BULL CITY SMILES
COSMETIC & FAMILY DENTISTRY

Welcome to our practice!

Welcome to Bull City Smiles! We respect your time and would like to make your visit to our office as enjoyable, efficient, and comfortable as possible. Please review the following information regarding your dental care.

Hygiene Policy

Appointments for adults (18 years and older) will consist of a full mouth series of x-rays and a comprehensive exam (full mouth measuring, education, and examination by the doctor). If you have had x-rays within the past 3 years, please bring them with you. If you cannot obtain your x-rays, new ones will be taken. Your ***estimated*** appointment time is 60 minutes. We cannot guarantee a cleaning on your initial visit because we do not know all patients' particular hygiene needs before their examination. In absence of periodontal disease, a cleaning will be completed.

Pediatric patients (under 18) will consist of a panoramic x-ray, 4 bitewing x-rays, a cleaning, and a comprehensive exam by the dentist. Your ***estimated*** appointment time is 45 minutes.

Patient Responsibility Dental Insurance

We request that you **complete** all patient registration and health history forms. This may be done online and **submitted via email**. You may **print and bring these completed forms with you** at your first scheduled appointment. Alternatively, you can **mail them** back to us at 2705 N. Duke St. Suite 100. Please try to have previous dental x-rays available at the time of your appointment. We reserve the right to take new x-rays if they could not be obtained, they are of poor quality, or they are over 2 years old.

Dental Insurance

We will be happy to file your dental claim ***as a courtesy to you*** as long as you are able to provide us with ***current*** dental information as well as a copy of your insurance card. We will **NOT** be able to file your insurance without this information. Without your insurance information payment in full at the time of your appointment is your obligation. If you have secondary dental insurance, we will also provide the courtesy of filing for you.

Payment Policy

We expect payment at the time of your appointment for your portion of the services performed, deductibles, and co-insurance. When checking out from your appointment, we will give you your ***estimated*** insurance coverage. The outstanding balance will need to be paid at the time of service. Regardless of your insurance benefits, payment for services remains your personal responsibility. Patients filing their own insurance will be provided with a full-itemized statement for their specific insurance company. For your convenience we accept cash, check, Visa, MasterCard, Discover, American Express, and Care Credit (an interest free payment plan). Should you have any questions, please feel free to call our office. We offer a 5% discount for all treatment over $2000 paid in cash or check.

Rescheduling/Cancellation/Emergency Policy

Broken and missed appointments create scheduling problems for our team as well as other clients. If you find that you must change your appointment, we require a minimum of **24** hours notice so that we may make every effort to accommodate other patients. Please notify us as early as possible if you are unable to keep your appointment. ***A fee of $50 per hour will be charged for any appointment broken with less than 24 hours notice.***

We would be happy to discuss our charges and how they relate to your particular situation. We also realize that temporary financial situations may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account. Most often, financial misunderstandings can be managed with a phone call. Please feel free to contact our wonderful staff at anytime to discuss any concerns you may have.
Thank you for understanding our Financial Policy.
I have read and agree to the Financial Policy and the Cancellation Policy of Bull City Smiles.

Signature of Patient or Responsible Party: _____ Date:_____

Thank you for your support of these policies. We look forward to providing you with the highest standard of dental care.

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Patient Information Form

DATE: _____

First Name: _____ **Middle Name:** _____ **Last Name:** _____
Preferred Name: _____ **Salutation:** _____
Address: _____
City, State, Zip: _____ **Home Phone:** _____
Work Phone: _____ **ext.** _____ **Cell/pager:** _____
Sex: ❒ **Male** ❒ **Female** **Marital status:** ❒ **Married** ❒ **Single** ❒ **Divorced** ❒ **Separated** ❒ **Widowed**
Birth Date: _____ **Soc. Sec:** _____ **Driver's License:** _____
E-mail: _____ **(please Print)**

Employment Status: ❒ Full Time ❒ Part Time ❒ Retired Employer: _____
Occupation_____
Student Status: ❒ Full Time ❒ Part Time Name of School: _____
Are you responsible for payment? ❒ Yes ❒ No If no, complete responsible party section below.

If Patient Is Under 18 Years Old:

Name of parents or legal guardian; _____ **Phone: (H)** _____ **(C)** _____
Address: _____

RESPONSIBLE PARTY (person responsible for account)

First Name: _____ **Middle Name:** _____ **Last Name:** _____
Preferred Name: _____ **Salutation:** _____
Address: _____
City, State, Zip: _____ **Home Phone:** _____
Work Phone: _____ **ext.** _____ **Cell/pager:** _____
Sex: ❒ **Male** ❒ **Female** **Marital status:** ❒ **Married** ❒ **Single** ❒ **Divorced** ❒ **Separated** ❒ **Widowed**
Birth Date: _____ **Soc. Sec:** _____ **Driver's License:** _____
E-mail: _____ **Relationship to Patient**: ❒ Spouse ❒ Parent ❒ Other _____
Does responsible party have an account with this office ____**Yes** ____ **No**

Please name someone to contact outside of immediate family in case of emergency: (not living with you)
Name: _____ Home# _____
Work#_____

If you have dental insurance please list all policies. Non-payment occurs if they are not filed properly.

