POLICY REGARDING DENTAL INSURANCE

As a courtesy to our patients, we will be happy to complete and file insurance claims for you. This service is done at no charge to you. But please note:

Dental insurance is a contract between you and your insurance carrier and has nothing at all to do with Wakefield Family Dentistry or Dr. Jennifer Q. Le, DMD PA. Our dental services are rendered to you and not your insurance company.

Your insurance benefits are determined only by the type of policy you have. Each policy is different. Since some policies provide more coverage than others, you should ask your employer about the particular benefits covered under your policy (or call your insurance company directly).

Most insurance companies will provide pre-estimates of benefits if requested by our office. While we do not routinely request pre-estimates, please inform a member of our staff if you wish us to do so for you. Please note a pre-estimate is still not a guarantee of payment.

Dental insurance is only an aid to help you pay for your professional dental services and is not intended to cover 100% of costs. Any unpaid portion is your responsibility.

We hope the above answers any insurance questions you may have. Please do not hesitate to ask our staff if you have additional questions.

__________________________  _________________________
Patient’s Signature              Date
OUR POLICY REGARDING ACCOUNT BALANCES

We value all of our patients and, for that reason, we try to keep all accounts in good standing. Therefore;

1. The portion of the service fee not covered by insurance is due at time of service. Payment may be made in cash or by any major credit card.

2. While we can estimate probable insurance coverage, please understand that this is only an estimate based on the best information available to us and is not guaranteed to be 100% accurate.

3. If your insurance company has not remitted payment after 45 days, the balance will automatically become your responsibility.

4. Any balance which remains unpaid after 45 days, whether partially paid by insurance or not, may be charged interest at a rate of 1.5% per month.

5. If you find that you are unable to pay the entire balance at once, please speak with any member of our staff about a Dental Payment Plan (Care Credit), which is available to qualified applicants.

Hopefully, the above information has been helpful. Questions regarding our office policies are strongly encouraged.

__________________________  ________________________
Patient’s Signature               Date

__________________________
Patient’s Printed Name
Dental Patient Registration

Patient Information

First Name: ___________________________ Middle: ___________________________ Last: ___________________________

How did you hear about us? ___________________________ Preferred Name: ___________________________

Address: __________________________________________________________

City, State, Zip: _____________________________________________________

Home Phone: ___________ Work Phone: ___________ Ext: ___________ Cellular: ___________________________

Email address: _______________________________________________________

By checking this box I agree to receive communications from the office regarding updates and promotions.

Birth Date: ___________________________ Social Security #: ___________________________

Sex: Male Female

Marital Status: Married Single Divorced Separated Widowed

How long has it been since your last dental exam? ___________________________

Insurance Information

Patient’s Relationship to Insurance Carrier: Self Spouse Child Other

Name of Insured if not patient: First: ___________________________ Middle: ___________________________ Last: ___________________________

Insured Address: _____________________________________________________

City, State, Zip: _____________________________________________________

Home Phone: ___________ Work Phone: ___________ Ext: ___________ Cellular: ___________________________

Insured Birth Date: ___________________________ Insured Soc Sec: ___________________________

Employer: __________________________________________________________

Insurance Company: _________________________________________________

Address: __________________________________________________________

City, State, Zip: _____________________________________________________

Phone: ___________________________
Please list all current medications:

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dosage</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>

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

Have you ever had a serious head or neck injury?  
- Yes  
- No

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

Are you HIV Positive or have you been diagnosed with AIDS?  
- Yes  
- No

Are you allergic to any of the following?  
<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aspirin</td>
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</tr>
<tr>
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<td></td>
<td></td>
</tr>
<tr>
<td>Acrylic</td>
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<tr>
<td>Metal</td>
<td></td>
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</tr>
<tr>
<td>Latex</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Local Anesthetics</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Do you use controlled substances?  
- Yes  
- No

Are you on a special diet?  
- Yes  
- No

Have you ever been hospitalized or had a major operation?  
- Yes  
- No

Have you ever had a serious head or neck injury?  
- Yes  
- No

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

Are you HIV Positive or have you been diagnosed with AIDS?  
- Yes  
- No

Are you under a physician’s care now?  
- Yes  
- No

Have you ever been hospitalized or had a major operation?  
- Yes  
- No

Do you use tobacco?  
- Yes  
- No

Do you use controlled substances?  
- Yes  
- No

Are you HIV Positive or have you been diagnosed with AIDS?  
- Yes  
- No

Are you allergic to any of the following?  
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Do you have, or have you had, any of the following?  
- Yes  
- No

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

Please list all current medications:

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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 ___________________________
Medical History Continued:

Current Primary Care Physician Name: ________________________________

Address: ________________________________

_____________________________________

_____________________________________

Phone: ________________________________

Fax: ________________________________

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 __________________________
CONSENT FOR USE AND DISCLOSURE
OF HEALTH INFORMATION

Section A-Patient Giving Consent

Name ___________________________________________________________________________________________
Address __________________________________________________________________________________________
Telephone _____________________________________________ Email ____________________________
Patient # ______________________________________ Social Security # _____________________________________

Section B-TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations at the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices including any revisions of our Notice at any time by contacting:
Contact Person: Jennifer Q. Le, DMD
Telephone: 919-488-0111
Fax: 919-488-0104
Address: 2810-115 Wakefield Pines Drive, Raleigh, NC 27614

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of you revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, __________________________________________________________________________, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment.

