Mary Moran Day, DDS, PA

Thank you for choosing us for your dental care. We are committed to the success of your treatment.

OUR APPOINTMENT POLICY

Your appointment is reserved just for you. It is *your* time with the doctor or team member. We do not "double book" appointments. If you must change an appointment, please give 48 hours notice. **If you fail to cancel your appointment appropriately or do not show up for your scheduled appointment, you may be charged a broken appointment fee of $50 per hour.** Please help us better serve you by keeping scheduled appointments.

_____ _____

Signature of Patient Date

OUR FINANCIAL POLICY

Please understand that payment of your bill is considered a part of your treatment. Payment is due on the day of your procedure(s) as outlined verbally and/or in the written financial arrangement. We accept cash, check, Visa, Master Card, Discover, American Express, and CareCredit.

Regarding insurance: You are responsible for payment of your account. We will be glad to submit insurance claim forms for you as a courtesy, and do all that we can to get the most in benefits reimbursed for you. We must emphasize however, that our relationship is with our patients, not with insurance companies. Your insurance is a contract between you and/or your employer and the insurance company only. It is also important to know that many times, insurance companies do not have your best dental health in mind. Therefore, we do not allow them to dictate our relationship with you, and we choose not to participate in their contracts. **Any outstanding balance over 90 days old is your responsibility, regardless of insurance assistance.**

A 1.5% late fee will be added to outstanding balances monthly. Our returned check fee is $30.

_____ _____

Signature of Patient Date

CONSENT FOR TREATMENT

I hereby authorize Mary Moran Day, DDS, PA and designated team members to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate to make a thorough diagnosis.

Upon such diagnosis, I authorize Dr. Day and team to perform all recommended treatment mutually agreed upon by me and to employ such professional assistance as required to provide proper care.

I agree to the use of anesthetics and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a recital of any possible complications.

I understand that there are certain risks associated with any dental treatment. These risks include, but are not limited to: post treatment sensitivity to pressure or temperature, pain, nerve inflammation. Other less common risks include, but are not limited to: infection, injury to adjacent teeth, gums, or tongue, swallowing or aspirating a piece of tooth or filling, and nerve disturbance (numb lips, tongue, cheek). The complications that result from these risks may be temporary or permanent.

I understand that Dr. Day's office uses the highest quality materials and laboratories, and that I have the option to choose other material if treatment allows.

I authorize the release of a full report of examination findings, diagnosis, treatment program and ongoing progress report to any referring dentist, physician, chiropractor, or other health care professionals as indicated on my release form. I additionally authorize the release of any medical information to insurance companies for legal documentation to process claims. **I understand that I am responsible for all charges for services regardless of insurance coverage.**

_____ _____

Signature of Patient Date

Mary Moran Day, DDS, PA

YOUR COMMITMENT TO YOUR DENTAL HEALTH

Your dental health takes a commitment from you as well as from us. This relationship involves teamwork. Just as we place high standards on ourselves, we ask the same from our patients.

Our Expectations of You, Our Patient:

Communication: We want to know how you feel about all aspects of your experience with us. We will develop a Personalized Dental Plan for you and expect you to tell us honestly about your thoughts and feelings. We are here to serve you and want you to be comfortable in making decisions concerning your appearance and your dental health. So ask questions when you do not understand something!

Finances and Cost: From the moment you step inside, you will notice that our office is different. Please do not be surprised to discover that our fees may be higher, for certain services, than those of an average dental office. We could not offer the level of technology and service we do otherwise. Because of this, we have designed payment arrangements that are comfortable and convenient, so cost is rarely a concern. The value you receive in the long run far outweighs the cost in the short run.

For our patients with ***dental insurance assistance*** – we will be happy to assist you in filing your claims. We have found that far too often however, insurance companies do not have your best dental health in mind. It is for this reason that we do not allow them to dictate our relationship with you, and we choose ***not*** to be contracted with them.

Referrals: We enjoy working with our patients just like you! We ask that whenever you have the opportunity to mention our name to your family and friends that you please do so. Please know that we will do our absolute best to provide them with the same level of dentistry that is truly exceptional. We especially enjoy treating patients that are referred by our existing patients. There is no better validation of a happy patient than hearing that same great news from one of the friends they recommend!

Following these guidelines will insure a long lasting relationship between us! We want to look forward to a wonderful relationship built on trust, credibility, and great dental solutions.

