MOUNTAINEER
DENTAL & SLEEP CENTER

PATIENT INFORMATION

Patient's Name: _____ Sex: M F Birthdate: _____ Age: _____

SS# _____ Today's Date: _____ If patient is a minor, give parent's or guardian's name: _____

Mailing Address: _____

Email Address: _____Whom may we thank for referring you to our office? _____

Phone: Home _____ Cell _____ Work _____ Ext: _____

Employer/student _____

RESPONSIBLE PARTY INFORMATION (IF DIFFERENT FROM ABOVE)

Name: _____ Mailing Address: _____

Best Contact Phone Number: _____ Relationship to Patient: _____

EMERGENCY INFO

Name: _____

Address: _____

City, State: _____Relationship: _____

Home: _____ Cell Phone: _____

Work Phone: _____ Ext: _____

DENTAL INSURANCE INFORMATION

Policy Holder's Name: _____ Employer: _____

Birthdate: _____ SS#: _____

Insurance Company: _____

Address: _____

Group #: _____ Policy #: _____

HEALTH INSURANCE INFORMATION

Policy Holder's Name: _____Employer:_____

Birthdate: _____ SS#: _____

Insurance Company:

_____

Address:

_____

Group #: _____ Policy #: _____

SECONDARY DENTAL INSURANCE INFORMATION

Policy Holder's Name: _____Employer:_____

Birthdate: _____SS#:_____

Insurance Company:

_____

Address: _____

Group #: _____ Policy #: _____

Medical History

	Yes	No
1. Do you have current health problems?	☐	☐
2. Have you been hospitalized in the last 2 years? If yes, for what? _____	☐	☐
3. Are you under physician's care now? If yes, for what? _____	☐	☐
4. Has a physician **(Medical Doctor)** recommended Taking antibiotics prior to every dental visit **(premed)**? (Example: joint replacement or heart conditions)	☐	☐
5. Women: Is there a possibility of pregnancy?	☐	☐

Expected delivery date _____
Are you nursing?

Are you taking Birth Control pills?
(Antibiotics may alter the effectiveness.)

6. Have you ever taken Bisphosphonates(Fosamax)
Phen-fen or redux?

7. What medications are you currently taking?

_____

_____

8. Are you allergic to or have you reacted adversely to any of the following medications?

- ☐ Ibuprofen
- ☐ Codeine
- ☐ Clindamycin
- ☐ Nitrous Oxide
- ☐ Penicillin
- ☐ Latex (balloons, gloves, etc.)
- ☐ Household Bleach
- ☐ Sulfa Drugs
- ☐ Aspirin
- ☐ Acrylic
- ☐ Metal
- ☐ Local Anesthetics/Epinephrine

9. Are you aware of being allergic to any other medication or substances? If yes, please list

_____

10. Do you use controlled substances?

HAVE YOU HAD OR DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING:

Yes

- ☐ Acid Reflux
- ☐ AIDS/ HIV positive
- ☐ Alzheimer's Disease
- ☐ Anaphylaxis
- ☐ Anemia/Blood Thinners
- ☐ Angina
- ☐ Anxiety
- ☐ Arthritis/Gout (Rheumatoidism)
- ☐ Artificial heart valves
- ☐ Artificial joints
- ☐ Asthma
- ☐ Back/neck problems
- ☐ Blood disease
- ☐ Cancer
- ☐ Chemical dependency
- ☐ Chemotherapy
- ☐ Cholesterol problems
- ☐ Circulatory problems
- ☐ Steroid treatments
- ☐ Cough up blood
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Problems
- ☐ Hemophilia (abnormal bleeding)
- ☐ Genital Herpes or Herpes
- ☐ Hepatitis A, B, or C (CIRCLE)
- ☐ Hypoglycemia
- ☐ Irregular heartbeat
- ☐ Jaw pain
- ☐ High blood pressure
- ☐ Kidney disease/malfunction
- ☐ Liver disease
- ☐ Low Blood Pressure
- ☐ Mitral valve prolapse
- ☐ Central nervous problems
- ☐ Osteoporosis
- ☐ Pacemaker/heart surgery
- ☐ Psychiatric care
- ☐ Rapid weight gain/loss
- ☐ Radiation treatment
- ☐ Respiratory disease
- ☐ Rheumatic/Scarlet fever
- ☐ Shingles
- ☐ Shortness of breath
- ☐ Sinusitis/Sinus Trouble
- ☐ Sleep Apnea/Snoring
- ☐ Stroke
- ☐ Swelling of feet or ankles
- ☐ Thyroid disease/malfunction
- ☐ Tobacco habit
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer/Colitis

MEDICAL CONTACTS

Primary Care Doctor:_____ Phone:_____

ENT:_____ Phone:_____

Sleep Doctor:_____ Phone:_____

Dentist:_____ Phone:_____

Neurologist:_____ Phone:_____

Other:_____ Phone:_____

Consent Statement

I affirm that the information above is accurate and complete to the best of my knowledge. I will not hold Dr. Snyder or any office member responsible for problems arising from errors or omissions that I made in the completion of this form. I consent to any advisable and necessary dental treatment to be administered by Dr. Snyder and staff for diagnostic purposes or dental treatment. I understand that the consequences of doing nothing that is recommended by Dr. Snyder and staff might be worsening of the condition, further infection, cystic formation, swelling, pain, loss of teeth, and/or other systemic disease problems.

