Date: _____
Name: _____
DOB: _____ **Age:**____ **Insurance Company:** _____
Email Address: _____
Home Phone: _____ **Cell Phone:**_____
Address: _____
Medicines: _____
Illnesses: _____
Surgeries: _____
Pregnant:____ **Smoke:**____ **Premed Needed:**_____
Drug Allergies: _____
Weight: _____ **Height:** _____ **Pharmacy:**_____
BP1: _____ **Pulse:**_____ **BP2:**_____
Water Type: City or Well Water (CIRCLE ONE)
How did you hear about us?_____

Dental Work Completed:

1. _____ **2.** _____

3. _____ **4.** _____

5. _____ **6.** _____

7. _____ **8.** _____

PATIENT/GUARDIAN SIGNATURE: _____

DOCTOR'S SIGNATURE: _____

EXTRACTION CONSENT: TEETH #
PATIENT/GUARDIAN SIGNATURE:_____

CROWN PREPS:
CONSENT TO SHADE:
PATIENT/GUARDIAN SIGNATURE:_____

DENTURE OR REMOVABLE DENTURE:
CONSENT TO SHADE:
PATIENT/GUARDIAN SIGNATURE:_____

NV:_____

PRE-AUTHORIZE:_____

The Dental Zone

501 N. HWY 16

Denver, NC 28037

Dental Office Policies-Cancellation Notice

*Please note any cancellation with less than a 24 hour notice will constitute a $75 charge to your account.

Broken/Missed Appointments: Our goal is to have a relationship of trust and respect with our patients. We are making a commitment to you and we know you are making a commitment to us. Please mark your reserved appointment day and time on your calendar.

Patient/Guardian Signature:_____ Date_____

THE DENTAL ZONE
REGISTRATION FORM
(Please Print)

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:	Home phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Chose clinic because/Referred to clinic by (please check one box): ❑ Dr. ❑ Insurance Plan ❑ Hospital ❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance ❑ [Insurance] ❑ [Insurance] ❑ [Insurance] ❑ [Insurance] ❑ [Insurance] ❑ [Insurance] ❑ [Insurance] ❑ [Insurance] ❑ Welfare *(Please provide coupon)* ❑ Other

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize The dental zone or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

Cynthia A. Leigh DDS PLLC

Eaglesoft Medical History

Patient Name: Birth Date: Date Created:

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.

Are you under a physician's care now?	○ Yes ○ No	If yes
Have you ever been hospitalized or had a major operation?	○ Yes ○ No	If yes
Have you ever had a serious head or neck injury?	○ Yes ○ No	If yes
Are you taking any medications, pills, or drugs?	○ Yes ○ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	○ Yes ○ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	○ Yes ○ No	If yes
Are you on a special diet?	○ Yes ○ No	
Do you use tobacco?	○ Yes ○ No	

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Do you use controlled substances?	○ Yes ○ No	If yes
Other?	☐	If yes

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

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

Have you ever had any serious illness not listed ○ Yes ○ No If yes

Comments:

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.

Signature of Patient, Parent or Guardian:

X Date:_____

HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.
MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITYS IN THE FUTURE.

_____ _____

Please ***print*** your name Please ***sign*** your name

_____ _____

Legal Representative Description of Authority

Your comments regarding Acknowledgements or Consents: _____

_____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:
☐ First Name Only ☐ Proper Sir Name ☐ Other _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

☐ Phone Message
☐ Text Message
☐ Email
☐ **Any of the Above**
☐ **None of the above** (opt out)

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment ____
I could not communicate with the patient ____
The patient refused to sign ____
The patient was unable to sign because ____
Other (please describe) ____

_____
Signature of Privacy Officer

HIPAA made EASY™
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Cynthia A. Leigh D.D.S. PLLC
HIPAA AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION ("Authorization")

By signing this Authorization, you agree to the release of your Protected Health Information as described in this Authorization. This Authorization is intended to comply with the requirements of the HIPAA Privacy Rule. If you have questions about this Authorization, please contact the Privacy Official for the Dental Practice, noted below. If you agree with this Authorization, please complete it, sign and date it at the end and provide to us.