Signature: ___________________________________ Date: ____________________________

If a personal representative on behalf of the patient signs this Consent, complete the following:

Personal Representative’s Name: ____________________________________________
Relationship to Patient: ______________________________________________________

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES

*You May Refuse to Sign This Acknowledgement*

I, _______________________________________________________________________, have received a copy of this office’s Notice of Privacy Practices.

___________________________________________________________
Please Print Name

___________________________________________________________
Signature

___________________________________________________________
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communication barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (Please Specify)

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________
Office Policies
Effective 04/26/2006

- **A complete exam includes x-rays.** The x-rays consist of 4 Bitewing x-rays, a panoramic x-ray and periapical (root x-ray) x-rays of certain teeth. Anything not covered by insurance will be your responsibility. If you have recent x-rays (bite wings less than one year and panoramic less than three years) at another dentist we ask you to have them emailed to us.

- If you have not had regular dental care it may be necessary to perform a general debridement in order to diagnose the health of your gums. A scaling and root planing may be recommended in some case. If either of these procedures is necessary the hygienist will discuss this with you prior to treatment.

- An adult, 18 years old or older, must accompany all patients under the age of 18. A signed waiver may be accepted from a parent/guardian for certain procedures.

- Your estimated portion is due at the time service is rendered. There are times when an insurance company will pay more than expected. In these circumstances any money owed to the patient under the amount of $100.00 will be left as a credit on the account. Refunds will be mailed within 4 to 6 weeks.

- Patients that cancel without a **24-hour notice** or no show will be charged a cancellation fee of **$25.00 per half hour**.

- There will be a fee of **$ 40.00** for all **returned checks**.

- We are happy to file insurance for you but please be aware that any portion not paid by your insurance will be your responsibility. We contact your insurance company prior to your new patient appointment to verify benefits and to obtain a general benefits breakdown. We will give you an estimate for any proposed treatment however it is your responsibility to be familiar with your dental plan. We are not responsible for any discrepancies between our estimate and the actual payment from your insurance company.

**PLEASE NOTICE:**
It is our office philosophy to try to provide our patients with the most up to date techniques and materials available in dentistry. When doing fillings, we use composite resin (tooth colored fillings) because they allow a more conservative and esthetic result. Amalgam (silver) fillings are reserved for circumstances when proper isolation is difficult. We understand that you may prefer to have amalgam fillings. If so, we can refer you to a dentist nearby.

**Some insurance companies do not cover composite resins, only amalgam (silver).** Once Dr. Le has gone over your treatment plan with you we will give you a print out of the total **estimated** charges. The **estimate** will have a break down of your portion and the insurance portion. We will not know the exact amount of coverage until the claim has been submitted, and we receive payment.

We appreciate the opportunity to provide you with care, in understanding that these office policies help our office run smoothly. If you would like a copy of our office policies please let us know.

I ____________________________________________ have read the information and fully understand its content.

_____________________________________________  _________________________
Signature    Date
### Compound Authorization for Release of Information

**Wakefield Family Medicine & Dentistry** is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient’s instructions.

<table>
<thead>
<tr>
<th>Entity to Receive Information</th>
<th>Description of information to be released</th>
</tr>
</thead>
<tbody>
<tr>
<td>Voice Mail</td>
<td>Results of lab tests/x-rays</td>
</tr>
<tr>
<td>Give information to employer</td>
<td></td>
</tr>
<tr>
<td>Give information to school</td>
<td>Appointment absentee information</td>
</tr>
<tr>
<td>Spouse</td>
<td>Family billing information</td>
</tr>
<tr>
<td></td>
<td>Financial</td>
</tr>
<tr>
<td></td>
<td>Medical as follows:</td>
</tr>
<tr>
<td>Parent (provide name)</td>
<td>Family Billing Information</td>
</tr>
<tr>
<td></td>
<td>Financial</td>
</tr>
<tr>
<td></td>
<td>Medical as follows:</td>
</tr>
<tr>
<td>Other (provide name)</td>
<td>Financial</td>
</tr>
<tr>
<td></td>
<td>Medical as follows</td>
</tr>
<tr>
<td>Support Group (provide name)</td>
<td>Demographic Information</td>
</tr>
</tbody>
</table>

### Rights of the Patient

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 by sending a written notification to Wakefield Family Medicine & Dentistry.

