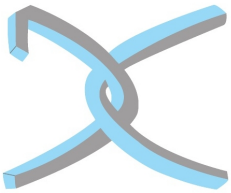
WELCOME TO OUR OFFICE



8732 University City Blvd
Charlotte, NC 28213
Phone: 704-549-1911
Fax: 704-549-1834
Information@thedentalconnection.net

Date:

Patients Name: _____ ☐M ☐F (check one) DOB _____/_____/_____
Last Mi First

SSN _____-_____-_____ Nickname _____

Home Address _____
City State ZIP CODE

Home Phone (_____)_____ Cell Phone (_____)_____ Email _____

Check one: ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed

In Case of Emergency Notify _____ Phone (_____)_____ Relationship _____

How did you hear about us? *(circle all that apply)*
Friend, Family, Co-worker, Insurance Website, Web Search, Phone Book, Postcard, Other _____

Account Information *(person who is responsible for this account)*
☐Self ☐Parent ☐Guardian *(paperwork must be provided)* ☐Other _____*(please explain)*

Name _____ Address _____ Phone (_____)_____

Insurance Information (if no Insurance check NONE and proceed to next section)

☐SELF Spouse ☐NONE ☐ Other _____☐_____

Policy Holder _____ DOB _____/_____/_____ SSN _____-_____-_____
Last Mi First

Policy Holders Employer_____ Dental Insurance Carrier_____

Member ID# _____ Group #_____ Customer Service # _____

** Did you know flex spending accounts (FSA's) can be used for Dental Services? Do you have a Flexible Spending Account? ☐ Yes ☐ No

I hereby accept responsibility for payment of this account. By signing below, I am aware that any balance of 60 days from each Service may be subject to a late fee penalty of 1.5% per month (18% per year). I also understand that any fees incurred in the Collection of this account, including attorney's fees, will be added to the balance, and will be payable by the responsible party. Any financial arrangements differing from these listed should be discussed and agreed upon in writing by both parties prior to the patient receiving treatment. After the second billing statement for a balance past due, we utilize an Account Management firm and an account management fee will be applied after appropriate notice by mail.

Signature X_____ Date _____
(Responsible party)

INSURANCE-RELEASE OF INFORMATION & ASSIGNMENT OF BENEFITS

In requesting examination and/or treatment, I authorize the release of all information (including "x—rays") necessary to process my claims. I authorize this office to affix my name to any and all insurance claims. I also authorize payment to be made directly to Modlin & Londry, DDS PLLC (d.b.a. dental connection) by my ins benefits otherwise payable to me, for professional services rendered. I understand that payment from my insurance company cannot be guaranteed despite any oral representations or reassurances by Employees of this practice, and I agree that I am financially responsible for and agree to pay any charges not covered by insurance. Payment will be due on any outstanding balance by 60 days from the date of each service, regardless of the status of any insurance claims. In the event that your dental insurance company sends you payment for services rendered by our office you must turn over any and all monies in a timely fashion. Failure to do so will result in your account being placed with our Account Management Firm. I authorize this office to contact and exchange information with credit agencies regarding any credit extended on my account.

Signature X _____ Date _____
(Patient, or parent if minor)

MEDICAL HISTORY

PATIENT NAME: _____

Height_____ Weight _____ Rate Health 1-10 _____

Do you have or have you ever had any of the following diseases, conditions or medical procedures?
(First read all conditions in the list, *then* circle either "Yes" answers or "No" answers to the left)

Any Troubles, Surgeries, defects, with these major organs:

Y N **Heart**: Attack, Angina/Pain, Murmur / MVP or other defect, Rapid Beat / Arrhythmias, Congestive Failure, Pacemaker, Surgeries: Bypass, Valve Replacement _____

Y N **Lung**: Asthma, Emphysema, Short of Breath, Cancer, TB, COPD, Other _____

Y N **Liver**: Hepatitis (types A, B, C), Jaundice / Cirrhosis, Enlargement, Cancer, Surgeries, Damage due to Alcohol or Drugs

Y N **Kidney / Bladder**: Stones, Cancer, Surgeries: Transplant, Removal, Non Functioning _____

Please summarize any other surgeries or further details from above: _____

_____

Do you have or have you had any of the following diseases, conditions, or medical procedures?

