Modern
Family Dental Care

Healthy Smiles. Healthy Family. Happy Life.

New Patient Registration

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

How did you learn of Modern Family Dental Care?
□ Direct Mailing □ Friend/Relative □ Internet Search □ Insurance Plan □ Newspaper Ad □ Exterior Sign □ Facebook □ Twitter
□ Other_____ If you were referred, whom may we thank for referring you?_____

Patient Information

Name _____ Nickname _____ Sex M F

SSN _____ Birth date _____ Cell Phone _____

Address _____ Home Phone _____

City _____ State _____ Zip _____ Work Phone _____

Email _____ Facebook _____ Twitter _____

Check appropriate box: □ Minor □ Single □ Married □ Divorce □ Widowed □ Separated

If student, name of school _____ FT / PT City _____ State _____ Zip

Patient or parent/guardian's employer _____ Work Phone _____

Employer Address _____ City _____ State _____ Zip _____

Emergency Contact _____ Phone _____

Responsible Party

Name of person responsible for account _____ Relationship to Patient _____

Address _____ Cell Phone _____

City _____ State _____ Zip _____ Home Phone _____

Email _____ DOB _____ Work Phone _____

Are you currently a patient of this office? □ Yes □ No Drivers License # / State _____

Employer _____ SSN _____

Insurance Information

Name of Insured _____ Relationship to Patient _____

DOB _____ SSN _____ Date Employed _____

Name of Employer _____ Address _____ Work Phone _____

City _____ State _____ Zip _____ Home Phone _____

Insurance _____ Group # _____ Policy/ID # _____

Insurance Address _____ City _____ State _____ Zip _____

Consent

I will answer all health questions on the Medical History From to the best of my knowledge_____ (Initials)

After explanation by the doctor, I hereby authorize the performance of dental services upon the above named patients and whatever procedures that the judgment of the doctor may decide in order to carry out these procedures. I also authorize and request the administration of any anesthetics and x-rays as may be deemed necessary and advisable by the doctor.

Signature _____ Date_____ Relationship to Patient_____

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Patient Medical History Form

Dental History

Why have you come in to see us today? (e.g.: pain, checkup, etc.)? _____

What is your biggest concern about your gums, teeth and/or mouth? _____

Previous Dentist & Location _____ Date of Last Cleaning _____

Do your gums bleed when flossing? ……..	☐ Yes ☐ No	Do you have frequent headaches? ……	☐ Yes ☐ No
Are your teeth sensitive to hot or cold? ……..	☐ Yes ☐ No	Do you clench or grind your teeth? ……..	☐ Yes ☐ No
Are your teeth sensitive to sweet or sour? ……..	☐ Yes ☐ No	Do you have bad breath or mouth odors? ……	☐ Yes ☐ No
Do you have loose teeth?	☐ Yes ☐ No	Do you bite your lips or cheeks frequently? ……	☐ Yes ☐ No
Do you feel pain in any of your teeth? ……...	☐ Yes ☐ No	Have you had difficult extractions in the past? ……	☐ Yes ☐ No
Do you have any sores or lumps in or near your mouth?	☐ Yes ☐ No	Have you had prolonged bleeding after extractions?	☐ Yes ☐ No
Have you had any head, neck, or jaw injuries? ……..	☐ Yes ☐ No	Have you had any orthodontic treatment? ……...	☐ Yes ☐ No
Do you have dental anxiety? ……..	☐ Yes ☐ No	Do you wear dentures or partials? ……	☐ Yes ☐ No
Do you avoid brushing part of mouth due to pain? ……	☐ Yes ☐ No	If yes, date of placement: _____	
Have you ever experienced any of the following:		Have you ever received oral hygiene instructions	
Jaw clicking, popping or locking? …….	☐ Yes ☐ No	regarding the care of your teeth and/or gums? …….	☐ Yes ☐ No
Pain (jaw, joint, ear, side of face)? …….	☐ Yes ☐ No	Do you like your smile? ……...	☐ Yes ☐ No
Difficulty opening or closing jaw? …….....	☐ Yes ☐ No	Do you want your teeth straight? …..……...	☐ Yes ☐ No
Difficulty chewing ……..	☐ Yes ☐ No	Do you want whiter teeth? ……...	☐ Yes ☐ No