Dental Insurance Primary:

Employee Name: _____
Employer Name: _____
Insurance Co. Name: _____
Insurance Co. Address:_____
_____
Subscriber I.D. #: _____
Group #: _____
Employee Date of Birth: _____

Dental Insurance Secondary:

Employee Name: _____
Employer Name: _____
Insurance Co. Name: _____
Insurance Co. Address:_____
_____
Subscriber I.D. #: _____
Group #: _____
Employee Date of Birth: _____

How did you hear about us?

❒ **Yellow Pages** ❒**Christmas Parade** **Name**: _____
❒ **Talking Phone Book** ❒ **Internet** **Patient / Friend / Other**
❒ **AT &T phone Book** ❒ **DUKE Directory**

Authorization:

I hereby authorize payment of insurance benefits otherwise payable to me directly to Willowdaile Family Dentistry. I understand that I am responsible for all costs of dental treatment. By signing this I have read and understand, Willowdaile Family Dentistry's financial, appointment and treatment policy.

Responsible Party's Signature: _____ **Date:** _____

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MEDICAL HISTORY FORM

PATIENT NAME _____ **BIRTH DATE** _____/_____/_____

Although dental professionals 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.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____
Have you ever been hospitalized or had an operation? ◯ Yes ◯ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____
Are you on a special diet? ◯ Yes ◯ No _____
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics
☐ Other If yes, please explain: _____

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

AIDS/HIV Positive	◯ Yes ◯ No	Cortisone Medicine	◯ Yes ◯ No	Hemophilia	◯ Yes ◯ No	Renal (kidney)Dialysis	◯ Yes ◯ No
Alzheimer's Disease	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No	Hepatitis A	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No
Anaphylaxis	◯ Yes ◯ No	Drug Addiction	◯ Yes ◯ No	Hepatitis B or C	◯ Yes ◯ No	Rheumatism	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Easily Winded	◯ Yes ◯ No	Herpes	◯ Yes ◯ No	Scarlet Fever	◯ Yes ◯ No
Angina	◯ Yes ◯ No	Emphysema	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No	Shingles	◯ Yes ◯ No
Arthritis/Gout	◯ Yes ◯ No	Epilepsy or Seizures	◯ Yes ◯ No	Hives or Rash	◯ Yes ◯ No	Sickle Cell Disease	◯ Yes ◯ No
Artificial Heart Valve	◯ Yes ◯ No	Excessive Bleeding	◯ Yes ◯ No	Hypoglycemia	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No
Artificial Joint	◯ Yes ◯ No	Excessive Thirst	◯ Yes ◯ No	Irregular Heartbeat	◯ Yes ◯ No	Spina Bifida	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Fainting Spells/Dizziness	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Stomach/Intestinal Disease	◯ Yes ◯ No
Blood Disease	◯ Yes ◯ No	Frequent Cough	◯ Yes ◯ No	Leukemia	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
Blood Transfusion	◯ Yes ◯ No	Frequent Diarrhea	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No	Swelling of Legs	◯ Yes ◯ No
Breathing Problem	◯ Yes ◯ No	Frequent Headaches	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Bruise Easily	◯ Yes ◯ No	Genital Herpes	◯ Yes ◯ No	Lung Disease	◯ Yes ◯ No	Tonsillitis	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Glaucoma	◯ Yes ◯ No	Mitral Valve Prolapse	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Chemotherapy	◯ Yes ◯ No	Hay Fever	◯ Yes ◯ No	Pain in Jaw Joints	◯ Yes ◯ No	Tumors or Growths	◯ Yes ◯ No
Chest Pains	◯ Yes ◯ No	Heart Attack/Failure	◯ Yes ◯ No	Parathyroid Disease	◯ Yes ◯ No	Ulcers	◯ Yes ◯ No
Cold Sores	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No	Psychiatric Care	◯ Yes ◯ No	Venereal Disease	◯ Yes ◯ No
Congenital Heart Disease	◯ Yes ◯ No	Heart Pace Maker	◯ Yes ◯ No	Radiation Treatments	◯ Yes ◯ No	Yellow Jaundice	◯ Yes ◯ No
Convulsions	◯ Yes ◯ No	Heart Issue/Endocarditis	◯ Yes ◯ No	Recent Weight Loss	◯ Yes ◯ No		

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes, please explain: _____

Comments: _____

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To the best of my knowledge, the questions on this 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 each visit.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ **DATE** _____

