CHARLES ASHLEY MANN, DDS
AND ASSOCIATES
Family and Cosmetic Dentistry

CARY | 315 E. Chatham Street, Suite 100 ▪ Cary, NC 27511 ▪ Phone: (919) 462-9338
GARNER | 1310 5th Avenue, Suite 100 ▪ Garner, NC 27529 ▪ Phone: (919) 838-7388
FUQUAY-VARINA | 280 Bramblehill Dr ▪ Fuquay Varina, NC 27526 ▪ Phone: (919) 552-1044

Hello and welcome to our office:

One of the goals of our practice is to do everything to make your dental visit just as pleasant as possible. If you happen to have a dental insurance plan, do not hesitate to ask any questions about your plan or any aspect of the treatment we are advocating. In order for us to make your dental plan work successfully, we must emphasize several important factors:

- We will be happy to file your insurance as a courtesy to you. Be aware that insurance is a contract between you, your employer, and the insurance company. We will gladly help you obtain your maximum insurance benefits. However, you will be responsible for any account balance not covered by your insurance.

- Any insurance benefits payable are assigned to the provider.

Please know that your estimated payment will be due at the time the service is rendered. Accepted methods of payment are cash, personal check, credit card (Visa®, MasterCard®, American Express®, or Discover®), and Interest-Free Financing. If your account becomes past due over 60 days, there will be a finance charge of 24% added to your account.

If you are scheduled for an emergency visit, 100% is due at the time of service.

Patient Name: _____

Patient Signature: _____ **Date:** _____

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Failure to Appear Policy

LAST MINUTE CANCELLATIONS AND NO SHOWS

FIRST TIME - $90 Cancellation/No Show Fee

Oh no, you missed your appointment; however, your time and our time is valuable.

SECOND TIME - 50% IS DUE

We hate you missed your appointment…we will only charge you half to reserve your next visit.

THIRD TIME - 100% IS DUE

We missed you, but your dental team has been waiting…

Please understand that when you forget or cancel your appointment without giving notice, we miss the opportunity to fill that reserved time. Patients on our waiting list miss out on the opportunity to receive treatment. Since the appointment time is reserved for you personally, our dental team misses out as well.

FOURTH TIME

If failure to appear occurs often, you will be asked to find another provider.

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Patient Registration

Patient Information:

First Name: _____ Middle Initial: _____ Last Name: _____

Nickname: _____ Home Phone: (_____) _____

Address: _____ Work Phone: (_____) _____

City: _____ State/Zip: _____ Cell Phone: (_____) _____

Birth Date: _____ Age: _____ Sex: Male Female Marital Status: _____

Social Security Number: _____ Drivers License Number: _____

E-mail: _____ How did you hear about the practice? _____

Would you like to receive email confirmation for your scheduled appointments? YES NO

EMERGENCY CONTACT: _____ Relationship: _____

Phone number: _____ Is patient a full or part time student? _____

Primary Dental Insurance Information: ☐

Subscriber Name: _____Relationship to patient: PLEASE CIRCLE: SELF / SPOUSE / CHILD / OTHER

Employer who provides the insurance coverage: _____ Subscriber ID# _____

Name of Dental Insurance Company: _____ Group # _____

Address of Dental Insurance Company: _____ SS # _____

_____ Date of Birth: _____

Secondary Dental Insurance Information:

Subscriber Name: _____Relationship to patient: PLEASE CIRCLE: SELF / SPOUSE / CHILD / OTHER

Employer who provides the insurance coverage: _____ Subscriber ID# _____

Name of Dental Insurance Company: _____ Group # _____

Address of Dental Insurance Company: _____ SS # _____

_____ Date of Birth: _____

Responsible Party (If someone other than patient)

Name: _____

Address: _____ Date of Birth: _____

_____ SS #: _____

Home #: _____ Work #: _____ Cell #: _____

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Dental Health History

Please check any of the following problems that apply to you:

- ☐ Sensitivity (hot, cold, sweet)
- ☐ Tooth pain or discomfort when chewing
- ☐ Headaches or cold sores
- ☐ Mouth ulcers or cold sores
- ☐ Jaw joint pain
- ☐ Broken tooth or fillings
- ☐ Grinding or clenching teeth
- ☐ Bleeding, swollen or irritated gums
- ☐ Loose, tipped or shifting teeth
- ☐ Bad breath or bad taste in your mouth

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

- ☐ Dentures
- ☐ Partial dentures
- ☐ Braces
- ☐ Gum treatment
- ☐ Sleepiness during the day
- ☐ Snoring
- ☐ Gasping or choking while sleeping

Please share the following dates:
Your last dental cleaning _____
Your last oral cancer screening _____
Your last complete set of x-rays _____

Previous Dentist:
Name of Practice/Dentist: _____
City and State: _____
Contact number: _____

What is the most important thing to you about future smile and dental health?