Medical History

Physician _____ Office Phone _____ Date of last exam _____

Are you under medical treatment now?	☐ Yes ☐ No	Do you use tobacco?	☐ Yes ☐ No
Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?	☐ Yes ☐ No	Are you allergic to or have reactions to the following:	
Are you any medication(s), including non-prescription?	☐ Yes ☐ No	Local Anesthetics (e.g. Novocaine)	☐ Yes ☐ No
Have you ever taken Fen-Phen/Redux?	☐ Yes ☐ No	Sulfa Drugs	☐ Yes ☐ No
Have you ever taken any cancer medications?	☐ Yes ☐ No	Barbiturates	☐ Yes ☐ No
Have you taken Viagra, Cialis, or Levitra in the last 24 hours?	☐ Yes ☐ No	Penicillin or Antibiotics	☐ Yes ☐ No
Do you use alcohol?	☐ Yes ☐ No	Sedatives	☐ Yes ☐ No
Do you use controlled substances?	☐ Yes ☐ No	Iodine	☐ Yes ☐ No
FOR WOMEN ONLY		Aspirin	☐ Yes ☐ No
Are you pregnant or think you may be pregnant?	☐ Yes ☐ No	Any Metals (e.g. nickel, mercury, etc.)	☐ Yes ☐ No
Are you nursing?	☐ Yes ☐ No	Latex Rubber	☐ Yes ☐ No
Are you taking oral contraceptives?	☐ Yes ☐ No	Other (please list below)	☐ Yes ☐ No

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

High Blood Pressure	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Chest Pains	☐ Yes ☐ No
Heart Attack	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Hay Fever Allergies	☐ Yes ☐ No
Rheumatic Fever	☐ Yes ☐ No	AIDS or HIV	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Swollen Ankles	☐ Yes ☐ No	Cardiac Pacemaker	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Fainting/Seizures	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Radiation Therapy	☐ Yes ☐ No

Medical History Cont.

Asthma	☐ Yes ☐ No	Angina	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No
Low Blood Pressure	☐ Yes ☐ No	Anemia	☐ Yes ☐ No	Recent Weight Loss	☐ Yes ☐ No
Epilepsy/Convulsions	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No
Leukemia	☐ Yes ☐ No	Cancer/Tumor	☐ Yes ☐ No	Heart Trouble	☐ Yes ☐ No
Kidney Disease	☐ Yes ☐ No	Arthritis	☐ Yes ☐ No	Respiratory Problems	☐ Yes ☐ No
Thyroid Problems	☐ Yes ☐ No	Joint Replacement/Implant	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No
Frequently Tired	☐ Yes ☐ No	Liver Disease/Jaundice	☐ Yes ☐ No	Hepatitis Type _____	☐ Yes ☐ No
Bleeding Disorder	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No	Psychiatric Treatment	☐ Yes ☐ No
STD	☐ Yes ☐ No	Stomach Trouble/Ulcer	☐ Yes ☐ No	Other	☐ Yes ☐ No

If you answered YES to any questions above, please explain:

Medications

Please list any medications that you are currently taking:

AUTHORIZATION & RELEASE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners.

X _____ Date _____

Signature of patient (or parent /guardian if a minor)

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Receipt of Privacy Practices and Authorizations

Patient's Name: _____ Birth Date _____
Address _____

Authorizes:

Modern Family Dental Care
Taj M. Haynes DMD, PA
8455 Pit Stop Ct NW, Ste 140
Concord, NC 28027

To use or disclose protected health and account information to the person(s) listed in the sections below for the following patient:

- Receiving Entity:_____ Birth Date:_____
  Address:_____
  Contact:_____ Relationship:_____

- Receiving Entity:_____ Birth Date:_____
  Address:_____
  Contact:_____ Relationship:_____

This authorization shall be enforced until revoked by the patient. This practice will verify the identity of any entity requesting protected health information by photo ID.