_____ _____

Patient Signature Date

_____ _____

Doctor Signature Date

Mary Moran Day, DDS, PA

Photography Agreement

Dr. Day and Team often take photographs for a variety of purposes. Please initial the purposes for which you grant permission for use.

_____ Case documentation; laboratory communication

_____ Media use (newspapers, magazine, website)

_____ Facebook

_____ In office "Before and After" book

I hereby grant permission for the use of any purposes initialed above. I also acknowledge that this is done voluntarily and without compensation.

_____ _____

Patient Signature Date

_____

Patient Printed Name

_____ _____

Doctor Signature Date

Mary Moran Day, DDS, PA

Compound Authorization for Release of Information

Patient Name_____ Birth Date_____

Mary Moran Day, DDS, PA

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.

With whom may we share your information?

_____ relationship_____

_____ relationship_____

Description of information to be released:

Appointment information	☐ yes	☐ no
Financial information	☐ yes	☐ no
Dental information	☐ yes	☐ no

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 written notification to **Mary Moran Day, DDS, PA.** I understand that a revocation is not effective in cases where the information has already been disclosed by 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_____

Patient or Personal Representative

_____

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

Mary Moran Day, DDS, PA

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**You May Refuse to Sign This Acknowledgment **

I acknowledge that 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 acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Other (Please specify)

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Morehead City, NC 28557
252.222.3333
www.daydentaldesigns.com

Patient Registration

Last name _____ First name _____ Middle initial ____ Preferred name_____

Emergency contact _____ Phone number_____ Relationship _____

Responsible Party (if someone other than the patient)

Last name _____ First name _____ Middle initial _____

Address _____

City _____ State _____ Zip code _____ Pager _____

Home phone _____ Work phone _____ Ext _____ Cellular _____

Birth date _____ SSN _____ Driver's License _____

Patient Information

Address _____

City _____ State _____ Zip code _____ Pager _____

Home phone _____ Work phone _____ Ext _____ Cellular _____

Gender: ☐ Male ☐ Female Date of Birth _____ Social Security Number _____

Driver's License _____ E-mail address _____

How do you prefer appointment reminders? ☐ Text ☐ Email ☐ Call (Number _____)

Employment Information

Employer's name _____ Employer's address _____

Employment status: ◯ Full time ◯ Part time ◯ Retired Student status: ◯ Full time ◯ Part time

Primary Dental Insurance Information

Name of insured _____ Relationship to Patient ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured SSN _____ Insured Birth date _____

Insured Employer _____ Insurance Company _____

Address _____ Employer ID _____

City, State, Zip _____

How do you plan to take care of your portion of today's balance?

☐ Cash ☐ Check ☐ Credit card ☐ Care Credit

Who may we thank for referring you? _____

_____ **I understand office policies and have read the Notice of Privacy Practices.**

Initials

_____ Patient Name

Medical and Dental History

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.

When was the last time you saw your physician? _____ For what reason? _____

Physician's name _____Phone number _____

Have you ever had a joint replaced? _____ Which joint(s)? _____ When? _____

Do you require *antibiotic premedication* before dental treatment due to a joint replacement, heart condition, or any other reason? _____
If yes, for what reason? _____

Do you take or have you taken *bisphosphonate* drugs? (Ex: Zomeda, Aredia, Boniva, Fosamax, Actonel) _____

Do you smoke? _____ How many packs per day? _____

Do you drink alcohol? _____ How many drinks per week? _____

Do you use recreational drugs? (Some interact negatively with numbing agents.) _____

Have you had the HPV (Human Papilloma Virus) vaccination? _____ When? _____

Women: Are you ☐ pregnant / trying to get pregnant ☐ nursing ☐ taking oral contraceptives ☐ none

Allergies ☐ Aspirin ☐ Codeine ☐ Penicillin ☐ Sulfa drugs ☐ Acrylic ☐ Metal ☐ Latex ☐ None
☐ Local Anesthetics ☐ Other, please explain_____