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 re-disclosure 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.

Signature of Patient or Personal Representative

Description of Personal Representative’s Authority (attach necessary documentation)

---

Jennifer Q. Le, DMD, CPCC, ACC  
*Diplomate of American Board of Dental Sleep Medicine*
The Epworth Sleepiness Scale

Name: ______________________________________     Today’s Date: _____________________

Age (years): ___________________        Sex:         ____ Male          ____ Female

This test is used world-wide to assess your level of sleepiness. This scale is not to be used to make a diagnosis but will help to identify your own level of daytime sleepiness.

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you.

Use the following scale to choose the most appropriate number for each situation.

0 = would never doze
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

<table>
<thead>
<tr>
<th>Situation</th>
<th>Chance of Dozing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sitting and reading</td>
<td></td>
</tr>
<tr>
<td>Watching TV</td>
<td></td>
</tr>
<tr>
<td>Sitting, inactive in a public place (e.g. theater or meeting)</td>
<td></td>
</tr>
<tr>
<td>As a passenger in a car for an hour without a break</td>
<td></td>
</tr>
<tr>
<td>Lying down to rest in the afternoon when circumstances permit</td>
<td></td>
</tr>
<tr>
<td>Sitting and talking to someone</td>
<td></td>
</tr>
<tr>
<td>Sitting quietly after lunch without alcohol</td>
<td></td>
</tr>
<tr>
<td>In a car, while stopped for a few minutes in traffic</td>
<td></td>
</tr>
</tbody>
</table>

TOTAL  ___________________  

A total score of 9 or higher is suggestive of a sleep disorder and your symptoms should be discussed with your provider today. (A score below 9 does not necessarily mean that you do not have a problem).
Getting To Know You!

Patient Name      Date       Birth date
________________________     _______________           _____/______/____

Occupation: ________________________________________________________________

List all family members currently seen at our office: __________________________________

Who selected our office?  □ Self    □ Spouse    □ Parent    □ Employer

How did you hear about our office? ____________________________________________

   □ Referred by friend
   □ Yellow Pages
   □ Relative
   □ Insurance Plan
   □ Welcome Wagon

   □ TV/Radio
   □ Newspaper
   □ Direct Mailings
   □ Sign by Building

Dental History

Why have you come in to see us today? (e.g.: pain, checkup, etc) _______________________
___________________________________________________________________________

Previous Dentist ___________________________ ___ Last Visit________________________

Reasons for changing dentists: ___________________________________________________

What problems have you experienced with past dental treatment? _________________________
___________________________________________________________________________

Are you nervous about seeing the dentist?  □ No
   □ Yes! If yes, why? ________________

How often do you brush? ______________

Do you floss?  □ No
   □ Yes, How often? ______________

(Please circle each that applies to you)

Y  N  I clench or grind my teeth during the day or while sleeping Y  N  My gums feel tender or swollen.
<table>
<thead>
<tr>
<th><strong>Y/N</strong></th>
<th><strong>My gums bleed while brushing or flossing.</strong></th>
<th><strong>Y/N</strong></th>
<th><strong>I have problems eating.</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Y/N</strong></td>
<td><strong>I like my smile. Rate smile from 1 to 10.</strong></td>
<td><strong>Y/N</strong></td>
<td><strong>I have had braces.</strong></td>
</tr>
<tr>
<td><strong>Y/N</strong></td>
<td><strong>I prefer tooth-colored fillings.</strong></td>
<td><strong>Y/N</strong></td>
<td><strong>I have had a facial or jaw injury.</strong></td>
</tr>
<tr>
<td><strong>Y/N</strong></td>
<td><strong>I avoid brushing part of my mouth due to pain.</strong></td>
<td><strong>Y/N</strong></td>
<td><strong>I want my teeth straight.</strong></td>
</tr>
<tr>
<td><strong>Y/N</strong></td>
<td><strong>I am interested in learning more about sleep apnea.</strong></td>
<td><strong>Y/N</strong></td>
<td><strong>I want my teeth whiter.</strong></td>
</tr>
<tr>
<td><strong>Y/N</strong></td>
<td><strong>I like listening to music to help me relax during my appointment.</strong></td>
<td><strong>Y/N</strong></td>
<td><strong>I have a history of oral cancer.</strong></td>
</tr>
<tr>
<td><strong>Y/N</strong></td>
<td><strong>I’ve been told previously I have gum disease.</strong></td>
<td><strong>N</strong></td>
<td></td>
</tr>
</tbody>
</table>

What are your dental priorities?  
(e.g.: dental health, financial considerations, etc.)

I would like to improve my smile by  
(e.g.: give examples of what you want to discuss with the dentist, straighten teeth, whiten teeth, etc.)