Rights of the Patient
I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

I understand that I have the right to revoke this authorization at any time by sending a written notification to the address listed at the top of this form I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I hereby acknowledge that I have received the Notice of Privacy Practices for the above office.

_____Date _____
Signature of Patient or Personal Representative (as defined by HIPAA)

_____
Description and/or relationship of Personal Representative's Authority:

Modern
Family Dental Care

Important Information for Our Patients

Terms of Payment

The following is a guide to the terms of payment we accept. We are committed to working with you to match a payment plan to your needs; therefore we offer different options to our patients, which allows for payment to be convenient and flexible. We are available to answer any questions you may have.

Dental Insurance

We will gladly assist you with your dental insurance plan. To help us assist you in determining your maximum benefit, please ***be sure to provide us with your dental insurance card.*** Most plans cover only a portion of the dental fee, therefore as a courtesy to our patients we will file your primary insurance for you but we ask that you pay the non-covered balance at the time of service unless prior arrangements have been made. If your insurance company has not paid within 60 days you will be billed for the unpaid balance and payment in full will be expected at this time. We recommend you become directly involved in communication with your insurance company in order to expedite payment.

We do accept secondary dental insurance; however, please refer to the Secondary Insurance policy.

Payment Options

- A pre-authorized 0% interest monthly payment plan on your credit card (requires no credit check)
- A convenient low payment plan through an outside financial institution (requires credit check)
- We accept Visa, MasterCard, AMX, money order, cash, or personal check.

Appointments

In order to allow the best possible care for our patients we reserve a specific time just for you and make every effort to see you as scheduled. We appreciate your promptness and your consideration in not changing your scheduled time. However, if you need to change your appointment a **48-hour notice is required** or you may be charged a $50 cancellation fee.

Patient Agreement

- I understand that my insurance policy is an agreement between myself and the insurance company, therefore I am ultimately responsible for all fees incurred for my dental treatment regardless of payment or denial of my insurance claims by my insurance company.
- I authorize insurance payment directly to Dr. Taj M. Haynes
- I authorize the release of necessary information to my insurance company to determine liability for payment and to obtain reimbursement for any claims.
- If this account is assigned to an attorney or collection agency, I agree to be responsible for any attorney fees, collection fees, and court cost incurred.

_____ _____

SIGNATURE OF RESPONSIBLE PARTY DATE

Modern
Family Dental Care

Patients with Commercial Health Insurance (Manage Care Plans)

This letter is to help you better understand the complexities of dental insurance; we realize how confusing it can be. To begin, the manage care plans, like Preferred Provider Organizations (PPO), are not designed to pay for all dental care. They will only pay for dental care services that are determined medically needed and are considered "covered services." Covered services are defined in the managed care plan's group dental agreement. Most contracts have limits and/or various degrees of co-payment. If a managed care plan determines that a service is not medically necessary or not covered, as defined in group dental agreement, then the manage care plan will not pay for the service or pay for the lowest cost alternative option.

All levels of payment by insurance companies, including allowed fees, usual and customary (UCR), are governed by the premiums paid. They have nothing to do with the actual charges. Our fees are based upon a combination of our costs, our time, and our constant dedication to delivering to our patients with the highest quality dental care. The treatment recommended by our office is never based on what your insurance company will pay; your treatment should not be governed by your insurance contract.

In certain cases, your doctor, based on his or her medical opinion, may request that the service, x-ray and/or test be performed that may not be considered a covered service as defined in your group dental agreement. Services a provider may request that may not be considered "covered services" may include, but not limited to:

- Periodic oral health maintenance examinations
- Certain screening or diagnostic tests
- Diagnostic x-rays or scans
- Oral biopsies
- Preventative treatments and services
- Other special procedures

However, it should be understood, **that the dental insurance contract is between the insurance company and the patient**, whom bears the ultimate financial responsibility.