PLEASE INITIAL_____
If you have any questions, please do not hesitate to ask. We are here to help you.

SIGNATURE_____
Date_____

WITNESS_____
Date_____

ACKNOWLEDGEMENT OF RECEIPT OF FINANCIAL POLICY AND NOTICE OF PRIVACY PRACTICES

I affirm that the information above is accurate and complete to the best of my knowledge. I understand that for my convenience Dr. Snyder accepts Cash, Checks, Visa, MasterCard, Discover or Care Credit. I also understand that with my Dental Insurance, Dr. Snyder files it as a courtesy and none covered amounts and deductibles are due at the time the services are rendered. If for any reason my insurance company does not pay its estimated portion, the balance will be my responsibility. A fee may be charged for patients who miss or cancel without 24-hour notice. A copy of Driver's License/Photo ID is required for every patient. I have read and understand the Financial Policy and Notice of Privacy Practices for the above-named practice.

_____ _____

Signature of patient or legal guardian Date

MOUNTAINEER
DENTAL & SLEEP CENTER

450 New Market Blvd, Ste. 2
Boone, NC 28607
Ph. 828-265-1112

Late and Missed Appointment Policy

At Mountaineer Dental, when we set up an appointment, a specific amount of time is reserved especially for you. We work very hard to see all of our patients in as timely a manner as we can. If for any reason you must cancel or change your appointment, it is important that you give our office a minimum of **24 hours notice** to offer that spot to someone else.

- **First missed appointment**: If an appointment is missed or canceled within the 24 hour window, a letter will be sent to your home reminding you of our policy and the effects of your missed appointment. We also reserve the right to charge you up to $25. This fee is charged to you, not to your insurance company.
- **Second missed appointment:** After your second missed appointment, another letter will be sent to your home notifying you of a change in status of your account and a $50 fee will be charged. This fee is charged to you, not to your insurance company. In order for you to schedule a future appointment with our doctors, a deposit must be made. The deposit is 50% of the cost of that appointment's treatment or $50, whichever is greater. Upon arrival, this fee is credited toward the cost of your treatment. If you do not show up to the appointment the deposit is non-refundable. If you choose to not pay the deposit you have the option of being placed on a short notice list and will be notified of last minute scheduling opportunities.
- **Third missed appointment:** After your third missed appointment, another letter will be sent to your home notifying you of our policies. If three appointments occur within a 2 year period, you will be dismissed as a patient in our dental practice.

We understand that true emergencies happen. If this is the case, please provide us with a doctor's note or other adequate proof and the missed appointment will be removed from your accounts record.

Late arrival: When we reserve time for you, we require all of that time to provide you with the best quality work possible. When you are late it decreases our ability to accomplish this. If you arrive more than 15 minutes late, your appointment may be rescheduled in order to meet the needs of those who are on time for their pre-reserved visit. If this happens it will be considered a missed appointment.

By signing below, you acknowledge that you have thoroughly read the above information and consent to our policies. If you have any questions, do not hesitate to ask us.

I have read the policy above. I understand and agree to abide by the listed terms.

Print Name _____ Date:_____

Patient or Legal Guardians Signature: _____

MOUNTAINEER
DENTAL & SLEEP CENTER

FINANCIAL POLICY

PAYMENT IS EXPECTED AT THE TIME SERVICES ARE RENDERED; WE ACCEPT CASH, CHECK (PROCESSED ELECTRONICALLY), VISA, MASTERCARD, AMERICAN EXPRESS, DISCOVER DEBIT AND CREDIT CARDS.

PAYMENT PLANS:

We have payment plans through care Credit. Care Credit must be approved before appointment is scheduled. We offer the 12 month interest free payment plans.

USUAL AND CUSTOMARY FEES:

Our fees are what are usual and customary in our area and designated by our preferred insurance community, not what your insurance company feels are usual and customary. You are responsible for any fees that are above your insurance company's usual and customary fees unless we have a contract fee with your insurance company or are a participating preferred provider (PPO) for your insurance company.

CONFIRMATION:

You are responsible for keeping your scheduled appointments. Starting two (2) DAYS before your appointment, we will attempt to contact you as a courtesy by phone to confirm your appointment. A prompt response to confirm your appointment is required to secure your appointment 24 hours prior to your scheduled appointment. If we cannot reach you by phone, it is your responsibility to contact us to secure your appointment. Failure to confirm your appointment may result in the cancellation and a "failed appointment status" of your appointment.

OFFICE FEES:

All major procedures will be collected before services are rendered.

PATIENT RESPONSIBILITY REGARDING INSURANCE USAGE

1. You must provide us with a copy of your dental insurance card. If you have any changes in your insurance information you are responsible for giving us the correct information before your appointment. Failure to do so will result in paying out of pocket for the visit.

