



WELCOME TO OUR PRACTICE

On behalf of the entire team at Waxhaw Dental Center, let us welcome you to our practice. We are grateful that you have chosen us to meet your dental needs, and trust that you will find your experience in our office to be pleasant, professional, and extraordinary. You may discover that we are different from the average dental practice. When you visit our office, you will find a unique and relaxing environment. Our team is friendly and attentive. All of our treatment is designed to be comfortable, to be long lasting, and to exceed all your expectations. We use the latest technology and techniques our profession has to offer. Our greatest strength lies in the unequalled advanced training in cosmetic and reconstructive dentistry we have received.

Enclosed in this Welcome Packet are several important documents that will explain our practice philosophy and policies along with selected questionnaires that will assist us in making your transition to our office as smooth as possible. Please have these papers completed and signed prior to your first appointment.

For more information regarding the services we offer and to meet the entire Waxhaw Dental Center team, be sure to visit our website at www.WaxhawDentalCenter.com. We look forward to serving all your dental needs.

Yours truly for better dental health,

Simon Adir, D.D.S

MEDICAL HISTORY

Patients Name _____ Date _____

Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry that you will be receiving. Thank you for answering the following questions.

General health: Excellent Good Fair Poor

Are you currently under the care of a physician? Yes No Date of Last Physical _____
Name of physician _____ Address _____ Phone _____

Do you smoke or use tobacco products? Yes No If yes, how much? _____
Are you pregnant or think you may be? Yes No If yes, expected delivery date _____
Are you nursing? Yes No
Are you taking birth control pills? Yes No
Do you or have you used controlled substances? Yes No
Do you bruise easily? Yes No
Do you take any daily blood thinners (e.g. aspirin, Plavix, Coumadin)? Yes No If yes, please list below.
Do you take anything for the treatment or prevention of osteoporosis (e.g. Fosamax)? Yes No If yes, please list below.

Please list any medications you are taking now:

1) _____ taken for _____ 4) _____ taken for _____
2) _____ taken for _____ 5) _____ taken for _____
3) _____ taken for _____ 6) _____ taken for _____

Have you ever had (check those that apply):

Abnormal blood pressure..... High <input type="checkbox"/> Low <input type="checkbox"/> No <input type="checkbox"/>	Heart murmur..... Yes <input type="checkbox"/> No <input type="checkbox"/>
AIDS or HIV..... Yes <input type="checkbox"/> No <input type="checkbox"/>	Heart surgery..... Yes <input type="checkbox"/> No <input type="checkbox"/>
Allergies..... Yes <input type="checkbox"/> No <input type="checkbox"/>	Hepatitis..... Yes <input type="checkbox"/> No <input type="checkbox"/>
Anemia Yes <input type="checkbox"/> No <input type="checkbox"/>	Jaundice..... Yes <input type="checkbox"/> No <input type="checkbox"/>
Arthritis..... Yes <input type="checkbox"/> No <input type="checkbox"/>	Joint replacement or implant (pre-med)..... Yes <input type="checkbox"/> No <input type="checkbox"/>
Asthma or Hay fever..... Yes <input type="checkbox"/> No <input type="checkbox"/>	Kidney trouble..... Yes <input type="checkbox"/> No <input type="checkbox"/>
Back Problems..... Yes <input type="checkbox"/> No <input type="checkbox"/>	Lymph node enlargement/swollen glands..... Yes <input type="checkbox"/> No <input type="checkbox"/>
Blood transfusion..... Yes <input type="checkbox"/> No <input type="checkbox"/>	Mental health care..... Yes <input type="checkbox"/> No <input type="checkbox"/>
Cancer..... Yes <input type="checkbox"/> No <input type="checkbox"/>	Mitral valve prolapse..... Yes <input type="checkbox"/> No <input type="checkbox"/>
Chemical dependency..... Yes <input type="checkbox"/> No <input type="checkbox"/>	Pacemaker..... Yes <input type="checkbox"/> No <input type="checkbox"/>
Chemotherapy for any cancers..... Yes <input type="checkbox"/> No <input type="checkbox"/>	Persistent diarrhea..... Yes <input type="checkbox"/> No <input type="checkbox"/>
Cold sores or Fever Blisters..... Yes <input type="checkbox"/> No <input type="checkbox"/>	Prolonged bleeding..... Yes <input type="checkbox"/> No <input type="checkbox"/>
Congenital heart lesions Yes <input type="checkbox"/> No <input type="checkbox"/>	Rheumatic fever..... Yes <input type="checkbox"/> No <input type="checkbox"/>
Diabetes..... Yes <input type="checkbox"/> No <input type="checkbox"/>	Sexually transmitted disease..... Yes <input type="checkbox"/> No <input type="checkbox"/>
Drastic weight loss..... Yes <input type="checkbox"/> No <input type="checkbox"/>	Sinus trouble..... Yes <input type="checkbox"/> No <input type="checkbox"/>
Eating disorders..... Yes <input type="checkbox"/> No <input type="checkbox"/>	Stroke..... Yes <input type="checkbox"/> No <input type="checkbox"/>
Epilepsy or Seizures..... Yes <input type="checkbox"/> No <input type="checkbox"/>	Thyroid problems..... Yes <input type="checkbox"/> No <input type="checkbox"/>
Excessive urination and/or thirst..... Yes <input type="checkbox"/> No <input type="checkbox"/>	Tuberculosis or lung disease..... Yes <input type="checkbox"/> No <input type="checkbox"/>
Fainting spells..... Yes <input type="checkbox"/> No <input type="checkbox"/>	Ulcers..... Yes <input type="checkbox"/> No <input type="checkbox"/>
Glaucoma..... Yes <input type="checkbox"/> No <input type="checkbox"/>	X-ray treatments for cancer..... Yes <input type="checkbox"/> No <input type="checkbox"/>
Heart disease..... Yes <input type="checkbox"/> No <input type="checkbox"/>	