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

☐ AIDS/HIV +	☐ Chest Pains	☐ Heart Murmur	☐ Mitral Valve Prolapse
☐ Acid reflux	☐ Cold sores/Fever Blisters	☐ Heart Pace Maker	☐ Radiation Treatments
☐ Anaphylaxis	☐ Congenital Heart Disorder	☐ Heart Trouble/ Heart Disease	☐ Renal Dialysis
☐ Anorexia	☐ Cough with blood/sputum	☐ Hepatitis A	☐ Rheumatic Fever
☐ Artificial Heart Valve	☐ Dementia	☐ Hepatitis B	☐ Sinus Trouble
☐ Artificial Joint	☐ Diabetes	☐ Hepatitis C	☐ Spina Bifida
☐ Asthma	☐ Drug Addiction	☐ High Blood Pressure	☐ Stroke
☐ Bulimia	☐ Epilepsy or Seizures	☐ Human Papilloma Virus (HPV)	☐ Stomach ulcers
☐ Bleeding problems/blood thinner	☐ Fainting Spells/ Dizziness	☐ Hypoglycemia	☐ Tuberculosis
☐ Cancer	☐ Heart attack/Failure	☐ Low Blood Pressure	☐ Tumors or Growths

Have you ever had any medical condition or illness not listed above? _____ Please explain _____

Please ***list all medications*** you are currently taking (including any vitamins, minerals, herbal supplements, pain medications)

_____

_____

Dental History

How often do you brush your teeth? _____ How often do you floss? _____

When were you last seen by a dentist? _____ When was your last cleaning? _____

When were your most recent x-rays? _____ When was your last Oral Cancer Screening?_____

Have you ever had an injury to your teeth, face, or jaw(s)? _____

Do you drink soft drinks? _____ How often? _____

Please check all that apply:

☐ Bad Breath	☐ Tinnitus (ringing in ears)	☐ Loose teeth	☐ Neck pain
☐ Broken teeth / fillings	☐ Hot sensitivity	☐ Limited Opening	☐ Deep cleaning
☐ Vertigo (dizziness)	☐ Dry mouth	☐ Headaches / Migraines	☐ TMJ pop / click
☐ Cold sensitivity	☐ Facial Pain / Sore face muscles	☐ Mouth sores / growths	☐ Tingling fingertips
☐ Bleeding gums	☐ Pain around ear	☐ Receding gums	
☐ Clench / grind teeth	☐ Sweet sensitivity	☐ TMJ Pain / Sore jaw joint	

To the best of my knowledge, the questions on the 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.

X

_____ _____

Signature of patient, parent, or guardian Date

Today's BP: _____ Pulse:_____ Perio type: _____ Plaque score: _____ Caries risk: _____

Assessment _____

_____ _____

Signature of dental team member Date

Questionnaire

Name _____ Date _____

1. Mouth Comfort
   - ☐ My mouth is very comfortable.
   - ☐ My mouth is moderately comfortable.
   - ☐ My mouth is not comfortable.

2. Appearance/Smile
   - ☐ I feel that the appearance of my mouth is very good.
   - ☐ I am satisfied with the appearance of my mouth.
   - ☐ I am not happy with the appearance of my mouth because:

     ☐ crooked/crowded ☐ discolored/stained ☐ chipped/broken/missing

     ☐ dark fillings ☐ worn teeth ☐ spaces ☐ gums ☐ uneven

     other: _____

3. Natural Teeth
   - ☐ I will do anything to keep my natural teeth.
   - ☐ I want to keep my natural teeth, but have certain budgets of time and money I am willing to spend on them.
   - ☐ I don't care whether I keep my teeth or not.

4. How healthy do you want your mouth?
   - ☐ Healthy
   - ☐ I can tolerate some disease.
   - ☐ I don't care.

5. If you need dental care, at what point would you want to initiate treatment?
   - ☐ When things are not ideal.
   - ☐ When things appear to be getting worse.
   - ☐ When something hurts or breaks.

6. If you need dental care, what kind of dental treatment would you want?
   - ☐ I want the best quality that gives the longest life.
   - ☐ I want the least expensive that will get me by for now.

7. What prevents you from getting the dental care you need?
   - ☐ Nothing – I see a dentist regularly.
   - ☐ Money / Cost
   - ☐ Time
   - ☐ Pain
   - ☐ Fear / Phobia
   - ☐ Not a priority – I go to the dentist when I have a problem.

8. Payment for dental services that works best for me:
   - ☐ Cash / Check
   - ☐ Credit Card
   - ☐ Payment Plan with Care Credit®

9. Why did you select our office? _____
   _____

10. What kinds of dental work have you had done in the past? _____
    _____

11. Have you had any negative experiences at a dental office before (in or out of the dental chair)?
    _____
    _____

12. What have you always wanted to do for your smile that you haven't had a chance to do?
    _____
    _____

13. Any other concerns you would like to discuss today? _____
    _____

Comfort Menu

Please select any you would enjoy:

☐ Neck pillow

☐ Blanket

☐ Headphones

☐ Sunglasses

☐ Massaging Chair