DENTAL HISTORY FORM

PATIENT NAME _____

What is your major dental concern? _____

Date of your last visit to a Dentist? _____ **Reason for the last visit (s):** _____

Date you last had dental X-Ray taken? _____

Do you use dental floss once a day?	❒ Yes ❒ No	Do you brush your teeth twice a day?	❒ Yes ❒ No
Is there fluoride in your drinking water?	❒ Yes ❒ No	Do you use toothpaste with fluoride?	❒ Yes ❒ No
Have you used any other form of fluoride?	❒ Yes ❒ No	Do any of your teeth ache?	❒ Yes ❒ No

Are you required, by your physician, to pre- medicate prior to dental procedures? **❒ Yes ❒ No**

Have you always had your teeth cleaned at least once a year? ❒ Yes ❒ No

Are you happy with the appearance of your teeth? ❒ Yes ❒ No

Do your gums bleed when you brush or when you eat? ❒ Yes ❒ No

Does food or dental floss catch between your teeth? ❒ Yes ❒ No

Are some of your teeth becoming loose? ❒ Yes ❒ No

Are there spaces between your teeth now where there were none before? ❒ Yes ❒ No

Is any of your teeth sensitive to hot, cold or pressure? ❒ Yes ❒ No

Are you experience pain or clicking in your jaw? ❒ Yes ❒ No

Are there any sores or growths in your mouth? ❒ Yes ❒ No

Have you experienced an unusual reaction to dental medication or anesthetic? ❒ Yes ❒ No

Are you worried about receiving dental treatment? ❒ Yes ❒ No

Have you ever fainted during a dental visit? ❒ Yes ❒ No

If yes, please explain: _____

Have you ever experienced prolonged bleeding following dental treatment? ❒ Yes ❒ No

If yes, please explain: _____

Have had any other complications following dental treatment? ❒ Yes ❒ No

If yes, please explain: _____

Do you have any other dental concern or complaints? ❒ Yes ❒ No

If yes, please explain: _____

INFORMED CONSENT

I am the patient or parent/legal guardian authorized to furnish the information requested. To the best of my knowledge, The questions on this 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 that may occur in my medical status. I understand that payment for professional services are my (or patient's) sole responsibility and are due as services are rendered. Non payment for services may result in additional collection fees. We do not render services on the basis that insurance companies will pay our fees, but we will be happy to assist you in filing claims for your insurance reimbursement.

I authorize Bull City Smiles to diagnose and provide dental treatment for myself (or patient) including any necessary x-rays or photographs, study models and any other diagnosis aids deemed to be appropriate to make thorough diagnosis.

Print Name _____ **Signature** _____ **Date** _____

BULL CITY SMILES
COSMETIC & FAMILY DENTISTRY

AUTHORIZATION FOR RELEASE OF INFORMATION (HIPPA)

Patient Name _____ **Date of Birth** ____/____/_____

Bull City Smiles is authorized to release protected health information about the above named patient to the entities checked below. Our communication is vital to proper care. The purpose of this form is to inform the patient or others of our forms of communication and protect privacy in keeping with the patient's instructions.

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.
☐ **VOICE MAIL/ANSWERING MACHINE**	☐ Results of lab tests/x-rays ☐ Appointments, follow-up calls or insurance
☐ **TEXT**	☐ Correspondences: Recall texts , etc ☐ Appointments, follow-up calls or insurance.
☐**EMAIL** **Email address**_____	☐Financial ☐ Correspondences: Recall cards, newsletters, announcements, etc. ☐Appointments, follow-up calls or insurance.
☐ **SPOUSE**	☐ Financial ☐Appointments, follow-up calls or insurance.
☐ **PARENT** (provide names) _____	☐ Financial ☐ Appointments, follow-up calls or insurance.
☐ **OTHER** (provide names) _____ _____	☐ Financial ☐ Appointments, follow-up calls or, insurance

Patient Information

I understand that I have the right to revoke this information at anytime 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 redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse or sign this authorization and that my treatment will be conditioned on signing and our ability to communicate. **This authorization shall be in effect until revoked by patient.**

_____ ____/____/_____

Signature of Patient or Personal Representative Date

Description of Personal Representative's Authority:

_____

_____ ____/____/_____

Signature of Bull City Smiles Witness Date

Revised 5/2015

BULL CITY SMILES
COSMETIC & FAMILY DENTISTRY

Financial Policies

The following Financial Policy is required prior to any dental treatment. Please understand we do not want to see financial constraints and/or broken appointments interfere with dental care and the doctor/patient relationship. To facilitate your payments, the following options are listed. Please read them carefully and sign in agreement.