Please take the time to review your contract thoroughly so we may best serve you. If you have a question or concern about a procedure that may not be covered by your insurance company, we encourage you to contact your insurance company directly. As always, you may feel free to ask any member of our staff for clarification on services, billing, and insurance.

_____ _____

Patient /Responsible Party Signature

Date

Modern
Family Dental Care

FINANCIAL POLICY

Welcome:
Thank you for choosing us as your dental care provider. Dr Haynes and staff members are dedicated to serving your dental needs with the best professional advice, care and service obtainable. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our financial policy which we require you to read and sign prior to any treatment. We are glad that you are here and we want to do our very best for you. We sincerely hope that your visit will be a pleasant and rewarding experience. If you have any questions during your dental exam today, please feel free to ask.

Payment:
We want to help remove financial barriers so you and your family can get the dental treatment you need. Many patients have some type of dental insurance, and we are able and pleased to assist you in maximizing your benefits. We also understand that not all of our dental families have dental insurance, and we want you to rest assured that we have payment options to meet most patient's needs.

We accept cash, checks, debit and most major credit cards. We offer two flexible financing options because we understand that monthly payments can help fit dental care into your budget. The first is through **Comprehensive Finance** (for those who qualify), with **Comprehensive Finance**, you can finance 100% of your treatment with no annual fees. **Comprehensive Finance** allows for flexible payments so you can find an option that works well for you and your family. The second is our in-house financing which offers convenient and flexible payment options, no interest, and no credit approval required.

Minors:
The parent that accompanies the minor child/children to the appointment is responsible for any payment due. For unaccompanied minors, non-emergency treatment will be denied unless a financial agreement has been arranged with the billing department prior to the appointment date along with a signed consent form.

Insurance:
We accept most insurance plans and are in-network with the majority of insurance plans. Insured patients will receive cost estimates broken down by insured and uninsured costs. For patients covered by insurance, we will accept assignment of benefits. This means that you sign the portion of your insurance that "assigns" payment to our office. Please note that estimates are based on information provided by your insurance and are not a guarantee of payment. Only after a claim is submitted and reviewed by your insurance company can final payment be determined. As a courtesy, we file claim forms electronically, provide postage for special claims, and track claims for you.

In order for us to file your insurance we must have a copy of your current insurance card. If you do not have your insurance card at your first visit, full payment is due at the time of service. You are responsible for all co-pays and deductibles. We do not accept assignment of benefits for secondary insurance, however, we will provide a claim form to you, allowing you to file and be reimbursed by your secondary carrier.

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Your claim will be filed immediately, and the benefits expected are typically paid within 30 days. The filing of an insurance claim does not relieve you from the responsibility of your bill or the timely payment on your account. If the claim is not paid by your carrier in 60 days, the unpaid portion will automatically become "self-pay" and a statement will be issued for the unpaid portion.

We file claims to many different insurance companies, and it is virtually impossible for us to know your individual insurance policies. Please be aware that some, and perhaps all, of the services provided may be considered by your insurance company to be NON-covered services and/ or might be subject to a deductible in addition to your co-pay. You are responsible for any amounts your insurance company chooses not to pay, for whatever reason.

We will not become involved in disputes between you and your insurance company regarding non-covered charges, diagnoses, co-pays or deductibles. Please refrain from asking our office to change a diagnosis or procedure code in order for the visit to be covered by your insurance company.

It is your responsibility to let us know of any insurance changes in a timely manner. Feel free to contact your insurance company regarding unpaid benefits. We will gladly provide you with a letter which would include all pertinent information which you may sign and mail.

Secondary Insurance:
We will gladly file to your secondary insurance. If you are interested, please ask for the secondary insurance policy when completing the new patient paperwork.

