morrisville
FAMILY DENTISTRY
~Josiah Chen, DDS, PA~

10290 Chapel Hill Rd, Suite 600, Morrisville, NC 27560
Telephone: 919-469-3669
appts@morrisvillefamilydentistry.com

PATIENT INFORMATION

Name			
Social Security Number		Date of Birth	
Street Address			
City	State	Zipcode	
Home Phone Num ( ) N/A	☐	◄ Please check your preferred contact method. Our office will use this preferred method to confirm all appointments approximately ONE WEEK in advance and TWO DAYS prior. We encourage patients to provide 48 hours notice if you are unable to keep your appointment to avoid a cancellation or no show fee, per office policy.	
Work Phone Num ( ) N/A	☐		
Cell Phone Num ( ) N/A	Allow Text Msgs ( ) Yes ( ) No ☐		
Email	☐		
Dental Insurance			
Policy Holder Name	Date of Birth		
Occupation		Employer	
How did you hear about our office?		If someone referred you, please provide their name	
Emergency Contact Name	Relationship	Ph Num	

PARENT/GUARDIAN INFORMATION (Must be completed for all patients under 18-years of age)
A Parent/Guardian MUST be present in the office waiting room at all times while a minor patient is being treated.

Name(s)	Relationship	Phone Num

DENTAL HISTORY

Date of last dental visit	Date of last cleaning	Date of last X-rays
How often do you brush?	How often do you floss?	
What are your goals for today's visit?		

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HEALTH HISTORY

Physican Name	Ph Num	Address
Please list ANY medications and dosages, including over-the-counter medications, currently being taken:		
Please list ANY allergies to any medications or substances:		

Please provide an answer for each item below:

Yes	No		Yes	No		Yes	No	
		Acid Reflux			Diabetes			Kidney Disease
		Allergies			Difficulty Breathing			Latex Sensitivity
		Anemia			Drug/Alcohol Abuse			Liver Disease
		Antibiotic Pre-Medication			Emphysema			Low Blood Pressure
		Arthritis			Epilepsy/Seizures			Mitral Valve Prolapse
		Artificial Bone/Joint			Fainting Spells			Neurological Disorder
		Artificial Heart Valve			Fen-Phen Use (previous)			Psychiatric Care
		Asthma			Glaucoma			Radiation Therapy
		Bacterial Endocarditis			Hay Fever			Rheumatic Heart Disease
		Bisphosphonate Use			Heart (Attack, Disease)			Sickle Cell Anemia
		Blood Transfusion			Heart Murmur			Sinus Trouble
		Cancer History			Hemophilia			Stroke
		Chemotherapy			Hepatitis A			Thyroid Problems
		Chest Pain			Hepatitis B			Tobacco Use
		Cold Sore/Fever Blister			Hepatitis C			Tuberculosis
		Congenital Heart Defect			High Blood Pressure			Ulcers
		Congenital Heart Disease			HIV/AIDS			Venereal Disease

Please list any other disease or condition if not detailed above:

Females Only

Yes	No		Yes	No		Yes	No	
		Pregnant, wks:			Nursing			Taking Birth Control

I have answered the questions above truthfully and to the best of my knowledge. I understand the information will be used to help provide dental care in a safe environment. I authorize any additional consultation with my other health care providers that may be required for certain medical conditions. I will notify the staff and doctor of any changes in my health or medications at each appointment.

Patient's Printed Name _____ Patient's/Parent's Signature _____ Date _____

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RELEASE OF MEDICAL INFORMATION FORM
(HIPAA RELEASE FORM)

Patient Name	Date of Birth

RELEASE OF INFORMATION

_____ INITIAL **I authorize the release of information including the diagnosis, records, and examination rendered to me and claims information. This information may be released to** (please select):

☐	**Spouse**	Name	
☐	**Child(ren)**	Name(s)	
☐	**Other**	Relationship ( ) Medical Doctor ( ) Dental Provider ( ) Other:	
		Name	
		Address	
		Phone	Email
☐	**Information is not to be release to anyone**		

This Release of Information will remain in effect until terminated by me in writing.

