toothbrush? ______________________

Date of last dental exam? ______________________

Date of last cleaning visit? ______________________

How often do you floss? ______________________

Previous Dentist's Name ______________________ Address ______________________

If there is anything else about having dental treatment that you would like us to know or if you had an experience in the past that you would like to share with us, please describe:

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Seamless Dentistry

MEDICAL HISTORY

PATIENT NAME ______________________ Birth Date ______________________

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: ______________________

Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: ______________________

Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: ______________________

Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: ______________________

Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No ______________________

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No ______________________

Are you on a special diet? ◯ Yes ◯ No

Do you use tobacco? ◯ Yes ◯ No

Do you use controlled substances? ◯ Yes ◯ No

Women: Are you

Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs

☐ Other If yes, please explain: ______________________

Do you have, or have you had, any of the following?

Condition		Condition		Condition		Condition	
AIDS/HIV Positive	◯ Yes ◯ No	Cortisone Medicine	◯ Yes ◯ No	Hemophilia	◯ Yes ◯ No	Radiation Treatments	◯ Yes ◯ No
Alzheimer's Disease	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No	Hepatitis A	◯ Yes ◯ No	Recent Weight Loss	◯ Yes ◯ No
Anaphylaxis	◯ Yes ◯ No	Drug Addiction	◯ Yes ◯ No	Hepatitis B or C	◯ Yes ◯ No	Renal Dialysis	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Easily Winded	◯ Yes ◯ No	Herpes	◯ 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
Artificial Heart Valve	◯ Yes ◯ No	Excessive Bleeding	◯ Yes ◯ No	Hives or Rash	◯ Yes ◯ No	Shingles	◯ Yes ◯ No
Artificial Joint	◯ 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	Frequent Diarrhea	◯ Yes ◯ No	Leukemia	◯ Yes ◯ No	Stomach/Intestinal Disease	◯ Yes ◯ No
Breathing Problem	◯ Yes ◯ No	Frequent Headaches	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
Bruise Easily	◯ Yes ◯ No	Genital Herpes	◯ 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	Hay Fever	◯ 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	Venereal Disease	◯ Yes ◯ No
						Yellow Jaundice	◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No ______________________

Comments: ______________________

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To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN ______________________ DATE ______________________

We gladly accept Your Dental Insurance!

In order for us to honor your dental insurance, please be sure to provide us with your dental insurance card. Please note that all professional services are rendered and charged to you, not your insurance company. We will file your primary insurance for you, however because most plans only cover a portion of the dental fee, you will be asked to pay the deductibles and co-payment amounts not covered at the time of service. Please understand that the contract is between you and your insurance company and payment for services is your responsibility. While we do try to help you maximize your benefits, our office will not enter into a dispute with your insurance company over your claim. Our insurance department will file your claim one time. If at the end of sixty (60) days, your insurance has not paid, you will be responsible for the entire balance regardless of benefit expectations. We recommend you become directly involved in communication with your insurance company in order in expedite payment. Upon request, we will supply you with a copy of your insurance claim so you may resubmit it if necessary. If verification cannot be made you will be responsible for full charges to be paid at the time of services. Please take the time to review your contract thoroughly so we may better serve you. If you have any questions or concerns about a procedure that may not be covered by your insurance company, we encourage you to contact your insurance company directly. You may feel free to ask any team member of our office for clarification on services, billing, and insurance.

Usual & Customary Fees:
Our fees are what is usual and customary in our area, not what your insurance company feels are usual and customary. You are responsible for any fees that are above your insurance company's usual and customary fees unless we have a contract fee with your insurance company or are a participation preferred provider (PPO) for your insurance company.

Fee Schedule:
Some insurance plans pay from a fee schedule. We may not have your insurance company's fee schedule. In order for us to accept assignment for your insurance, you will need to provide us with a copy of your fee schedule. You will find this in your benefits book or you can obtain it from your human resources department.

