

**Baywood Family Dental**  
**Laurence R. Mester, Jr. DDS & Associates II, PA**  
**124 Baywood Rd, Suite 100**  
**Fayetteville, NC 28312**  
**Phone: (910) 829-0220**

Account #: \_\_\_\_\_  
 Today's Date: \_\_\_\_\_

**PATIENT INFORMATION**

Name:		Birth date:		Social Security #	
Address:			City:	State:	Zip Code:
Home Phone: ( )		Work Phone: ( )		Cell Phone: ( )	Sex: M <input type="checkbox"/> F <input type="checkbox"/>
Employer:			Employer Phone: ( )		
Email:		Spouse or Parent's Name:		Phone: ( )	
Who to contact in case of emergency				Phone: ( )	
How did you hear about us?					

**RESPONSIBLE PARTY**

Name of Person:		Relation to Patient:			
Address:			City:	State:	Zip Code:
Birth date:		Social Security #		Email:	
Employer:				Work Phone#: ( )	

**PRIMARY DENTAL INSURANCE INFORMATION**

Name of Insured:		Relation to Patient:			
Birth date:		Social Security #			
Employer:		Insurance Company:			
ID #:	Group #:		Ins. Phone #:		

**ADDITIONAL DENTAL INFORMATION**

Name of Insured:		Relation to Patient:			
Birth date:		Social Security #			
Employer:		Insurance Company:			
ID #:	Group #:		Ins. Phone #:		

For the following questions, please (X) whichever applies, your answers are for our records only and will be kept confidential in accordance with applicable laws. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

**DENTAL INFORMATION**

Reason for Today's Visit _____		Former Dentist _____	
Date of Last Dental Exam _____		Date of Last Dental X-Rays _____	
Former Dentist Contact Information _____			
Please (X) a response to indicate if you have or have not had problems with any of the following:			
Yes/No	Yes/No	Yes/No	Yes/No
<input type="checkbox"/> <input type="checkbox"/> Bad Breath	<input type="checkbox"/> <input type="checkbox"/> Grinding or Clenching	<input type="checkbox"/> <input type="checkbox"/> Biting Pain	
<input type="checkbox"/> <input type="checkbox"/> Bleeding Gums	<input type="checkbox"/> <input type="checkbox"/> Loose or Broken Teeth	<input type="checkbox"/> <input type="checkbox"/> Mouth Sores or Ulcers	
<input type="checkbox"/> <input type="checkbox"/> Clicking or Popping	<input type="checkbox"/> <input type="checkbox"/> Bone Loss	<input type="checkbox"/> <input type="checkbox"/> History of Oral Trauma	
<input type="checkbox"/> <input type="checkbox"/> Food Impaction	<input type="checkbox"/> <input type="checkbox"/> Sensitivity _____	___ Dental Anxiety (scale 1-10)	
<input type="checkbox"/> <input type="checkbox"/> Have you had a serious/difficult problem associated with any previous dental treatment? If yes, explain:			
_____			

**MEDICAL INFORMATION**

Are you in good health? \_\_\_\_\_  
 Has there been any change in your general health within the past year? \_\_\_\_\_  
 Have you had any serious illness, operation, or been hospitalized in the past 5 years? \_\_\_\_\_  
 If yes, what was the illness or problem? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Date of Last Physical Exam: \_\_\_\_\_  
 Physician Name: \_\_\_\_\_  
 Phone: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Have you ever taken any drug for cancer treatment or osteoporosis? (Examples are Fosamax, Actonel, Boniva, Zometa) \_\_\_\_\_  
 Currently Taking/How long? \_\_\_\_\_  
 Do you smoke or use tobacco products? \_\_\_\_\_  
 How Long? \_\_\_\_\_  
 Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?  
 \_\_\_\_\_

If yes, what antibiotic and dose? \_\_\_\_\_  
 Physician Name \_\_\_\_\_  
 Phone: \_\_\_\_\_

**ALLERGIES**

Are you allergic to or have you had a reaction to?  
 Yes/ No  
  Local Anesthetics  
  Aspirin  
  Penicillin or other antibiotics  
  Sulfa drugs  
  Codeine or other narcotics  
  Latex  
  Metals  
 Other \_\_\_\_\_

**WOMEN ONLY**

Are you pregnant or nursing? \_\_\_\_\_  
 Are you taking birth control pills or hormonal replacement?  
 \_\_\_\_\_

Please (X) a response to indicate if you have or have not had any of the following diseases or problems.