Our Dental Practice contact information:

Dental Practice Name:	**Cynthia A. Leigh DDS PLLC**
Privacy Official for Dental Practice:	**Cynthia A. Leigh DDS PLLC**
Dental Practice mailing address:	**501 N. Highway 16** **Denver, NC 28037**
Dental Practice email address:	**info@thedentalzonedenvernc.com**
Dental Practice phone number:	**704-489-2009**

Your contact information (please complete):

Patient name:	
Patient mailing address:	
Patient email address: (Optional)	
Patient phone number:	

Protected Health Information that I am authorizing the Dental Practice to release (please check the records to which this Authorization applies):

I authorize the Dental Practice named above to release the following Protected Health Information:

___ Dental report(s) ___ Dental image(s)

___ All dental records relating to (specify injury or illness):_____

___ All dental records received or created by the Dental Practice between the following dates: _____

___ Other (specify) _____

The reason for the release of the Protected Health Information (please check the reason(s) that apply):

___ Patient Request ___ Review Patient's current care ___ Treatment/ continued care

___ Payment for care, including insurance ___ Legal ___ Obtaining Social Security Disability or other public benefits

___ Other(specify):_____

BY MY SIGNATURE, I CERTIFY THAT I HAVE READ AND UNDERSTAND THIS AUTHORIZATION. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY PROTECTED HEALTH INFORMATION AS DESCRIBED IN THIS AUTHORIZATION.

Name_____ Date ___/___/___

OR

_____
Signature of Personal Representative

Authority of Personal Representative to Sign for Patient (check one):

□ Parent □ Guardian □ Power of Attorney □ Other:_____

Cynthia A. Leigh D.D.S. LPPC
ACKNOWLEDGEMENT OF RECEIPT OF
HIPAA NOTICE OF PRIVACY PRACTICES
("Acknowledgement")

I acknowledge that I have received a copy of this Dental Practice's **HIPAA Notice of Privacy Practices**.

_____
Patient Name (Please Print)

_____ _____
Patient Signature Date

OR

_____
Signature of Personal Representative

Authority of Personal Representative to Sign for Patient (check one):

□ Parent □ Guardian □ Power of Attorney □ Other: _____

Please Note: It is your right to refuse to sign this Acknowledgement.

Dental Office Use Only

I tried to obtain written Acknowledgement by the individual noted above of receipt of our **Notice of Privacy Practices**, but it could not be obtained because:

__ An emergency prevented us from obtaining acknowledgement.

__ A communication barrier prevented us from obtaining acknowledgement.

__ The individual was unwilling to sign.

__ Other:

_____

_____ _____
Staff Member Signature Date

Dental Treatment Consent Form

Dentist Name: Cynthia A. Leigh

Patient Name: _____

- **1. X-RAYS** (Initials :_____)
- **2. DRUGS AND MEDICATIONS**
  I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling tissues, pain, itching, vomiting, bleeding, infection, injury to adjacent teeth or surrounding tissue including the jaw joint, increased sensitivity and/or in some cases death of the tooth after treatment, temporary or permanent numbness of the chin, lip, cheek, gums, and/or anaphylactic shock (severe allergic reaction) (Initials:_____)
- **3.CHANGES IN TREATMENT PLAN**
  I understand that during treatment it may be necessary to change or add to procedure because of the condition found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permissions to the Dentist to make any/all changes and additions necessary. (Initials:_____)
- **4. REMOVAL OF TEETH**
  Alternatives to removal have been explained to me (root canal therapy, crowns, and periodontal surgery, etc.) and I authorize the Dentist to remove the following teeth and any others necessary for reasons in paragraph # 3. I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue, and surrounding tissue (Paresthesia) that can last for an indefinite period of time (days or months) or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost which is my responsibility.
  (Initials:_____)
- **5. CROWNS,BRIDGES, AND CAPS**
  I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes to my new crown, bridge, or cap (including shape, fit, size, color) will be before permeant cementation.
  (Initials:_____)
- **6. DENTURES, COMPLETE OR PARTIAL**
  I realize that full or partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The problems of wearing these appliances have been explained to me, including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new dentures (including shape, fit, size, placement, and color) will be the "teeth in wax" try in visit. I understand that most dentures require reining approximately three to twelve months after initial placement. The cost for this procedure is not included in the initial denture fee.
  (Initials:_____)
- **7. ENDODONTIC TREATMENT (ROOT CANAL)**
  I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur during treatment, and that occasionally metal objects are cemented in the tooth or extend through the root, which does not necessarily affect the success of the treatment, I understand occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy).
  (Initials:_____)
- **8. Fillings**
  I understand that care must be exercised in chewing on fillings especially during the first 24 hours to avoid breakage. The tooth is restored with either composite (tooth colored filling) or amalgam (silver filling). I understand that a more expensive filling than initially diagnosed may be required due to additional decay. I understand that significant sensitivity is a common after effect of a newly placed filling. The nerve of the tooth could possibly become damaged and may require root canal therapy or extraction of the tooth. (Initials:_____)
- **Nitrous Oxide (Laughing Gas)**
  I have agreed to not eat or drink for 6 hours prior to my appointment due to possible nausea, vomiting, and aspiration into the lungs which would become an emergent situation requiring hospitalization. **I have advised the dentist and her staff of all medications I am currently taking and that I am not pregnant (if a parent is pregnant they will not be able to be in the room with the child if Nitrous Oxide is being used).** Research has found that Nitrous Oxide may have a negative affect with any form of autism. (Initials:_____)
- **Dentures**
  I understand the wearing of dentures is difficult. Sore spots altered speech and difficulty in eating are common problems. Immediate dentures (placement of dentures immediately after extractions) may be painful. Immediate dentures may require considerable adjusting and several relines. A permanent reline will be needed later. This is not included in the denture fee. I understand that it is my responsibility to return for delivery of the dentures. I understand that failure to keep my delivery appointment may result in poorly fixed dentures. If a remake is required due to my delays of more than 30 days there will be additional charges. (Initials:_____)