If you have entered "yes" please explain: _____

Are you allergic to or have you had reactions to:

Local anesthetics like Novocain..... Yes <input type="checkbox"/> No <input type="checkbox"/>	Latex/Rubber..... Yes <input type="checkbox"/> No <input type="checkbox"/>
Penicillin or other antibiotics..... Yes <input type="checkbox"/> No <input type="checkbox"/>	Aspirin..... Yes <input type="checkbox"/> No <input type="checkbox"/>
Sulfa drugs..... Yes <input type="checkbox"/> No <input type="checkbox"/>	Any metal (gold, nickel, etc.)..... Yes <input type="checkbox"/> No <input type="checkbox"/>
Barbiturates, sedatives, sleeping pills..... Yes <input type="checkbox"/> No <input type="checkbox"/>	Other (please list) _____

Signature: _____ Date: _____

CUSTOMIZED TREATMENT AND PRESENTATION QUESTIONNAIRE

Patient Name

Reason for visit: _____ Approximate date of last dental visit: _____

What is your primary concern that you would like us to address first? _____

Has anything ever happened in previous experiences at the dentist that was reason not to return? Yes No
If yes, please explain _____

If we were sitting here together a year from now, what needs to happen for you to consider our office an excellent choice for you? Examples might be: Being pain free, in great dental health, having whiter teeth, no more silver fillings, cost, etc.

Please write answer below.

What do you value most in a dental office? **Please write answer below.**

Cosmetic – You most value how your teeth look. Want them straight. Want them white.

Function – You most value an ability to enjoy your favorite foods and drinks. Don't want to be limited to just eating on one side or area. No food or drink should be off limits to you.

Comfort – You most value NOT being in pain or having any tooth or gum sensitivities. Example: I can't eat this anymore because it hurts or is sensitive.

Longevity – You most value the ability to have your natural teeth forever. You wish to have the work you have done in the chair to last as long as possible.

What is the most important objection or obstacle you have to visiting a dental office? **Please write answer below.**

No objections or obstacles – I come faithfully every 6 months and value my dental health.

Fear – Of pain. Noises. Environment. Past experiences.

Time – Tight schedule. Getting appointments to suit your schedule. Not able to take off work, etc. Getting in and out of office quickly.

Have NOT had a sense of urgency – Nothing really hurts so haven't seen need to go to dentist in years or something has been hurting at some level for awhile but I've been able to live with it.

Budget – Knew I needed a lot of work, didn't have money to address any issues found.

No Trust – Felt you were told you needed treatment you didn't need. Felt ripped off. Bad previous experience. Didn't give me any data to support treatment they recommended.

When the Dentist or Dental Team Member needs to talk to you about options to restore your dental health (such as crowns, dentures, implants, etc.), do you prefer: **Please write answer below.**

A simplified oral explanation and description of dental treatment needed.

Both detailed oral and visual explanations which could include video animations demonstrating the procedure recommended and or photographs of the procedure or photos of other patients' mouths who had similar treatment.

Have physical models on hand to hold and feel to aid in visualizing the work needed to be performed.

APPOINTMENT AGREEMENT

At Waxhaw Dental Center, we understand that your time is very valuable. We are constantly striving to make your experience here more pleasant than any other place you have previously been. Trying to accommodate every patient's individual needs and work schedule can be challenging. We make every effort to stay on time so that our patients will not have to wait unnecessarily.