No Blanks, and please circle appropriate selection where more than one is listed.

Y N Blood Pressure, High or Low or Borderline
Y N Clotting / Bleeding Problems / Vascular Problems
Y N Anemia: Iron, Pernicious (B-12), Sickle Cell
Y N Stroke: Major, TIA's (mini)
Y N Diabetes: Circle 1 2 - Are you a "brittle" diabetic?_____
Y N Other Endocrine (hormone) problems?
Y N Poor or Delayed Healing
Y N Thyroid: Hyper (overactive) or Hypo (underactive)
Y N Seizures/Epilepsy, controlled? Y or N
Y N Cancer/Tumors/Leukemia
Y N Chemotherapy
Y N Radiation Therapy (for cancer)
Y N Occupational Radiation Exposure
Y N Skin Disorders / Rashes / Shingles
Y N HIV+ / AIDS / ARC
Y N Any other Infectious Conditions? _____
Y N Tobacco: Circle: Cigarettes, Cigars or Oral; pks/day____yrs ____
Y N Stomach, GI, IBD, GERD, Ulcers, U. Colitis, Chrohn's, Gluten, Allergy
Y N Fainting Spells
Y N Frequent Headaches / Migraines
Y N Head Injuries
Y N Learning: ADD / ADHD / Dyslexia
Y N Sleep Disorders / Apnea (CPAP used?_____)
Y N Venereal Disease
Y N Jaw Joint (TMJ) Disorders (Biteguard? _____)
Y N Jaw or Facial Surgery
Y N ENT: Circle: Eye, Ear, Nose, Throat, Sinus
Y N Do You Have Difficulty Swallowing?
Y N Nervousness / Depression
Y N Other Psychiatric Disorder (_____)
Y N Alcohol Abuse (treated? _____)
Y N Drug Abuse / IV Drug History
Y N Arthritis, Rheumatism; Back Pain, Neck Pain
Y N Artificial Bones / Joints Replaced? Date_____
Y N Glaucoma
Y N Multiple Sclerosis

Medicine & Drug Allergies

Y N Do you have a **Latex Allergy**?

Y N **Allergies to Any Medicines** (List. Include Antibiotics, Pain Killers, Local Anesthetics: _____

_____

Y N Have you taken any Prescription Steroids for *more than 2 weeks in the last 2 years*? _____

Y N **BLOOD THINNERS**? Circle: Coumadin/Warfarin; Plavix; Pradaxa; Daily aspirin_____mg/ Other Medications:_____

Y N Osteoprosis Medicines? Circle: **alendronate (Fosamax), pamidronate (Aredia), risedronate (Actonel, Atelvia) Zoledronate, (Zometa, Reclast, Aclasta), etidronate (Didronel), raolxifene (Evista), ibandronate (Boniva)**

Women:

Y N Are you pregnant? How long? _____
Y N Are you Nursing?
Y N Are you taking Birth Control Pills?

Please List All Medications You Take:

_____
_____
_____

Authorization for Treatment

I authorize the doctor and staff to perform any necessary dental services needed after diagnosis and oral discussion. I agree that the Information filled out on this form is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his staff responsible for any errors or omissions that I may have made in the completion of this form. I understand it is my responsibility to inform this office of any changes to the information I have provided, including medications.

Print Patient Name _____

Signature X_____ _____

Patient, or Parent, or Legal Guardian Date

DENTAL HISTORY

PATIENT NAME: _____

-What is Your Main Dental Concern? _____

-Approximate Date & Reason for Last Dental Visit _____

-I usually brush _____ times per day and floss _____times per _____.