Patient Agreement to above and the following:

- ✓ We only verify if you have coverage and the basic breakdown of your benefits. You are responsible for knowing what services your insurance company does and does not cover and when services were last rendered to you.
- ✓ If after 30 days you insurance company has not paid, it is your responsibility to call your insurance company to see why they have not paid your claim.
- ✓ You are responsible to pay all deductibles and co-payments at the time of your service. If you cannot pay in full you may set up financial arrangements prior to your service.
- ✓ Insurance companies do not guarantee us payments so any fees stated to you are **estimates only**.
- ✓ We must be able to verify that you have coverage with this insurance. If we cannot verify your insurance you will have to pay for your visit in full and we will provide you with the proper paperwork to file your claim.
- ✓ You are responsible for any monies that your insurance company does not cover, i.e. alternate benefits, oral cancer screening, denied claims due to missing tooth clause, frequency of services, age limitations, deductibles, plan limitation, etc.

We understand that it can be frustrating and confusing when it comes to your dental insurance. We want you to know that our team is committed to making your visit with us a positive one! The dental treatment in our office will never be based on what your dental insurance does or does not cover. Your overall health is our main priority.

I understand my insurance plan may not cover for all services. I will be responsible for any non-covered services. I agree to be fully responsible for a timely payment of the charges amount.

____________________________________ ____________________

Patient/Responsible Party Date

Patient Financial Policy

Thank you so much for choosing our office for you and your family. We try to make your experience with us like no other and we are dedicated to giving you the best dental care possible. We try to make it possible to get you dental care because your health is so important to us. We do currently offer same day dentistry to save you trips to our office. All financial arrangements must be made with a Financial Coordinator prior to starting any treatment. We accept cash, money order, checks, debit cards and most major credit cards. The following is our financial policy. We do require that you read and sign prior to any treatment.

Flexible Payment Plans~

We make it a priority to find a payment plan that fits your budget so you can get the dental care you deserve! We have seen so many families that cannot afford dental care due to financial reasons. This includes patients with or without dental insurance. We want to make it possible for you to have healthy, beautiful teeth without breaking the bank! So we can fit your dental care into your budget, we gladly offer a range of payment options to meet most patient's needs. Again, financial arrangements must be made with the Financial Coordinator prior to starting treatment. All in house payment plans must be paid accordingly or a $25 fee will incur for each instance. If multiple payments are declined, treatment will cease until payment is current and future treatment is paid in full. If treatment has been completed, full payment will be due immediately.

Insurance~

We accept and are in network with most major insurance companies. Please provide us with your dental card. As you can imagine, it is virtually impossible to know each patient's insurance coverage for there are thousands of different plans. We only verify if you have coverage and the basic breakdown of your benefits. You are responsible for knowing what services your insurance company does and does not cover and when services were last rendered to you. Please understand that this contract is between you and your insurance company and payment for services is your responsibility. Our insurance department will gladly file your claim one time. If at the end of 60 days, your insurance company had not paid, you will be responsible for the entire balance.

Office fees/Other~

If you present a check for insufficient funds, or place a stop payment on an issued check, you will be charged a $35 fee for processing. Insufficient fund will not be reprocessed and you must pay by cash, credit card or money order. If you are not on a payment plan, all balances are due at time of service. Any past due balances will go to collections after 90 days.

Broken Appointment Policy~

Please consider your scheduled appointments carefully. In order to allow the best possible care for our patients we reserve time on our schedule just for you. We require a 48 hour cancellation notice. Although we understand things come up, if we do not receive a 48 hour cancellation notice you may be charged with a broken appointment fee. We appreciate your promptness and your consideration in not changing your scheduled time.

I understand and agree to the financial policy of Seamless Dentistry. Regardless of what my insurance pays, I am ultimately responsible for the timely payment of my account and I hereby authorize the payment of my dental insurance benefits to be made directly to Seamless Dentistry.

____ ____________________

Patient/Responsible Party Date

Acknowledgement of Receipt
For Notice of Privacy Practices

Patient Name: ___________________________________

I have received a copy of the Notice of Privacy Practices for the above named practice.