Your appointment is a commitment of time between you and our office. We ask that you make every effort to keep that commitment. We do provide a courtesy reminder call one to two days prior to your appointment.

If you find that you cannot keep your appointment, we do require a minimum notice of 24 hours so we are able to assist other patients with their dental needs. If our office is not notified within the 24 hours, you will be subject to a \$50 late cancellation charge.

By signing below, I agree to fulfill my obligation as a patient at Waxhaw Dental Center and agree to the "broken appointment" fee should I not give proper notification.

Signature of patient or responsible party

Date

FINANCIAL POLICY

As a condition of the treatment performed by the providers of the office, financial arrangements must be made in advance for the full cost of proposed treatment. The practice's vitality depends upon payment for services as rendered and it is the responsibility of the patient or patient's parent/guardian to satisfy the costs incurred in dental care. Financial arrangements on the part of each individual must be determined prior to treatment completion.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are rendered. Additionally, a discount can be extended, at the management's discretion, for payments in full with cash or check. (Inquire for more details.)

Individuals who carry dental insurance understand that all dental services furnished are charged directly to the patient and that said patient is personally responsible for payment of all dental services provided, regardless of dental insurance reimbursement. As a customer courtesy, this office will help prepare and submit patients' insurance forms as well as assist in making collections from insurance companies. We will credit any such collections to the appropriate account. However, this dental office cannot render services on the assumption that our charges will be paid in part or in full by an insurance company. (Please understand that the amount to be paid by your particular policy is pre-determined and agreed to by your employer and the insurance company. If you have any questions about the amount the plan will pay or the treatments your plan will cover, you should refer these questions to your employer.) Additionally, there may be a deductible, a co-insurance factor, and a yearly maximum to be considered. Most policies cover what they consider a "usual and customary fee." However, the insurance company sets these fees, and they are not always the same as the fees that may be charged in this or any office. All these factors may combine to reduce the benefits you will ultimately receive. We will do our best to see that you receive your full benefits within the structure of your particular dental plan but any balance that remains on your account, whether your insurance company covered the procedure in question or not, is ultimately your responsibility to pay.

A service charge of 2% per month (24% per annum) on any unpaid balance will be charged on all accounts exceeding 60 days from date of service, unless previously written financial arrangements are agreed upon and satisfied. I understand that the fee estimate listed for any proposed dental care can only be extended for a period of six months from the date of diagnosis and/or examination. I further acknowledge that the proposed treatment plan can shift and/or change from the diagnosed treatment plan once treatment is begun due to unforeseen circumstances beyond the doctors' control.

In consideration for the professional services rendered to me by the doctor, at the provider's recommendation, or at my own request, I agree to pay the reasonable value of said services to said doctor, or his assignee, at the time said services are rendered. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time allotted for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition, and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to Waxhaw Dental Center and/or Waxhaw Dental Center's financial coordinator to telephone me at home or at my place of business to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent or guardian

Date

Relationship to patient

Signature of guarantor of payment/responsible party

Date

Relationship to patient

AUTHORIZATION FOR RELEASE OF INFORMATION

Name of Patient _____ Date of Birth _____

Waxhaw Dental Center 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.

Check entity/person that you approve to receive information.

Check description of information to be released to entity/person at left.

<input type="checkbox"/> Voice Mail (Home or Mobile)	<input type="checkbox"/> Appointment Reminders
<input type="checkbox"/> Email _____ (Provide Email Address)	<input type="checkbox"/> Appointment Reminders, X-Rays, Financial
<input type="checkbox"/> Spouse _____ (Provide Name and Phone Number)	<input type="checkbox"/> Appointment Reminders <input type="checkbox"/> Financial <input type="checkbox"/> Treatment Plans
<input type="checkbox"/> Parent _____ (Provide Name and Phone Number)	<input type="checkbox"/> Appointment Reminders <input type="checkbox"/> Financial <input type="checkbox"/> Treatment Plans
<input type="checkbox"/> Other _____ (Grand-parent, Step-parent, Nanny) (Provide Name and Phone Number)	<input type="checkbox"/> Appointment Reminders <input type="checkbox"/> Financial <input type="checkbox"/> Treatment Plans

Patient Information

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. 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 shall be in effect until revoked by the patient.

Signature of Patient or Personal Representative

Date

Receipt of Notice of Privacy Practices Acknowledgment Form

I hereby acknowledge that on _____ I received the Notice of Privacy Practices from Waxhaw Dental Center in Waxhaw, which sets forth the ways in which my personal health information may be used or disclosed by Waxhaw Dental Center, and outlines my rights with respect to such information.

Patient's Signature

Date