If you could whiten your teeth for an affordable rate, would you?

Do you smoke or use chewing tobacco?
How much? For how long?

If you could change your smile, you would:

- ☐ Make my teeth whiter
- ☐ Make my teeth straighter
- ☐ Close spaces
- ☐ Replace metal fillings with colored fillings
- ☐ Repair chipped teeth
- ☐ Replace missing teeth
- ☐ Replace old crowns that don't match
- ☐ Have a smile makeover

On a scale of 1—10, with 10 being the highest rating:

How important is your dental health to you?
1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health?
1 2 3 4 5 6 7 8 9 10

What is the <u>most</u> important thing to you about your dental visit today?

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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.

	YES	NO	If you answer yes to any of the following questions please explain here:
Are you under a physician's care now?	☐	☐	
Have you ever been hospitalized or had a major operation?	☐	☐	
Have you ever had a serious head or neck injury?	☐	☐	
Are you taking any medications, pills, or drugs?	☐	☐	
Do you take or have you taken Phen-Fen or Redux?	☐	☐	
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	☐	☐	
Are you on a special diet?	☐	☐	
Do you use tobacco?	☐	☐	
Do you use controlled substances?	☐	☐	

Women: Are you	YES	NO		YES	NO		YES	NO
Pregnant or Trying to get pregnant?	☐	☐	Taking oral contraceptives?	☐	☐	Nursing?	☐	☐

Are you allergic to the following? Indicate which of the following allergy you have?

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

Are you allergic to anything not previously mentioned? _____

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

Have you ever had any serious illness not listed above? YES or NO if yes please explain: _____

_____

_____

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: _____ DATE: _____

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Acknowledgement of Receipt of Notice of Privacy Practices

Patients Name: _____

Patients 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 _____

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Authorization for Release of Information – Compound Release

Name of Patient _____ Date of Birth _____

_____ 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

*Description of Personal Representative's Authority (attach necessary documentation)

Revised March 2016

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To accept insurance payments, we now require that a credit / debit card be left on file with our office.

I authorize the office of Dr. C Ashley Mann and Associates to keep my signature on file and to charge my credit card account for balance of charges not paid by my insurance carrier, and not to exceed $50.00. We will call on all balances over $50.00 for authorization before charging your credit card.***

Any overpayment on the account will be refunded to the same credit card used for payment.

I assign my insurance benefits to the provider listed above. I understand this form is valid unless I cancel the authorization through written notice and provide alternative payment for committed amount. I understand that this credit card information will not be shared with any outside sources.

Patient's Name: _____

Cardholder Name: _____

Please Designate: ☐ Visa ☐ MasterCard ☐ American Express ☐ Discover

Account #: _____ Expiration Date:_____

Card CVV _____ Billing Zip Code:_____

Cardholder's Signature: _____ Date: _____

Witness' Signature: _____ Date: _____

*** If your balance exceeds $50.00 and no payment attempts have been made, this agreement authorizes the office of Dr. C Ashley Mann and Associates to charge the above account for the full balance after 60 days of non-payment.

CHARLES ASHLEY MANN, DDS AND ASSOCIATES
Family and Cosmetic Dentistry

Charles Ashley Mann, DDS & Associates

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED BY [Practice Name] AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

YOUR RIGHTS: When it comes to your health information you have certain rights. This section explains your rights.