- | Yes/No  | Yes/No  | Yes/No  |
|---|---|---|
| <input type="checkbox"/> <input type="checkbox"/> Abnormal Bleeding       | <input type="checkbox"/> <input type="checkbox"/> Diabetes              | <input type="checkbox"/> <input type="checkbox"/> Pacemaker/Heart Surgery |
| <input type="checkbox"/> <input type="checkbox"/> Anemia                  | <input type="checkbox"/> <input type="checkbox"/> Epilepsy/Seizures     | <input type="checkbox"/> <input type="checkbox"/> Psychiatric Disorders   |
| <input type="checkbox"/> <input type="checkbox"/> Arthritis, Rheumatism   | <input type="checkbox"/> <input type="checkbox"/> Fainting              | <input type="checkbox"/> <input type="checkbox"/> Radiation Treatment     |
| <input type="checkbox"/> <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> <input type="checkbox"/> Glaucoma              | <input type="checkbox"/> <input type="checkbox"/> Respiratory Disease     |
| <input type="checkbox"/> <input type="checkbox"/> Artificial Joints       | <input type="checkbox"/> <input type="checkbox"/> Headaches             | <input type="checkbox"/> <input type="checkbox"/> Rheumatic Fever         |
| <input type="checkbox"/> <input type="checkbox"/> Asthma                  | <input type="checkbox"/> <input type="checkbox"/> Heart Murmur          | <input type="checkbox"/> <input type="checkbox"/> Shortness of Breath     |
| <input type="checkbox"/> <input type="checkbox"/> Autoimmune Disorder     | <input type="checkbox"/> <input type="checkbox"/> Heart Problems        | <input type="checkbox"/> <input type="checkbox"/> Stroke                  |
| <input type="checkbox"/> <input type="checkbox"/> Back Problems           | <input type="checkbox"/> <input type="checkbox"/> Hepatitis A/B/C/D     | <input type="checkbox"/> <input type="checkbox"/> Swollen Feet or Ankles  |
| <input type="checkbox"/> <input type="checkbox"/> Blood Disease           | <input type="checkbox"/> <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> <input type="checkbox"/> Thyroid Problems        |
| <input type="checkbox"/> <input type="checkbox"/> Cancer                  | <input type="checkbox"/> <input type="checkbox"/> HIV/AIDS              | <input type="checkbox"/> <input type="checkbox"/> Tuberculosis            |
| <input type="checkbox"/> <input type="checkbox"/> Chemotherapy            | <input type="checkbox"/> <input type="checkbox"/> Kidney Disease        | <input type="checkbox"/> <input type="checkbox"/> Ulcer/Colitis           |
| <input type="checkbox"/> <input type="checkbox"/> Circulatory Problems    | <input type="checkbox"/> <input type="checkbox"/> Liver Disease         | <input type="checkbox"/> <input type="checkbox"/> Venereal Disease/STDs   |
| <input type="checkbox"/> <input type="checkbox"/> Cough, Persistent       | <input type="checkbox"/> <input type="checkbox"/> Mitral Valve Prolapse |   |

**MEDICATIONS**

**List medications you are currently taking: (include OTCs, herbals):**  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**AUTHORIZATION AND RELEASE**

I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

SIGNATURE OF PATIENT/LEGAL GUARDIAN

DATE

## Patient Financial Responsibility Form

As your family dentist, our staff works as a team to provide you with the best possible care as well as old-fashioned courtesy and compassion. We are committed to do this at an affordable cost. In order to achieve these goals, we need your assistance and your understanding of our financial policy.

