Office Information and Policies

Insurance Information

There is no direct relationship between our office and your insurance company. The type of plan chosen by you and/or your employer determines your insurance benefits; **dental insurance policies vary**. While it is your responsibility to understand your insurance policy, we will do what we can to help you understand and maximize your insurance benefits. We ask that you be responsible for the payment the day you have dental treatment rendered. We accept **payment for services rendered either directly from your primary insurance company, and/or directly from you,** in which case the office will submit your insurance claim so that **your insurance company may reimburse you**.

Prior to treatment, our office will attempt to contact your insurance company to estimate/determine available benefits. This will inform our office what your insurance company is **estimating** to cover. This is only an **estimate of benefits,** and not a guarantee of payment. We suggest that you call your insurance company to verify benefits as well. **You will be responsible for payment of the balance not covered by your *primary* insurance (your co-pay) at the time treatment is rendered.**

If financial arrangements for the patient's portion of the fee are necessary, they must be arranged ***prior*** to treatment. After 45 days, any unpaid balance not covered by your insurance company (including delays in insurance company payment/processing) will be billed to you and is due within 15 days. Overdue accounts (balances due over 30 days) will be charged finance charges of 2.5% monthly (18% annually). Overdue/unpaid accounts will be subjected to collections actions. The patient or guardian will be responsible for collections agency, attorney, court and all associated fees incurred by Dr. Ashley Flowers DDS, PA if collection actions are necessary.

Medicaid Information

Our office accepts Medicaid coverage from North Carolina residents. However, due to the large volume of Medicaid recipients in our area, any new patient would have to be put on a waiting list. The patient's current Medicaid card must be submitted at each appointment along with a $4 or $5 co-pay for services rendered. Patient will be responsible for full payment of services if Medicaid coverage has been terminated. Some dental procedures, such as dentures and partials, require prior approval, which can take up to several months. Our office will submit all the necessary forms for treatment approvals and notify the patient when approval has been achieved or denied. Not all dental procedures are covered by Medicaid. If any Medicaid recipient misses their first scheduled appointment, without 24 hours notice, our office will be unable to reschedule that appointment. Any Medicaid recipient who misses any following appointments, with under 24 hours notification, will be placed again on the waiting list for at least 6 months or pay $35 fee.

Insurance/Communication Authorization/Scope of Care

By signing below, you authorize the release of any information contained in my dental files for the purpose of your treatment, billing and processing of insurance claims. You permit a copy of this signature, if needed, to be used in place of the original on all your insurance submissions. In addition, you authorize release of any information contained in your dental files to the/your referring dentist(s) and/or treating dentists and/or physician(s). Also, you authorize my medical physician to release any or all information/lab work that is pertinent to your dental treatment with Dr. Flowers and staff.

Broken Appointment Policy

Your appointment time has been reserved especially for you. If you are unable to keep your appointment, **please notify us at least 24 hours in advance.** As a courtesy to our patients we will attempt to confirm your appointment, but it is the patients' (or guardians') sole responsibility to keep and confirm scheduled appointments. **Broken appointments, late arrival (more than 15 minutes after your scheduled appointment) requiring rescheduling, and appointments cancelled with less than 24 hours notice will be charged $35 per appointed hour.**

Office Fee Policy

A fee of **$50** will be charged for insufficient funds/returned checks.

After examination an initial treatment plan will be established and fees will be reviewed. During treatment, unexpected situations may be discovered. The actual fee(s) charged will depend on services rendered in order to best treat the patient and restore or maintain optimal oral health.

I understand and agree to the office information and policies.

Signature of responsible individual: _____ Date: _____

CONSENT FOR TREATMENT

1. I hereby authorize Dr. Flowers or designated staff to take x-rays, study models, photographs and any other diagnostic aids deemed appropriate to make thorough diagnosis for
_____’s dental needs.
full name of patient

2. Upon such diagnosis, I authorize Dr. Flowers and/or designated staff to perform all recommended treatment mutually agreed upon by me, including fluoride treatment and to employ such assistance as required to provide proper care.

3. I understand that this office files my insurance claims as a courtesy. Any claim not paid within 45 days of treatment is my responsibility.

4. Lastly, I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, a late charge of 1.5% (18 APR) for any balance over 30 days will be assessed to my account.