Y N Are you satisfied with your previous Dental Care?
Y N Are you aware of any Clenching or Tooth Grinding?
Y N Any Pain in Jaw Muscles or Around your Ears?
Y N Do your Jaws Click or Pop?
Y N Do you Currently wear a Biteguard at Night?
How old is the Bite guard? _____yrs
Y N Do your Gums Bleed? Whenever I brush____
Whenever I floss ____
Y N Past Orthodontic Treatment (braces)? Approx. Age _____
Y N Do you wear removable Partial Denture or Complete Denture?
When was it made_____ Last Reline _____

Y N Are you dissatisfied with the appearance of your smile?
Y N Do you have spaces or gaps between your teeth?
Y N Do you have old fillings or dental work which you Perceive to be unattractive?
Y N Do you feel nervous about dental treatment?
Y N Have you ever had a bad experience in a dental office?
Y N Do you have Sensitive teeth?
Y N Does food trap between your teeth?

-Are your teeth (please check the following that apply): Chipped, protruding, crowded or misshapen?
-If you answered yes to being nervous about dental treatment what can we do to alleviate your nervousness?
_____
-If you could change one thing about your smile, what would it be? _____
- How would you like your teeth to look in 15 years? _____

AUTHORIZATION FOR RELEASE OF INFORMATION TO FAMILY AND/OR FRIENDS

MODLIN & LONDRY, DDS PLLC (D.B.A. DENTAL CONNECTION) IS authorized to release protected health info about the above named patient to the entities Named here: _____

The above person(s) may receive the following information: (Please initial each that is subject to authorization)

_____ Financial Information _____ Information from tests or x-rays. _____ Family Billing information

Medical information as follows: _____ other information as described: _____

May we leave information on your voicemail? _____

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 Modlin & Londry, DDS PLLC

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.

This authorization shall be in force and effect until revoked by the patient or representative signing the authorization.

X_____ _____

Signature of Patient, Parent, or Legal Guardian **Date**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This form is posted in our waiting area, and is available online on our website at www.thedentalconnection.net
If requested, I have received a written copy of the Notice of Privacy Practices.

X_____ _____

Signature of Patient, Parent, or Legal Guardian **Date**

IF YOU DO NOT HAVE DENTAL INSURANCE YOU MAY SKIP THIS PAGE

Dental Connection

ABOUT YOUR DENTAL INSURANCE COVERAGE

Dental insurance coverage is ever changing. Our staff is here to help you understand your particular dental insurance coverage. For every patient or family, we contact the insurance company and gather information that helps us *interpret* coverage, with the key word being "interpret."

Although we use a form to gather detailed information about waiting periods, downgrades in treatment coverage, and restrictions of treatment, sometimes an insurance company may not disclose additional information which is out of the norm that would be helpful to us. It is not a perfect "science" in other words.

You can assist us in several ways:

- Please read your policy and try to be familiar with the details of coverage including waiting periods, maximum payment per year, excluded treatment, etc.
- Please ask our receptionist for a listing of the plans we accept. Only the insurance plans that the doctor is signed Up for at this particular address pertain to this practice.
- Before appointing, Please inform us of any change or update with your coverage.
- For any treatment plan that you feel warrants a pre-estimate of pre-authorization, this may give you greater Information about what is covered (but keep in mind this may delay treatment by 30 to 60 days.

The patient should understand that the quality of the insurance is determined by the premium paid for the policy, and there are many levels of dental insurance. There are many policies these days that do not cover at or near 100% for preventative needs (the norm in the past), and the patient should research this ahead of the appointment. We are sometimes asked to make adjustments on the account for payment deficiencies or payment denials by the insurance company, but we are sorry that we are not able to accommodate these types of requests.

It should be understood by each patient, insured, and Financially Responsible Party that by us assuming this role as your assistant in interpreting your dental insurance, the patient, insured, or Financially Responsible Party is the ultimate responsible party in this regard. We will do our best to inform you , but in the end, without exception, and regardless of how competently you feel we have assisted you in interpreting your coverage, any fees due to the office which are not paid by the insurance company are due from the financially Responsible Party.

Is there anything you would like to note about your dental insurance? _____
_____.
_____
_____

X_____ _____

Signature of Patient, Parent, or Legal Guardian, and Financially Responsible Party — Date