2. We will attempt to verify that you have coverage with this insurance. If we cannot verify your insurance, you will need to pay for your visit in full and we will provide you with a copy of services rendered to file your claim. If your insurance requires a social security number to verify benefits you must provide it to us or we will not file your insurance.

3. We only verify your insurance coverage and basic breakdown of your benefits. You are responsible for knowing what services your insurance company does and does not cover and when services were last rendered to you.

4. Insurance companies do not guarantee us payments, so any fees stated to you are estimates only.

5. Services are rendered to you, not your insurance company. We will not be involved with any disputes you have with your insurance company.

6. You may have your services pre-authorized by your insurance company. This will tell us an estimate of what your insurance company will pay for services and what your portion of the services will be. Insurance never gives a guarantee of payment.

7. It is your responsibility to call your insurance company to find out why they have not paid your claim.

8. You are responsible for any monies that your insurance does not cover. IE: Alternate benefits, denied claims due to missing tooth clauses, frequency of services, age limitations, deductibles, plan limitations. Etc.

9. You are responsible for paying all deductibles and co-payments at the time of service.

10. It is your responsibility to pay any amount over what your insurance company's reasonable and customary fees are.

I HAVE READ, UNDERSTAND AND AGREE TO THE STATEMENT OUTLINED ABOVE.

Patient Printed Name:_____ Date: _____

_____

Patient or Guardian Signature

MOUNTAINEER
DENTAL & SLEEP CENTER

I hereby authorize my dentist, Dr. Julia Tyson Snyder, DDS and whoever she may designate as her assistants and/or hygienists to perform upon me those dental procedures which, upon discussion, I have accepted in the treatment plan. If any unforeseen condition arises in the course of these designated procedures calling, in their judgment, for procedures in addition to or different from those now contemplated, I further request and authorize upon discussion what he/she deems advisable.

I am informed and fully understand that there are certain risks in any dental treatment. These risks include but are not limited to: post-treatment pressure and temperature sensitivity, pain or throbbing, pulpal inflammation, fracturing of new restorations due to early biting pressures, tenderness of abutment teeth, tenderness of tissues under removable dentures, post-operative pain and throbbing, swelling and re-infection, fracturing of files or the crown portion of the tooth during and following root canal therapy, sensitivity of teeth and gums during and following dental cleanings.

The most common of these complications in oral surgery include post-operative bleeding, swelling or bruising, discomfort stiff jaws, and loss or loosening of dental restorations. Other less common complications include, but are not limited to: infection, loss or injury to adjacent teeth and soft tissues, jaw fractures, sinus exposure and swallowing or aspiration of teeth and restorations, nerve disturbances (e.g. numbness in mouth and lip tissues), and small root fragments remaining in the jaw which might require extensive surgery for removal. These complications may be temporary or permanent.

I further consent to the administration of any drugs that may be deemed necessary in my case, including, but not limited to: local anesthetics, antibiotics, and analgesics. I understand that there is a slight element of risk inherent in the administration of any drug or anesthesia. This risk includes, but is not limited to, the following complications: adverse drug response (e.g. allergic reactions), cardiac arrest, thrombophlebitis (e.g. irritation and swelling of a vein), aspiration, pain, discoloration, and injury to blood vessels and nerves which may be caused by injections or any medications or drugs.

A more complete explanation of all complications is available to me upon request from the DOCTOR.

I am aware that, in spite of the possible complications and risks, my treatment is necessary and desired by me. I realize that the practice of dentistry is not an exact science, and I acknowledge that no guarantees have been made to me concerning the results of the procedures.

Patient Printed Name:_____
Date_____

Patient or Guardian Signature: _____

Authorization for Release of Information

Name of Patient _____ Date of Birth _____

Julia Snyder DDS, PA, is authorized to release protected health information about the above-named patient in the following manner and to identified persons.

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	☐ Results of lab tests/x-rays ☐ Other_____
☐ Other person (s) (provide name and phone number)	☐ Financial ☐ Medical
☐ Email communication-Provide email address* _____ *For email communication to occur, please accept the disclosure below:	☐ Financial ☐ Medical ☐ Appointment reminders ☐ Breach notification
☐ Text communication – Provide number * _____ *For text communication to occur, accept the disclosure below:	☐ Appointment reminder ☐ Other: _____
☐ For **email and/or text communication** 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 receive email and/or text communication as selected.	
☐ Photo of patient received by patient or legal guardian ☐ Photo taken by staff (Example: pre/post procedure) ☐ Other	☐ May be posted in office ☐ May be posted on website ☐ Other_____

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.

This authorization will remain in effect until revoked by the patient.

_____Date _____

Signature of Patient or Personal Representative

Julia Snyder D.D.S, P.A.

Acknowledgement of Receipt
Of Notice of Privacy Practices

Patient Name & Address:

_____

I have received a copy of the Notice of Privacy Practices for the above named practice.

_____ _____

Signature Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- ❑ An emergency existed & a signature was not possible at the time.
- ❑ The individual refused to sign.
- ❑ A copy was mailed with a request for a signature by return mail.
- ❑ Unable to communicate with the patient for the following reason:

  _____

- ❑ Other:_____

Prepared By _____

Signature _____Date:_____