PERSON COMPLETING FORM:

Signature: _____ Date: _____

If other than patient, indicate relationship: _____

REMINDERS:

Please indicate the form of reminder you would like 2 weeks prior to your appointment:

- ☐ Email :_____
- ☐ Text message: _____
- ☐ Post card

Please indicate the form of reminder you would like 2 business days prior to your appointment:

- ☐ Email :_____
- ☐ Text message: _____
- ☐ Phone call: _____

Ashley Flowers, DDS, PA
507 North Main Street • Sparta, NC 28675 • 336-372-3434

PATIENT REGISTRATION

NAME _____ MARITAL STATUS _____ SEX _M / F_
Last First Middle

DATE OF BIRTH _____ SS# _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

EMAIL ADDRESS _____

CELL PHONE _____

HOME PHONE _____ WORK PHONE _____

IF PATIENT IS UNDER 18 YEARS OLD:

Name of Parents/Legal Guardian _____
Address if Different than Patient _____
Home Phone _____ Work Phone _____

PERSON RESPONSIBLE FOR PAYMENT _____

ADDRESS _____ CITY _____ STATE ___ ZIP _____

DATE OF BIRTH _____ SS# _____ DL# _____ STATE _____

EMPLOYER _____ ADDRESS _____

EMERGENCY CONTACT NAME AND PHONE # _____

DENTAL INSURANCE COVERAGE

PATIENT RELATIONSHIP TO THE INSURED: SELF / SPOUSE / CHILD / OTHER

INSURED'S NAME _____ SS# _____

DATE OF BIRTH _____ INSURED ID# _____ GROUP # _____

EMPLOYER NAME _____

ADDRESS _____ PHONE # _____

INSURANCE COMPANY NAME _____ PHONE # _____

ADDRESS _____ CITY _____ STATE ____ ZIP _____

(Please let us know if you have secondary insurance)

In order to provide you with prompt service, please return this form along with a current insurance card to staff at front desk upon completion.

MEDICAL HISTORY

PHYSICIAN _____ PHONE _____ Date _____

1. Are you in good health? Yes No

2. Has there been any change in your health in the last year? Yes No
   If yes, explain: _____

3. Have you ever been hospitalized, had a major operation or serious illness? Yes No
   If yes, explain: _____

4. Date of your last visit to your doctor? _____ Reason for last visit _____

5. Are you currently receiving treatment or regular medical care by your doctor? Yes No
   If yes, for what condition(s)? _____

6. Are you taking any of the following medications? If yes, please list name and milligrams.

a. Antibiotics or sulfa drugs …… Yes No_____
b. Anticoagulant (blood thinners) Yes No _____
c. Medicine for high blood pressure …… Yes No_____
d. Cortisone (steroids) Yes No_____
e. Tranquilizers …… Yes No_____
f. Antihistamines Yes No_____
n. Fosamax or any meds related to osteoporosis …… Yes No_____
g. Aspirin Yes No_____
h. Insulin, tolbutaminde (Orinase) or other drugs for diabetes …… Yes No_____
i. Digitalis or drugs for heart trouble Yes No_____
j. Nitroglycerin ……Yes No_____
k. Birth control pills or other hormones Yes No_____
I. Pain medications such as Advil, Nuprin, Motrin or Naprosyn ……Yes No_____
m.Synthroid or other thyroid medication Yes No_____
o. Others, please list:

_____
_____
_____

7. Are you allergic to or have you had any reactions to the following? Yes No *(Please Circle)*
A. Penicillin B. Aspirin C. Codeine D. Sulfonamides E. Barbiturates
F. Iodine G. Latex H. Foods:
Other *(Please List)* _____

HAVE YOU EVER HAD OR BEEN TREATED BY A DOCTOR FOR:
(Circle your response and underline any condition(s) that apply)

8. Damaged heart valves or artificial heart valves, including heart murmur, pacemaker rheumatic fever, rheumatic heart disease Yes No
9. Mitral Valve Prolapse …… Yes No
10. Congenital heart problems Yes No
11. Heart trouble, heart attack, high blood pressure, stroke …… Yes No
    a. Do you have pain in your chest upon exertion? Yes No
    b. Are you ever short of breath after mild exercise? …….. Yes No
    c. Do your ankles swell? Yes No
12. Prosthetics/Knee replacement or Organ transplant? …… Yes No
13. Severe or frequent headaches? Sinus problems? Yes No
14. Blood disorders such as anemia or hemophilia? ……Yes No
15. Blood transfusion Yes No

16. Breathing problems, emphysema, tuberculosis or other lung problems? ……..Yes No
17. Asthma, hay fever or hives? Yes No
18. Stomach or intestinal disease, or ulcers? ……... Yes No
19. Cancer, x-ray treatments, or chemotherapy? Yes No
20. Diabetes or blood sugar problems? ……Yes No
21. Hepatitis, jaundice, or liver disease? Yes No
22. Kidney infections, frequent urination, or renal (kidney) dialysis? …… Yes No
23. Stroke, seizures, fainting spells, numbness or other neurologic problems? Yes No
24. Herpes? …….. Yes No
25. AIDS, AIDS-related condition or HIV positive? Yes No
26. Tumors or growths? …….. Yes No
27. Arthritis or rheumatism? Yes No
28. Phobias, severe anxieties, depression, psychoses, unusual fears, or other mental problems?
……..……...Yes No
29. Psoriasis, seborrhea, or other skin diseases? Yes No
30. Have you lost weight without dieting or gained weight in recent months? …...Yes No
31. Do you have complaints regarding your eyes, ears, or nose? Yes No
If yes, explain: _____
32. Do you wear contact lenses? ……..Yes No
33. Do you smoke cigars/cigarettes or use smokeless tobacco products? Yes No _____ per day
34. Do you drink alcoholic beverages? ……Yes No _____ per day
35. For women, are you pregnant or do you think you may be pregnant? Yes No
36. Are there any other problems about your health that you know of? ……..Yes No
If yes, describe: _____

SIGNATURE OF PATIENT:
I understand the need for these questions to be answered truthfully. To the best of my knowledge, the answers I have given are accurate. I also understand it is very important to report any changes in my medical or dental status to the dentist at the earliest possible time, and I agree to do so. I give my permission to the dentist to obtain from my physician or dentist, any additional information regarding my medical history needed to provide me the best dental treatment possible.