Late Payments:
If payments are late, declined, or if you request a change in date or amount not in accordance to this agreement, a $25 processing charge will incur for each instance. In the event that multiple payments are declined, treatment will cease until payment is current and future treatment is paid in full. If treatment has been completed, full payment will be due immediately.

Credits:
If after all payments have been received, the patient account has a negative balance, the credit card on file will be credited the exact amount within 60 days.

Collections:
If this account is assigned to an attorney or collection agency, I agree to be responsible for any attorney fees, collection fees, and court cost incurred.

Missed Appointments:
Once an appointment has been made, that time is reserved specifically for you. If you need to cancel an appointment, we ask for at least a 48-hour notice. This allows us to offer the appointment to another patient. If you fail to keep your appointments without letting us know in advance, a $50.00 charge will be billed to your account.

Returned Check:
A returned check fee of $35 will be added to your account for any returned check. Before we accept another payment by check, the $35 fee plus full payment for the check that did not clear must be paid in cash, or by Visa, MasterCard, AMEX, or Discover.
I understand and agree to this financial policy. I have read the financial policy and agree that a photocopy of the financial policy shall be considered as effective and valid as the original. Regardless of what insurance coverage I have, I am ultimately responsible for the timely payment of my account and I hereby authorize the payment of insurance benefits to be made directly to Modern Family Dental Care.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

Signature of Patient or Responsible Party: _____ Date: _____

Modern
Family Dental Care

Modern Dental Care Warranty

Our office believes that excellent dental care solutions should last a very long time provided that patients maintain regular visits to the dentist and maintain the proper home care and diet. Our goal is to not only maintain your oral health by correcting your dental problems, but also to have our solutions last for many years into the future. This will save you both time and unnecessary expenses in the future. We also believe that our dental work is some of the best available. Know that with our dental care solutions, you can now have:

- **Peace-of-Mind** – know the workmanship of your restorative, cosmetic and other dental solutions is guaranteed for an extended period of time.
- **No Fault Coverage** – on repairs or replacement of covered restorations
- **No Cost Repair or Replacement** – repair damaged or broken restorations up to the amount of your original fee for that work.

We therefore offer our patients the following five-year (5) warranty on the following dental care solutions.

Dental Sealants
Sealants are plastic coatings placed on the chewing surfaces of the teeth to prevent decay in grooves of the teeth. These are the most common areas to get cavities. We will repair or replace sealants for a period of 5 years after placement. If decay is present on the chewing surface, the replacement filling will be done at no charge.

Composite (tooth-colored) Fillings
We will replace or repair the composite filling in the event of failure for a period of 5 years. If the tooth breaks and requires a crown or onlay, we will credit the cost you paid of the filling towards the crown or onlay.

Crowns, Bridges, Inlays, Onlays, and Porcelain Fillings
We will warranty these most comprehensive solutions for a full 5 years. We will replace or repair them at no charge during this five year period if they break, are lost, or decay with normal use. This does not include accidents that could also break normal healthy teeth.

Full Dentures and Partial Dentures
Full dentures and partial dentures will be covered for a period of 5 years. If a tooth chips or breaks under normal use, it will be repaired at no cost. This warranty does not cover accidents such as dropping your full denture or partial denture. Full upper and lower denture patients must be seen once every 12 months. Patients with some of their own natural teeth must be seen at the prescribed oral health maintenance appointment or this warranty is null and void (minimum every 6 months).

Disclaimers and Conditions

The warranty period begins at the time of placement or insertion of the dental solution. The long-term success of the dental treatment we provide for you depends upon your continuing home care of your teeth and gums, regular professional oral health maintenance appointments, cleanings, and fluoride treatments.
All repairs of the provided dental solutions are warranted against defects in material and workmanship under normal use and wear for a period of 5 years, with the following conditions:

- You must maintain uninterrupted membership in our practice
- Maintain your prescribed regular oral health maintenance appointments (with no appointment varying more than (15) days of our recommended schedule)
- Chips or damage to the dental work due to gum issues arising from neither surrounding/adjacent teeth nor accidents.
- Maintain your account in good standing. There can be no outstanding balance on any account for you or an immediate family member.
- Have all recommended restorative dental treatment performed by Modern Family Dental Care, including the use of bite appliances if recommended treatment plan.
- Cash refunds for any treatment rendered.
- Does not cover damage of dental work caused by or related to other dental offices other than our office, trauma, bone disease or gum disease after done post treatment.