Upon written request:

- Ask to see or get an electronic or a paper copy of your health record or other information we have about you. We will also provide a summary of your health information if requested. We will charge a reasonable, cost based fee. We will provide this information as soon as possible but no later than 30 working days of the request.
- Ask us to correct your health information you think is incorrect or incomplete. We may say "no" but will tell you why in writing within 60 days.
- You can ask us to communicate with you in a certain way (for example, home or office phone) or to send mail to a different address. We will accommodate all reasonable requests.
- Ask us not to use or share certain health information for treatment, payment or our operations. We are not required to agree with your request and may say "no" if it would affect your care.
- If you pay for a service or health care item out of pocket in full and you ask us not to share that information for payment or our operations with your health insurer we will agree unless we are required by law to share that information.
- Ask us for a list or an accounting of the times we have shared your health information for reasons other than treatment, payment, healthcare operations, and when you have asked us to share information. We will provide a list for the past six years for the request. One request per year will be provided free of charge. For additional requests we will charge a reasonable, cost based fee.
- Revoke an authorization to use or disclose PHI at any time except where action has already been taken.

You may also:

- Choose someone to act on your behalf. If you have given someone medical power of attorney or they are your legal guardian, that person can exercise your rights and make choices about your health information. We will ask for proof of this relationship before we take any action.
- Ask for a paper copy of this document even if you have agreed to receive the notice electronically. We will provide that copy promptly.
- File a complaint. If you feel your rights have been violated you may contact the designated Privacy Officer, [Practice officer, address, phone number and email address]
- File a complaint with the US Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Ave, S.W., Washington, D.C. 20201, calling 1.877.696.6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints.
- We will not retaliate for filing a complaint.

OUR RESPONSIBILITIES: The law requires us to:

- Maintain the privacy and security of your protected health information.
- Notify you promptly if a breach occurs that may compromise the privacy or security of your information.
- Follow the duties and privacy practices described in this notice and give you a copy of it.
- Not to use or share you information other what is described in this notice unless you tell us we can in writing. If you tell us we can and then change your mind, just let us know in writing you have changed your mind.

YOUR CHOICES - For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in situations described below, talk to us.

- In these cases you have both the right and the choice to tell us to: share information with your family, close friends, or others involved in your care and share information in a disaster relief situation.

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

- In these cases we never share your information unless you give us written permission:
  - Marketing purposes
  - Sale of your information
  - Most sharing of psychotherapy notes
  - In the case of fundraising, we may contact you for fundraising efforts, but you can tell us not to contact you again.

OUR USES AND DISCLOSURE – We typically use or share your health information in the following ways:

Treatment: We can use your health information and share it with other professionals who are treating you. Example: we may share your health information to an outside doctor for referral. We will also provide your health care providers with copies of various reports to assist them in your treatment.

Payment: We can use or share your health information to bill and get payment from health plans or other entities. Example: we give information about you to your health insurance plan so it will pay for your healthcare.

Health Care Operations: We can use and share your health information to run our practice, improve your care, and contact you when necessary. Example: we use health information about you to manage your treatment and services.

Other ways we can use or share your health information – We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

- **Help with public health and safety issues:** We can share health information about you for certain situations such as: preventing disease, helping with product recalls, reporting adverse reactions to medication, reporting suspected abuse, neglect, or domestic violence, and preventing or reducing a serious threat to anyone's health and safety.
- **Comply with the law**: We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see if we are complying with federal privacy law.
- **Respond to organ and tissue donation requests:** We will share health information about you with organ procurement organizations.
- **Work with a medical examiner or funeral director:** We can share health information with a coroner, medical examiner, or funeral director when you die.
- **Address workers' compensation, law enforcement, and other government requests:**
  - For workers' compensation claims
  - For law enforcement purposes or with a law enforcement official
  - With health oversight agencies for activities authorized by law
  - For special government functions such as military, national security, and presidential protective services
- **Respond to lawsuits and legal actions:** We can share your health information to respond to a court or administrative order, or in response to a subpoena.
- **Research:** We can use or share your information for health research.

CHANGES TO THIS NOTICE - We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office and on our website.

Privacy Officer (Cary Office): Crystal Pion | Email: crystalp@smilemann.com | Phone: 919.462.9338

Privacy Officer (Garner Office): Nikki Smith | Email: nikki@smilemann.com | Phone: 919.838.7388

Privacy Officer (Fuquay-Varina Office): Vanessa Hernandez | Email: vanessa@smilemann.com | Phone: 919.552.1044

Effective date: 10/2021