I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

Signature of Patient:_____

Signature of Parent/Guardian:_____

Date:_____

Cynthia A. Leigh, DDS
704-489-2009

501 N. Hwy 16
Denver, NC 28037

DENTAL OFFICE POLICIES

PATIENTS WITH DENTAL INSURANCE: As a courtesy to you, our office will gladly submit to your insurance. We are able to bill to all traditional, indemnity insurance plans.

PAYMENTS: We accept cash, check (returned check fee $25), VISA, MasterCard and Discover. Payment of your "estimated" portion is due at the time services are rendered, such as your annual deductible and/or percentage of the treatment not covered by insurance. As a courtesy, we will gladly contact your insurance in order to provide an "estimate" of your patient portion. However, despite this, we cannot guarantee the payment of insurance benefits nor can we provide 100% accuracy of this estimated amount since many factors are involved that determine the actual payment of benefits once submitted and processed by your insurance. Keep in mind that many insurance companies base their quoted percentage of coverage (i.e. 100%, 80%, 50%, etc.) on their own fee schedule and not our office's actual fees which may result in a balance due higher than expected. Should an outstanding balance due result after your insurance company processes your claim, you will then be sent a statement. Payment in full is due by the due date printed on the statement. Our office policy does not allow partial payments. If a credit balance should result after insurance processes your claim, a refund will be promptly issued.

UNPAID INSURANCE CLAIMS: All dental services rendered, whether or not covered by insurance, are ultimately the financial responsibility of the account holder. We will give your insurance company 60 days to remit payment. If there is still no payment after this time, in order to keep your account current, you will be financially responsible for 100% of the outstanding insurance claim. A statement will be sent to you, and payment in full will be due on the due date printed on the statement. It is the responsibility of the account holder to follow up with their own insurance company regarding the non-payment of a claim. Should our office eventually receive a payment from your insurance after it has been paid by you, a prompt refund will be issued.

PAST-DUE ACCOUNTS: Account aging begins the day your charges are incurred. If payment is not received by the due date printed on the statement, then your account is considered past-due. We reserve the right to charge a 5% per month billing charge on all past-due accounts. Accounts that are ninety days past due will be turned over to a third party collection agency. This action will cause an additional fee of 45% of your unpaid balance to be added to your account. We dislike doing this and will do so only if all other efforts to collect your unpaid balance have failed. Once an account is turned over to collections, we will ask you to seek the services of another dentist and will no longer take responsibility for your family's dental care.

PATIENTS WITHOUT DENTAL INSURANCE: Payment in full is expected at the time services are rendered. We accept cash, check (returned check fee $25), VISA, MasterCard and Discover.

BROKEN/MISSED APPOINTMENTS: Our goal is to have a relationship of trust and respect with our patients. We are making a commitment to you and we know you are making a commitment to us. Please mark your reserved appointment day and time on your calendar. We look forward to seeing you.

Dr. Leigh reserves the right to update and make changes to the above stated office policies at any time without prior notification.

By signing below I verify that I completely understand, agree, and accept the policies outlined above. I further acknowledge that I am responsible for all dental services rendered for me and my dependents (if applicable).

Patient Name (print):_____ **Date:**_____

Responsible Party Signature:_____ **Relationship to patient:**_____