Our obligation under this warranty is limited to the repair or replacement of the solutions which is reported to us within the applicable warranty period and which, upon examination by the Doctor proves to be defective. The provider reserves the right to replace the failed restoration with a different material or procedure, as he deems necessary. The warranty does not cover:

- Failure or repairs resulting from acts of god, neglect, abuse, violent acts, failure of supportive tooth or tissue structures, improper adjustments or improper dental hygiene.
- Incidental or consequential damages, including inconvenience, lost wages or pain and suffering.
- Additional required treatment on warranted teeth such as gum or nerve treatment.
- Accidents (car, trauma, etc.) that cause damage to teeth or dental prosthesis.

Signature _____ Date_____

Modern
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PHOTOGRAPHY AGREEMENT and RELEASE

We will be taking some photos during your treatment. Most of these pictures are used for planning, records and lab communication. They are also used to communicate with you about your teeth at different points during your treatment.

We would like to ask your permission to potentially use your photos for articles, advertisements, office brochures and educational purposes. By singing this agreement, you are giving us your permission to use the photos that we take.

Thank you!

Name Relationship to Child (if applicable)

Child's Name (if applicable)

Address

City State Zip

Signature Phone Number

_____Initial Decline

Modern
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Facts about Dental Insurance

Fact #1
Your dental insurance is based upon a contract between your employer and the insurance company. Should questions arise regarding your dental insurance benefits, it is best for you to contact your employer or insurance company directly.

Fact #2
Dental insurance benefits differ greatly from general health insurance benefits. In 1971, dental insurance benefits were approximately $1000 per year. Figuring a 3% rate of inflation per year, you should be receiving $3300 per year in dental benefits. Your premiums have increased, but your benefits have not. Therefore, dental insurance is NEVER a pay-all; it is only an aid.

Fact #3
You may receive a notification from your insurance company, stating that dental fees are "higher than usual and customary." An insurance company surveys a geographic area, calculates an AVERAGE fee, takes 80% of that fee and considers it customary. Included in this survey are discounted clinics and offices that take Dental Maintenance Organizations (DMO) plans, which bring down the average. The fee-for-service dentist in private practice will have fees that insurance companies define as higher than "usual and customary." Our practice is a high quality practice, offering the very best in dental services available. We are not a "cut-rate" practice; rather we offer total dental care for the patient who wants to keep their teeth in an optimum state for a lifetime.

Fact #4
There have been tremendous advances in the last ten years in the way dental care is performed. Insurance companies continue to promote their cover out-dated and unhealthy ways of restoring teeth while rejecting many of the newer, healthier and long-lasting materials and methods used in this practice to restore teeth. We have made a concerted effort to adopt and use the newest and best materials and technologies available like laser treatments.

Fact #5
Many plans tell their participants they will be covered up to "80% or up to 100%", but do not clearly specify the plan fee-schedule allowances, annual maximums or limitations. It is more realistic to expect dental insurance to cover 35% to 65% of major services. Remember, the amount a plan pays is determined SOLELY by how much your employer paid for the plan. You get back only what your employer put in, less the profits of the insurance company. Remember, the goal of insurance companies is NOT to help obtain the best quality of dental care. Their mission and goal is to garner profit for the insurance stockholders.

Fact #6
Many routine and preventative dental care services are NOT covered by insurance companies

Fact #7
Every insurance company pays varying amounts, depending on the plan sold to the employer. When we agreed to accept "assignment" from companies such as Delta Dental or Blue Cross & Blue Shield, we have to accept what the insurance company deems to be a "reasonable & customary" fee. This means we have to discount our rates.