PATIENT REGISTRATION

First Name: _____ **Last Name**: _____ **MI**: ___
Patient Is: __ **Policy Holder** **Preferred Name**: _____
__ **Responsible Party**

Responsible Party (IF SOMEONE OTHER THAN THE PATIENT)
Name: _____ **Last Name**: _____ **MI**: ___
Address: _____
City, State, Zip: _____
Home Phone: _____ **Cell Phone**: _____ **Other**:_____
Birth Date: _____**Social Security**: _____**Drivers License**: _____
__ **Responsible Party is also a Policy Holder for Patient** __ **Primary Insurance Holder** __ **Secondary Policy Holder**

Patient Information
Address: _____
City, State, Zip: _____
Home Phone: _____ **Cell Phone**: _____ **Other**:_____
Sex: __Male __Female **Marital Status**: __Married __Single __Divorced __Separated __Widowed
Birth Date: _____ **Age**: ___ **Social Sec**: _____ **Drivers Lic**:_____
Email: _____**I would like to receive correspondences via e-mail** ____
Emergency Contact: _____ **Emergency Contact #**: _____
Employment Status: ___ **Full Time** ___ **Part Time** ___ **Retired**
Student Status: ___ **Full Time** ___ **Part Time**
Medicaid ID:_____ **Employer ID**:_____ **Carrier ID**:_____
Prev. Dentist: _____ **Pref. Pharmacy**: _____

Primary Insurance Information
Name of Insured: _____ Relationship: __ Self __ Spouse __ Child
Insured Social: _____ Insured Birth Date: _____
Employer: _____ Ins. Company: _____
Employer Address: _____
City, State, Zip: _____
Insurance Company Address: _____
City, State, Zip: _____

Secondary Insurance Information
Name of Insured: _____ Relationship: __ Self __ Spouse __ Child
Insured Social: _____ Insured Birth Date: _____
Employer: _____ Ins. Company: _____
Employer Address: _____
City, State, Zip: _____

Medical History
Date:

Patient Name: _____
Date of Birth: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is 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_____
Have you ever been hospitalized? __ Yes __ No If yes_____
Serious head or neck injury? __ Yes __ No If yes_____
Are you taking any medications? __ Yes __ No If yes_____
_____
Do you take, or have you ever taken, Phen-Fen or Redux? __ Yes __ No If yes, when_____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?
__ Yes __ No If yes, when? _____
Are you on a special diet? __ Yes __ No
Do you use tobacco? __ Yes __ No

Women: Are you…

___ Trying to get pregnant ___ Nursing ___ Taking oral contraceptives

Are you allergic to any of the following?

___ Aspirin ___ Penicillin ___ Codeine ___ Acrylic ___ Metal ___ Latex ___ Sulfa Drugs ___ Local Anesthetics
Other _____

Do you use controlled substances? ___ Yes ___ No If yes, what?_____
_____

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

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

Any illness not listed above? _____

Signature: _____ Date: _____

Dr. Nicole Sullens
1998 Hendersonville Road, Suite #21
Asheville, N.C. 28803
(828) 681-2003
Sullens_nicole@bellsouth.net

HIPAA- CONSENT OF INFORMATION

Nicole Sullens DDS, PA, in order to comply with the HIPPA privacy regulation, requires an authorization from the patient before detailed messages are left with the patient. This policy is to protect the privacy of the patient and to protect the physicians and staff of Nicole Sullens DDS, PA from violating the patient's confidentiality. If there is not a singed a consent on file, physician and staff will only leave their name and telephone number on an answering machine, voicemail or with a live person answering the phone requesting the patient to return the call.

By completing the consent below, you are allowing Nicole Sullens DDS, PA physician and its staff to leave a message on an answering machine, voicemail or with a specified individual. You may specify what information is left with whom by noting the information of the bottom of this form. By signing, you are also consenting to the mailing or faxing of any results, requested by you, to your primary care physician or another physician.

