



Jennifer Q. Le, DMD, CPCC, ACC
Diplomate of American Board of Dental Sleep Medicine

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



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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



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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: _____

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Medical History

NAME: _____

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? | <input type="radio"/> Yes | <input type="radio"/> No | If yes, please explain: _____ |
| Have you ever been hospitalized or had a major operation? | <input type="radio"/> Yes | <input type="radio"/> No | If yes, please explain: _____ |
| Have you ever had a serious head or neck injury? | <input type="radio"/> Yes | <input type="radio"/> No | If yes, please explain: _____ |
| Do you take, or have you taken, Phen-Fen or Redux? | <input type="radio"/> Yes | <input type="radio"/> No | If yes, please explain: _____ |
| Are you on a special diet? | <input type="radio"/> Yes | <input type="radio"/> No | If yes, please explain: _____ |
| Do you use tobacco? | <input type="radio"/> Yes | <input type="radio"/> No | |
| Do you use controlled substances? | <input type="radio"/> Yes | <input type="radio"/> No | |
| Are you HIV Positive or have you been diagnosed with AIDS? | <input type="radio"/> Yes | <input type="radio"/> No | |

Women: Are you
 Pregnant/Trying to get pregnant?
 Nursing?
 Taking Oral Contraceptives?

Are you allergic to any of the following?
 Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics
 Other If yes, please explain: _____

- Do you have, or have you had, any of the following?
- | | | | | |
|--|---|---|---|--|
| <input type="radio"/> AIDS/HIV Positive | <input type="radio"/> Chest Pains | <input type="radio"/> Frequent Headaches | <input type="radio"/> Irregular Heartbeat | <input type="radio"/> Scarlet Fever |
| <input type="radio"/> Alzheimer's Disease | <input type="radio"/> Cold Sores/Fever Blisters | <input type="radio"/> Genital Herpes | <input type="radio"/> Kidney Problems | <input type="radio"/> Shingles |
| <input type="radio"/> Anaphylaxis | <input type="radio"/> Congenital Heart Disorder | <input type="radio"/> Glaucoma | <input type="radio"/> Leukemia | <input type="radio"/> Sickle Cell Disease |
| <input type="radio"/> Anemia | <input type="radio"/> Convulsions | <input type="radio"/> Hay Fever | <input type="radio"/> Liver Disease | <input type="radio"/> Sinus Trouble/Sleep Apnea |
| <input type="radio"/> Angina | <input type="radio"/> Cortisone Medicine | <input type="radio"/> Heart Attack Failure | <input type="radio"/> Low Blood Pressure | <input type="radio"/> Spina Bifida |
| <input type="radio"/> Arthritis/Gout | <input type="radio"/> Diabetes | <input type="radio"/> Heart Murmur | <input type="radio"/> Lung Disease | <input type="radio"/> Stomach/Intestinal Disease |
| <input type="radio"/> Artificial Heart Valve | <input type="radio"/> Drug Addiction | <input type="radio"/> Heart Pace Maker | <input type="radio"/> Mitral Valve Prolapse | <input type="radio"/> Stroke |
| <input type="radio"/> Artificial Joint | <input type="radio"/> Easily Winded | <input type="radio"/> Heart Trouble/Disease | <input type="radio"/> Pain in Jaw Joints | <input type="radio"/> Swelling of Limbs |
| <input type="radio"/> Asthma | <input type="radio"/> Emphysema | <input type="radio"/> Hemophilia | <input type="radio"/> Parathyroid Disease | <input type="radio"/> Thyroid Disease |
| <input type="radio"/> Blood Disease | <input type="radio"/> Epilepsy or Seizures | <input type="radio"/> Hepatitis A | <input type="radio"/> Psychiatric Care | <input type="radio"/> Tonsillitis |
| <input type="radio"/> Blood Transfusion | <input type="radio"/> Excessive Bleeding | <input type="radio"/> Hepatitis B or C | <input type="radio"/> Radiation Treatments | <input type="radio"/> Tuberculosis |
| <input type="radio"/> Breathing Problem | <input type="radio"/> Excessive Thirst | <input type="radio"/> Herpes | <input type="radio"/> Recent Weight Loss | <input type="radio"/> Tumors or Growths |
| <input type="radio"/> Bruise Easily | <input type="radio"/> Fainting Spells/Dizziness | <input type="radio"/> High Blood Pressure | <input type="radio"/> Renal Dialysis | <input type="radio"/> Ulcers |
| <input type="radio"/> Cancer | <input type="radio"/> Frequent Cough | <input type="radio"/> Hives or Rash | <input type="radio"/> Rheumatic Fever | <input type="radio"/> Venereal Disease |
| <input type="radio"/> Chemotherapy | <input type="radio"/> Frequent Diarrhea | <input type="radio"/> Hypoglycemia | <input type="radio"/> Rheumatism | <input type="radio"/> Yellow Jaundice |

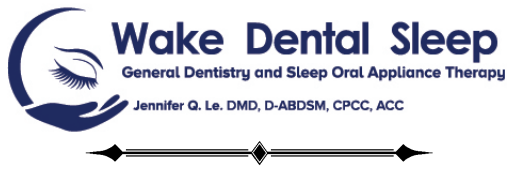
None of the conditions listed

Have you ever had any serious illness not listed above? Yes No If yes, please explain: _____

Please list all current medications:

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 _____



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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 _____



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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.



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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)



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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



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Compound Authorization for Release of Information

Name of Patient _____ Date of Birth _____

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.

Entity to Receive Information. Check each person/entity that you approve to receive information.	Description of information to be released. Check each that can be given to person/entity on the left in the same section.
<input type="checkbox"/> Voice Mail	<input type="checkbox"/> Results of lab tests/x-rays <input type="checkbox"/> Other
<input type="checkbox"/> Give information to employer <input type="checkbox"/> Give information to school	<input type="checkbox"/> Appointment absentee information
<input type="checkbox"/> Spouse	<input type="checkbox"/> Family billing information <input type="checkbox"/> Financial <input type="checkbox"/> Medical as follows:
<input type="checkbox"/> Parent (provide name)	<input type="checkbox"/> Family Billing Information <input type="checkbox"/> Financial <input type="checkbox"/> Medical as follows:
<input type="checkbox"/> Other (provide name)	<input type="checkbox"/> Financial <input type="checkbox"/> Medical as follows
<input type="checkbox"/> Support Group (provide name)	<input type="checkbox"/> Demographic Information

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.

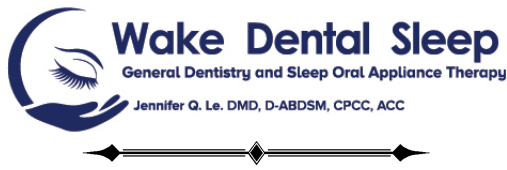
I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

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.

Date _____

Signature of Patient or Personal Representative

Description of Personal Representative's Authority (attach necessary documentation) _____



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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

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



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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 Mail
- Sign by Building
- Other _____

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.

Y N My gums bleed while brushing or flossing.

Y N I have problems eating.

Y N I like my smile. Rate smile from 1 to 10 _____

Y N I have had braces.

Y N I prefer tooth-colored fillings.

Y N I have had a facial or jaw injury.

Y N I avoid brushing part of my mouth due to pain.

Y N I want my teeth straight.

Y N I am interested in learning more about sleep apnea.

Y N I want my teeth whiter.

Y N I like listening to music to help me relax during my appointment.

Y N I have a history of oral cancer.

Y N I've been told previously I have gum disease.

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.)