PERSON COMPLETING FORM:
Signature:_____ Date:_____
If other than patient, indicate relationship: _____

DO NOT WRITE BELOW THIS LINE

MEDICAL HISTORY REVIEW

_____
_____
_____
_____

SIGNATURE, ATTENDING DENTIST:___ _____ , DDS Date: _____

DENTAL HISTORY

Referred by_____How would you rate the condition of your mouth? ❑ Excellent ❑ Good ❑ Fair ❑ Poor
Previous Dentist _____How long have you been a patient?_____Months/Years
Date of most recent dental exam _____/_____/_____ Date of most recent x-rays _____/_____/_____
Date of most recent treatment (other than a cleaning) _____/_____/_____
I routinely see my dentist every: ❑ 3 mo. ❑ 4 mo. ❑ 6 mo. ❑ 12 mo. ❑ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:	YES	NO
Personal History		
1. Are you fearful of dental treatment? Scale of 1 to 10 (very) _____	❑	❑
2. Have you had an unfavorable dental experience?	❑	❑
3. Have you ever had complications from past dental treatment?	❑	❑
4. Have you ever had trouble getting numb or reactions to local anesthetic?	❑	❑
5. Did you ever have braces, orthodontic treatment or had your bite adjusted?	❑	❑
6. Have you had any teeth removed?	❑	❑
Smile Characteristics		
7. Is there anything about the appearance of your teeth that you would like to change?	❑	❑
8. Have you ever whitened (bleached) your teeth?	❑	❑
9. Are you self conscious about your teeth?	❑	❑
10. Have you been disappointed with the appearance of previous dental work?	❑	❑
Bite and Jaw Joint		
11. Do you / would you have any problems chewing gum?	❑	❑
12. Do you / would you have any problems chewing bagels or other hard foods?	❑	❑
13. Have your teeth changed in the last 5 years, become shorter, thinner or worn?	❑	❑
14. Are your teeth crowding or developing spaces?	❑	❑
15. Do you have more than one bite or do you clench (squeeze) to make your teeth fit together?	❑	❑
16. Do you have any problems with sleep or wake up with an awareness of your teeth?	❑	❑
17. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)	❑	❑
18. Do you have tension headaches or sore teeth?	❑	❑
19. Do you wear or have you ever worn a bite appliance?	❑	❑
Tooth Structure		
20. Have you had any cavities within the past 3 years?	❑	❑
21. Do you have a dry mouth?	❑	❑
22. Are any teeth sensitive to hot, cold, biting or sweets?	❑	❑
23 Have you ever had a toothache, cracked filling, broken, chipped or cracked tooth?	❑	❑
24. Do you avoid brushing any part of your mouth?	❑	❑
Gum and Bone		
25. Have you ever been diagnosed or treated for periodontal (gum) disease?	❑	❑
26. Have you ever experienced gum recession?	❑	❑
27. Is there anyone with a history of periodontal disease in your family?	❑	❑
28. Do your gums bleed when brushing, flossing or eating?	❑	❑
29. Are your teeth becoming loose?	❑	❑
30. Have you ever noticed an unpleasant taste or odor in your mouth?	❑	❑
31. Have you experienced a burning sensation in your mouth?	❑	❑

Patient's Signature_____ Date_____

Doctor's Signature_____ Date_____

Ashley Flowers Family Dentistry

507 North Main Street
Sparta, NC 28675
336-372-3434

Notice of Privacy Practices (NPP) Acknowledgement and Authorization to Release Information

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your NPP. I acknowledge that I am aware a copy of the NPP is available in the waiting room for me to review. I also understand that this practice has the right to change its NPP and that I may request a current copy of the NPP at any time.

Outside of what is covered under HIPAA, Ashley Flowers Family Dentistry will only release medical information to the person(s) you authorize to obtain that information. Unless otherwise specified, this release includes all patient information (including treatment results, dental findings, x-rays, and any dental treatment plans for future appointments).

I authorize Ashley Flowers Family Dentistry to release my medical information to the following persons:

_____
Name and Relationship

_____
Name and Relationship

_____
Name and Relationship

We may leave appointment reminder messages or message to return a call from us on your home or cell phone. Yes☐ No☐

_____ _____
Patient or Legal Guardian Signature **Date**

_____
Witness Signature