____ ______________________
Patient/Responsible Party Date

For Office Use Only

We are unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because of the following:

- ☐ **An emergency existed and a signature was not possible at this time.**
- ☐ **The individual refused to sign.**
- ☐ **A copy was mailed with a receipt for a signature by return mail.**
- ☐ **Unable to communicate with the patient for the following reason:**

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- ☐ **Other:** ____

Team Member: _____________________________________ **Date:** ________________________

Notice of Privacy Practices

This Notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review carefully. The privacy of your health information is important to us.

USES AND DISCLOSURES OF HEALTH INFORMATION
We may use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to another dentist or healthcare provider providing treatment to you, or if we refer you to another health care provider.

Payment: We may use and disclose your health information to obtain payment for services we provide to you. We may need to share part of your health information with our billing department, your insurance company, collection agencies or attorneys assisting us with collections, and others who are responsible for your bills, such as your spouse, as necessary for us to collect payment. For example, we may give information about a dental procedure that you had to your dental insurance company so it will pay us or reimburse you for your dental procedure.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, and licensing or credentialing activities.

To Your Family, Friends, and Other Persons Involved in Your Care: We may share with a family member, friend or other person identified by you, your health information that is directly related to that person's involvement in your care or payment for your care, or to notify such individuals of your location or general condition, but only if you agree that we may do so, or, based on our professional judgment, we determine that you would not object to the disclosure. We will also use our professional judgment and our experience in allowing a person to pick up supplies, x-rays, or other similar forms of health information on your behalf.

Use and Disclosure of Health Information Required by Law: We may use and disclose your health information when required by federal or state law; when required in court or administrative proceedings; for public health activities; to health oversight agencies; to coroners, medical examiners, and funeral directors; to the military; to federal officials for lawful intelligence and national security activities; to correctional institutions regarding inmates; to law enforcement officials; to report abuse, neglect, or domestic violence; to avert a serious threat to your health or safety or the health and safety of others; and as authorized by state worker's compensation laws.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Contacting You: We may use and disclose your health information to contact you about appointments and other matters, and to send you electronic billing statements. We may contact you by telephone, email, or mail. We may leave you messages at the telephone number you give us.

Health-Related Services: We may use and disclose your health information to send you information by mail or email about our health-related products and services available to you, general dental health news and information, and offers available only to our patients. We will tell you how to cancel these communications.

Your Authorization: s explained in this Notice, we may use and disclose your health information for treatment, payment, or health care operations; in certain situations if you agree or object; as required by law; to contact you; and to send you health-related information, but we cannot use or disclose your health information for any other reason without your written authorization. You may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any uses or disclosures already made with your authorization while it was in effect.

PATIENT RIGHTS

Right to See and Copy Your Health Information: You have the right to see or get copies of your health information, with limited exceptions. If we deny your request due to one of these exceptions, we will respond to you in writing with the reason we cannot grant your request, and describe any rights you may have to request a review of our denial. You must make a written request us to access your health information. Your written request must be signed and dated. We may charge you a fee for expenses such as copies, staff time, and postage. Instead of providing you with a copy of your health information, we may prepare a summary or an explanation of your health information for a fee, if you agree in advance to the form and fee of the summary or explanation.

Right to Accounting of Disclosures of Your Health Information: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, and healthcare operations, and certain other activities for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a fee for responding to these additional requests. You must submit a written request that is signed and dated.

Right to Request Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information, including uses or disclosures for treatment, payment, and health care operations, and to family members, friends, or others involved in your care or payment for your care. We are not required to agree to these additional restrictions, but if we do we will abide by our agreement (except in certain situations, such as to provide you with emergency treatment).

Right to Request Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. For example, you can ask that we only contact you at work, or only by mail. You must make your request in writing and your request must be signed and dated. Your request must specify the ways in which you wish to be contacted. You do not need to tell us the reason for your request.

Right to Request Amendment: You have the right to request that we amend your health information. You must submit a written request that is signed and dated. Your request must explain why your health information should be amended.

Right to Written Notice: If you receive this Notice on our website or by email, you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact our Office: Seamless Dentistry

Phone: 704-938-0559

Address:

4949 Professional Park Drive Suite 203
Kannapolis, NC 28081

****You make keep this Notice for your records. Page 6 will be a signed acknowledgement of receipt for our office.**