Patient Name: _____

Name of Person Responsible for Account: _____

Relationship to Patient: _____

Drivers Lic. #: _____ **State:** _____ **Exp. Date:** __/___/____ **Date of Birth:** __/___/___

Employer Name & Work Phone #: _____

Payment Options:

IF YOU DO NOT HAVE INSURANCE, payment is due in full at the time treatment is provided. For your convenience, we accept Cash, MasterCard, Visa, Debit Cards, Discover, pre-approved personal checks and Care Credit financing, pending credit approval. .

IF YOU HAVE INSURANCE, we will submit your insurance claim to your primary insurance carrier as a courtesy to you. The amount of coverage paid by your insurance company may be based on your insurance company's Usual and Customary Rates and/or Fee Schedule. Please note: we are not contracted with any insurance company, but Delta Dental. You are responsible at the time of your appointment for any deductible and co-pay not covered by your insurance company, as well as any remaining balance that they fail to pay. If your insurance company does not remit payment within 60 days (and we will make every effort to help this happen), the balance will be due from you and may be subject to service charges. If you have a secondary insurance, we will print your secondary claim form for you to facilitate payment. However, it is your responsibility to file any secondary insurance claims. Outstanding balances are due prior to scheduling your next dental visit.

Broken Appointment Policy:

Dr. Bolton and staff are striving to provide the best quality care to our patients in an efficient and timely manner. Your appointment is reserved exclusively for you. Of course emergencies do happen- and we understand. Needless missed appointments effect many schedules and could be used for another patient in need. We ask that you keep your scheduled appointments to help us keep our fees low and our efficiency high. We thank you for your cooperation and gesture of good will.

If you are unable to keep your reserved appointment, please give us at least 24 hours notice. If you have a Monday appointment and need to cancel or reschedule, please contact our office no later than Thursday, the week before. Arriving over 15 minutes late is considered a broken appointment, as treating you would make us unfairly late for our next appointment. We charge $50 per hour scheduled for all broken appointments, no shows, and rescheduled appointments if less than 24 hour notice is not given. We thank you for this courtesy.

Additional Costs:

Dental Service fees are due at the time of treatment. Bull City Smiles will file your insurance claim within 24 hours of your dental procedure. We can only estimate, but not guarantee benefits. You are responsible for co-pays, deductibles, and any fees your insurance does not pay. We regret that you will also be responsible for attorney fees, collection agency fees, billing fees, interest charges, small claims court costs and any other expenses incurred in collecting your account if it is not paid for in full within 60 days of the date of service.

I agree to the above financial policies set forth by Bull City Dentistry:

Signature of Responsible Party: _____ **Date:** _____

Bull City Smiles
Debora Bolton, D.D.S., P. A.
2705 N. Duke Street Suite 100
Durham, N.C. 27704
(919) 381-5900 phone
appointments@bullcitysmiles.com
www.bullcitysmiles.com

Records Release Request

Patient's Name:_____ Date of Birth _____

I hereby authorize the release of my dental records or copies of such:

☐ **Clinical Notes** ☐ **X-Ray Film(s)** ☐ **Other: _____**

To be sent: (Please check one) ☐ to or ☐ from the office of Bull City Smiles.

Releasing Office Information

Office/ Doctor's Name: _____

Address: _____

City:_____ State:_____ Zip: _____

Phone: _(_____)_____ Fax: ____(_____)_____

Email: _____

☐ I would like to pick up my records. My current phone # : _____
☐ Mail or E-Mail records to: _____

Special Request: If possible, please *Email Digital X-rays in .jpeg format and chart note as .PDF*

- You have the right to obtain a copy of your medical records. The law requires a **signed authorization form** which contains certain criteria included on this form. This form must be **fully completed** before any medical information can be released.
- I understand this Authorization can be revoked at any time according to Bull City Smiles's Notice of Privacy Practices. This request must be made in writing and sent to the same place that the original request was made. Attach a copy of this release.
- Treatment, payment, enrollment in any health plan, or eligibility for benefits is not conditioned on signing this Authorization.
- The facility, its employees and officers, and attending physician(s) are released from legal responsibility or liability for release of the above information to the extent indicated and authorized.
- If you would like to pick up your records, indicate this on the form with a phone number where you can be contacted. Otherwise, records will be mailed to the address listed on the authorization, or may be e-mailed for easy upload by another dentist if they are digital.

I HAVE READ AND UNDERSTAND THIS INFORMATION. I HAVE RECEIVED A COPY OF THIS FORM AND I AM THE PATIENT OR AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS DOCUMENT VERIFYING AUTHORIZATION FOR THE USE OR DISCLOSURE OF THE PROTECTED HEALTH INFORMATION UNDER THE ABOVE STATED TERMS.

_____ _____
Date Signature of Patient

If patient is unable to sign, secure consent of
legal representative and indicate reason below:
☐ Minor ☐ Incompetent

_____
Signature of Legal Representative and Relationship to Patient