I give my consent to Nicole Sullens DDS, PA physicians staff to leave a message regarding scheduling, treatment, surgery, lab or radiology results or other information as necessary (Check all the apply):

__ via text message
__ on an answering machine or voicemail at home or cell phone
__ on an answering machine or voicemail at work
__ with_____relationship_____
__ with_____relationship_____

____ I do not consent to messages being left at home, work or with any other person. I wish to be contacted directly

_____ _____
Patients name (Please Print) Date of birth

_____ _____
Patients signature Date

_____ _____
Witness Date

HIPPA- Notice of Privacy practice acknowledgment

_____ I have been provided a copy of Nicole Sullens DDS, PA notice of privacy practice.

____ I have declined a copy of Nicole Sullens DDS, PA notice of privacy practice.

_____ _____
Patients signature Date

Dr. Nicole Sullens
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(828) 681-2003
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AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name _____

I AUTHORIZE THAT MY DENTIST OFFICE NAMED ABOVE HAS THE AUTHORITY TO RELEASE HEALTH INFORMATION IDENTIFYING ME (INCLUDING IF APPLICABLE; INFORMATION ABOUT HIV/AIDS, SUBSTANCE ABUSE TREATMENT, AND ANY INFORMATION ABOUT MENTAL HEALTH SERVICES)

UNDER THE FOLLOWING TERMS AND CONDITIONS:

1.) **DETAILED DESCRIPTION OF THE INFORMATION TO BE RELEASED**
   - DENTAL X-RAYS / MEDICAL INFORMATION / LAB TESTS

2.) **TO WHOM THE INFORMATION MAY BE RELEASED**
   - OTHER DENTIST / SPECIALIST / MEDICAL PROFESSIONAL

3.) **THE PURPOSE OF THIS RELEASE**
   - REFERRALS OR CONSULTING DENTAL / MEDICAL PROFESSIONALS

THIS AUTHORIZATION WILL REMAIN IN EFFECT FOR THE DURATION OF TREATMENT. WHEN HEALTH INFORMATION IS DISCLOSED, THE RECIPIENT OFTEN HAS NO LEGAL DUTY TO PROTECT ITS CONFIDENTIALITY. IN MANY CASES, THE RECIPIENT MAY RE-DISCLOSE THE INFORMATION AS THEY WISH. SOMETIMES STATE OR FEDERAL LAW CHANGES THIS POSSIBILITY.

DATE:_____

SIGNATURE:_____

IF YOU ARE SIGNING THIS AS A PERSONAL REPRESENTATIVE OF THE PATIENT, DESCRIBE YOUR RELATIONSHIP TO THE PATIENT AND AUTHORITY TO SIGN THIS FORM.

RELATIONSHIP TO PATIENT:_____

Dr. Nicole Sullens
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OFFICE POLICIES

Broken/Cancelled Appointments:

We have reserved special time for your dental care so that you may have quality time with the Doctor and staff. We request that you give us at least 24hours notice for changing or cancelling an appointment. Less than 24 hours' notice is considered a broken appointment. There will be a $75.00 broken appointment fee for not showing to your appointment, or last-minute cancellations. You will only be allowed to miss (2) appointments in a (12) month time frame. After that you will be dismissed from our practice.
Your $75.00 broken appointment fee must be paid prior to rescheduling your appointment.

Parent / Guardian: A parent or guardian must complete, sign and date a minor's health history information form. A parent or guardian must be in the waiting room at all times during treatment of a minor in case of the need for a change of planned treatment or emergency. The responsible party who accompanies the patient to the office is responsible for payment at the time services are rendered. We ask that an adult always accompany younger children with restroom visits.

Smoking: This is a smoke free facility. Please refrain from smoking inside our building

Confirmation Calls: We will require current phone numbers, for reminder calls, so if you change your phone number, please inform our office, if you have not been contacted, please call our office to ensure that you indeed do have an appointment that day. If you are more than 10 minutes late for your scheduled appointment, you may be asked to reschedule.