MESSAGES

Please call (select one):

☐	**My home**	Number
☐	**My work**	Number
☐	**My cell**	Number

If unable to reach me (select one):

☐	You may leave me a detailed message
☐	Please leave a message asking me to return your call
☐	Other:

The best time to reach me is (day) between (time)

Patient's/Parent's Signature: _____ Date: _____

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FINANCIAL POLICIES

Thank you for choosing our dental office to provide dental health care for you and your family. Our goal is to provide the best care possible in a clean, relaxed setting.

LATE AND CANCELLATION POLICIES

INITIAL

Your appointment time has been reserved especially for you and often requires specialized preparation. If you are unable to keep your appointment with Dr. Chen, please notify us at least 48 hours in advance if possible. This courtesy enables us to offer your appointment time to another patient who may be waiting to be seen sooner.
A late cancellation fee of $50 will be assessed if you cancel with less than 48 hours notice.
If you arrive late by 15 minutes or more, we reserve the right to cancel your appointment, assess the late cancellation fee, and reschedule your appointment.

PAYMENT POLICY

INITIAL

Payment is due in full at your appointment for all treatment rendered that day; i.e., the total balance for self-pay patients and the estimated portion of cost for insured patients. Treatment includes, but is not limited to, emergency visits, examinations, consultations, and any procedure that is performed. While we can estimate probable insurance coverage, please understand that this **only an estimate** based on the best information available to us and is not guaranteed to be 100% accurate.

We accept the following forms of payment: cash, personal check, Visa, Mastercard, and Discover credit cards; CareCredit (www.carecredit.com); and debit cards with the Visa or Mastercard logo.

After 60 days, accounts with an unpaid balance will incur a 1.5% per month interest fee. After 90 days, accounts with an unpaid balance may be transferred to our collections partner. Any initial collections fees will be added to the patient account for reimbursement.

FAMILY BALANCES

INITIAL

Accounts within our practice are established by family group with statements compiled by family. In many cases, one family member may have a credit on their individual account while another family member may have a balance. If you would like for us to transfer credit amounts among family members to reduce outstanding balances remaining after insurance payments, please indicate your agreement with your initials to the right. This authorization will remain in effect **until revoked by an adult family member in writing.**

INSURANCE

INITIAL

As a courtesy to you, we will file a claim to your primary insurance carrier. **We do not file claims with secondary insurance carriers, BCBSNC, or BCBS Federal Programs.** This service is performed at no charge to you. All benefits will be assigned to our office. Please note:

- Dental insurance is a contract between you and your insurance carrier and has nothing at all to do with Morrisville Family Dentistry or Dr. Josiah Chen, DDS, PA. Our dental services are rendered to **you** and not your insurance company.
- Your insurance benefits are determined only by the type of policy you have. Each policy is different. Since some polices provide more coverage than others, you should ask your employer about the particular benefits covered under your policy, or call your insurance company directly.
- Most insurance companies will provide pre-estimates of benefits if requested by our office. While we do not routinely request pre-estimates, please inform a member of our staff if you wish us to do so for you. Please note a pre-estimate is still not a guarantee of payment.
- Dental insurance is only an aid to help you pay for your professional dental services and is not intended to cover 100% of costs. **Any unpaid portion is your responsibility.** After **30** days, if your insurance carrier has not paid your dental claim, you are responsible for the full balance.

We will file claims for most insurance companies; however we are in-network for only a few insurance providers. Please inquire regarding in-network or out-of-network status with your provider.

For further questions regarding how we handle insurance companies, please contact our office. If you have questions **regarding your specific insurance benefits, please contact your insurance representative.**

Patient's Printed Name	Patient's/Parent's Signature	Date