1. **Payment Due.** Payment is due at the time services are rendered. We welcome cash, checks, Carecredit, Citi HeathCard, MasterCard and Visa. Each returned check will be subject to a \$25 fee.
2. **Dental Insurance.** If you have a dental insurance, we will be glad to file claims and accept payments directly from your insurance company. While we file insurance claims as a courtesy to our patients, please understand that:
  - a. Your insurance is a contract between you and your insurance company. As a dentist, we are not a part of that contract and we have no control over what insurance would pay and what your copayment would be. We will make every effort to help you achieve maximum-allowed-benefits under your plan. However, your cooperation is needed to facilitate the claim process and there is no guarantee that your insurance company would pay as expected.
  - b. Insurance benefits and coverage may vary from time to time. Not all services are covered benefits. Some insurance companies may arbitrarily select certain services they will not cover or downgrade them to low-cost alternatives. Since your insurance company may pay all, some, or none of your bill, you are ultimately responsible for the balance. If your insurance does not make payment within 30 days, you will be billed for the unpaid balance.
3. **Payment Estimates.** To improve the collection process, our office will estimate your copayment when the service is rendered. However, please keep in mind that this is only an estimate. For an insured patient, your final copayment is based on the Explanation of Benefits (EOB) sent from your insurance company. For a self-pay patient, your copayment is based on our Office Fee Schedule. Should there be any difference between our estimate and the actual copayment due, you will receive a statement from us in 30 days requesting paid-in-full.
4. **Treatment Plans.** After your visit at our office, we will provide you with a copy of your treatment plans, which lists the dental work recommended by your dentist along with the estimated cost. Please understand that the treatment plan is an estimate only and it is time-sensitive. The cost information contained in the treatment plan may not be accurate and is subject to change over time with or without notice. The procedures we perform may also change during the treatment with or without notice due to circumstances.
5. **Broken Appointment Fee.** There is a \$25 charge for each broken appointment cancelled without 48 hours (2 business days) advance notice. The office reserves the rights to dismiss patients who repeatedly break their appointments.
6. **Deposits.** There are a \$50-\$100 deposit required for large procedures such as Root Canals, Crowns, Bridges, Wisdom Teeth Extractions and Implants. The deposit is collected at the time of making the appointment and will be applied toward your copayment. Should you cancel the appointment without 48 hours (2 business days) notice, the deposit is non-refundable regardless of the reason.
7. **No Refund.** Medical conditions, remaining tooth structure, density of bones, infection, sensitivity, gum disease or accidents are among many critical factors that affect the success rate of a dental procedure. In addition, the patient's general health, good oral hygiene, regular dental checkups, diet, and allergy can all play an important role. Because of this, no guarantees can be made or assumed to be made about the longevity and success rate of any dental procedures. No refund will be rendered for services that have been performed.
8. **Account Balance.** Balances older than 30 days will be subject to an interest charge of 1 ½ % per month and additional collection charges. We reserve the right to send the overdue accounts to collection agencies and pursue all available legal remedies to satisfy the unpaid balance including but not limited to credit bureau reporting and court proceedings.

We realize that dental treatment can be costly and temporary financial problems may occur that affect the payment of your account. If such problems do arise, please don't ignore the bills that you can't pay. Instead, contact us promptly for assistance in the management of your account. If you have any questions about the above information or any uncertainty regarding insurance coverage, please don't hesitate to ask us. We are here to help you!

**I hereby authorize Laurence R. Mester, Jr. DDS & Associates II, P.A. to submit claims and assign benefits, on my behalf to**

\_\_\_\_\_ **Insurance Company.**

**I have read and understand the above.**

Signed: \_\_\_\_\_  
(Patient / Legal Guardian)

Date: \_\_\_\_\_



# Authorization for Release of Information – Compound Release

Name of Patient \_\_\_\_\_ Date of Birth \_\_\_\_\_

\_\_\_\_\_ is authorized to release protected health information about the above named patient in the following manner and to persons listed.

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 Other _____
<input type="checkbox"/> Spouse (provide name and phone number) _____	<input type="checkbox"/> Financial <input type="checkbox"/> Medical
<input type="checkbox"/> Parent (provide name and phone number) _____	<input type="checkbox"/> Financial <input type="checkbox"/> Medical
<input type="checkbox"/> Email communication-Provide email address* _____	<input type="checkbox"/> Financial <input type="checkbox"/> Medical <input type="checkbox"/> Appointment reminders <input type="checkbox"/> Breach notification
<p>*In order for email communication to occur, please accept the disclosure below:</p>	
<input type="checkbox"/> For <b>email communication</b> I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to move forward to allow email communications to occur.	

**Patient Rights:**

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

The information is released at the patient’s request and this authorization will remain in effect until revoked by the patient.

\_\_\_\_\_ Date \_\_\_\_\_

Signature of Patient or Personal Representative

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

\_\_\_\_\_