THIS OFFICE FOLLOWS THE GUIDELINES FOR X-RAY PROTOCOL RECOMMENDED BY THE NORTH CAROLINA DENTAL SOCIETY AND THE ADA:

In order to provide you with the best and most appropriate care, we must have current diagnostic x-rays of your mouth and surrounding structures. **Adults:** Panoramic and Bite Wings. **Children & Teenagers** Require bitewings and panoramic films, or as needed for selected cases, bases on clinical need.
The protocol for x-rays is determined by the individual patient's professional need. Bitewings for adults as recommended by the ADA and the federal government is recommended yearly, and required every (2) years. Panoramic films will be taken every (5) years. Individual x-rays will be as necessary similar to new patients above, determined on an as need basis.
Dr. Nicole Sullens will not preform dental services without the necessary x-rays to manage the patient with a standard of care acceptable to this community and within existing government guidelines. Patients who insist that no x-rays be taken will be asked to find dental services at another office. We will be glad to refer your records to the dentist of your choice, if you are unable to comply with the Dental Association and this office's x-ray policy.

BY SIGNING BELOW, I AM STATING THAT I UNDERSTAND YOUR OFFICE POLICIES AND X-RAY PROTOCOL POLICIES. I AUTHORIZE AND CONSENT TO ALL DENTAL TREATMENT AS DETERMINED BY DR. SULLENS.

Patient Signature/Legal Guardian if a minor _____ Date _____

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FINANCIAL POLICY

PAYMENT IS EXPECTED AT THE TIME WORK IS RENDERED. We do not bill for services. If a party not present at the appointment is responsible for payment, payment arrangements must be made prior to the day of the appointment. For your convenience, we accept cash, checks, MasterCard, Visa, Discover, American Express, and Care Credit. Care Credit is a 3rd party payment plan consisting of a separate line of credit for dental purposes only, with little or no notice. Processing the application will only take a few moments.
As a courtesy to our patients without insurance we provide a 10% discount when paying with cash or check (credit cards are excluded).

Dental Insurance Subscribers: As a courtesy for patients, we do accept most insurance plans and will accept payment directly from the insurance company. For all dental treatment including fillings, crowns, periodontal services, removable dentures/partials, we require your percent of the estimated fee at the time of treatment. This helps us keep our quality dentistry more affordable for everyone as insurance processing is complex, time consuming, and can have delays for numerous reasons. To help keep this process as smooth as possible, please make sure that we have all necessary information correct including: full legal name, policy number, plan ID, social security number, date of birth, address, and phone numbers. If any of the above information has changed, please notify us immediately to help avoid any delay in your benefits.

Special Notes for Dental Insurance Subscribers:

1. We are an in-network provider for **most** insurance companies. Insurance plans are a contract between you, your employer, and the insurance company. The dollar amount set for each procedure is set by the individual's contract. Therefore, we can never guarantee what any particular plan will pay toward your treatment.
2. Please be aware that insurance companies may elect not to cover certain services such as sealants, white fillings, and some periodontal services. Insurance companies also have annual plan limitations, which set cost parameters in which you can spend. Once you spend over your annual plan limits, payment in full is required for all dental services thereafter. Most plan benefits renew on January 1st.
3. Payment in full is required for all esthetic and elective work, including tooth whitening, veneers, and removable prosthodontic services (dentures and partials).
4. We do not file secondary insurance, but will be happy to provide assistance for those who need it.
5. Any unpaid portion of your treatment, regardless of the reason, is your full responsibility and payment in full is required within 45 days from the time of service to avoid collection services.

BY SINGING BELOW, I AUTHORIZE RELEASE OF INFORMATION NECESSARY TO PROCESS MY DENTAL INSURANCE CLAIMS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL COSTS OF DENTAL TREATMENT. I AUTHORIZED PAYMENT DIRECTLY TO DR. NICOLE SULLENS FOR INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.

Patient Signature (or Parent/Guardian if minor)_____Date:_____