DENTAL OASIS
OF CLAYTON

Welcome to Dental Oasis of Clayton,

please complete the following pages so that we can get to know you better.

¿Prefieres comunicarte en español? Sí/No

Patient Information:

First Name: _____ MI: _____ Last Name: _____ Preferred Name: _____

Address: _____ City: _____ State/Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Birth Date: _____ Age: _____ Social Security Number: _____

Drivers License Number: _____ Marital Status: _____

Sex: □ Male □ Female Email Address: _____

Previous Dentist & Location: _____

EMERGENCY CONTACT: _____ Relationship: _____ Phone Number: _____

How did you hear about our office? Please mark all that apply

___Location/Sign ___Radio ___Insurance Company

___Facebook ___Instagram ___Yelp ___Google ___Mailer

___Care Credit ___Internet Search ___Marketing Event ___Website

___Friend/Family/Staff (who can we thank? _____)

___Referring Doctor (who can we thank? _____)

Dental Insurance Information:

Subscriber Full Name (First/Last): _____

Relationship To Patient: _____ Subscriber's Phone Number: _____

Subscriber's Birth Date: _____ Subscriber's Employer: _____

Insurance Company: _____ Group Number: _____

Subscriber ID: _____ Subscriber's SS #: _____

Responsible Party (If Someone Other Than Patient)

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

Address: _____ City: _____ State/Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Birth Date: _____ Social Security Number: _____ Drivers License Number: _____

Medical History.

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 medications 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, why? _____

Have you ever been hospitalized or had a major operation? Yes/No If yes, why? _____

Have you had a serious neck/head injury? Yes/No If yes, please explain:_____

Are you taking any medications, pills or drugs? Yes/No If yes, what medications are you taking and what are you taking them for? _____

Do you or have you taken Phen-Fen/Redux? Yes/No If yes, when?_____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes/No

If yes, when?_____

Are you on a special diet? Yes/No If yes please explain:_____

Do you use tobacco? Yes/No If yes, how often _____

Do you use controlled substances? Yes/No If yes, please list what you are taking: _____

Do you need to pre-medicate? Yes/No If yes please explain:_____

Women are you: Pregnant/Trying to get pregnant? Yes/No Taking oral contraceptives? Yes/No Nursing? Yes/No

Are you allergic to any of the following? Aspirin Penicillin Codeine Acrylic Local Anesthetics

Metal Latex Sulfa Other? _____

Please circle any of the following that you have or have had:

AIDS/HIV Positive	Cortisone Medicine	Hemophilia	Recent Weight Loss
Alzheimer's Disease	Diabetes	Hepatitis A	Renal Dialysis
Anaphylaxis	Drug Addiction	Hepatitis B or C	Rheumatic Fever
Anemia	Easily Winded	Herpes	Scarlet Fever
Angina	Emphysema	High Blood Pressure	Shingles
Arthritis/Gout	Epilepsy or Seizures	High Cholesterol	Sickle Cell Disease
Artificial Heart Valve	Excessive Bleeding	Hives or Rash	Sinus Trouble
Artificial Joint	Excessive Thirst	Hypoglycemia	Sleep Apnea
Asthma	Fainting Spells/Dizziness	Irregular Heartbeat	Spina Bifida
Blood Disease	Frequent Cough	Kidney Problems	Stomach/Intestinal Disease
Blood Transfusion	Frequent Diarrhea	Leukemia	Stroke
Breathing Problems	Frequent Headaches	Liver Disease	Swelling of Limbs
Bruise Easily	Genital Herpes	Low Blood Pressure	Thyroid Disease
Cancer	Glaucoma	Lung Disease	Tonsillitis
Chemotherapy	Hay Fever	Mitral Valve Prolapse	Tuberculosis
Chest Pains	Heart Attack/Failure	Osteoporosis	Tumors or Growths
Cold Sores/Fever Blisters	Heart Murmur	Pain in Jaw Joints	Ulcers
Congenital Heart Disease	Heart Pacemaker	Parathyroid Disease	Venereal Disease
Convulsions	Heart Trouble/Disease	Psychiatric Care	Yellow Jaundice
COPD		Radiation Treatments	

Other illness not listed: _____

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. I understand it is my responsibility to inform Dental Oasis of Clayton of any changes to the information listed above.

_____ Date: _____

Signature of Patient/Parent/Guardian

Do you know that Dental Oasis of Clayton is pleased to offer Botox & Dermal Fillers? We can help treat your migraines, TMD, gummy smiles, frown lines, forehead lines, clenching & grinding as well as fill-in any folds/lines around you mouth, black triangles between your teeth and cheeks, all to help improve your smile.

What cosmetic changes would you be interested in?

Smile Rejuvenation Restore Facial Volume Reverse Signs of Aging

Wrinkle Reduction Lip Rejuvenation Reduction of Gummy Smile

Reduction of Frown Lines Reduction of Eye Wrinkles Reduction of Smile Lines

Other: _____

What conditions would you like to alleviate?

TMD Teeth grinding & clenching Headaches Facial pain Gummy smile

Cracks & sores at the corners of your mouth Volume loss around the mouth

Jaw muscle hyperactivity Spaces between teeth Asymmetric smile

Other: _____

Have you ever had BOTOX®, Xeomin®, or Dysport® treatments done before? YES NO

If yes, when was your last treatment? _____

Please list the areas treated: _____

Have you had dermal fillers done before? YES NO

If yes, when was your last treatment? _____

Please list the areas treated: _____

If yes, circle what material(s) or filler(s) were used for your treatment:

Restylane® Juvederm® Voluma® Vollure® Versa® Volbella® Belotero®

Sculptra® Artefill® Radiesse® Collagen Silicon Other:_____

Do you suffer from periodic and/or chronic cold sores? YES NO

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Welcome to Dental Oasis of Clayton, the office of Lindsey Williams, DDS, P.A. We appreciate the opportunity to provide for your dental needs. We do our best to provide you with superior dental and patient care. Please read this document thoroughly and sign this page acknowledging that you have read and understand this document.

Financial Guidelines: We do a complimentary insurance benefit check for those patients who have dental insurance coverage to better understand your coverage. It is ultimately your responsibility to be aware of your own dental coverage and provide us with as much information as possible, in order to better assist you. We will accept assignment of benefits, paid directly to our office. We will estimate as closely as possible what portion your insurance will cover, but be aware that plans differ in coverage. We will collect estimated co-payments and deductibles on the day services are rendered. After 60 days, the balance on the account will be due in full from you if your insurance has not paid, as you are responsible for all payments made to your account. A finance charge may be added to your account after 90 days of no payments or accounts could be turned over to an outside collection agency. Patients without insurance are expected to pay in full by cash, check, or major credit cards the day services are rendered, unless financial agreements have been made prior to treatment beginning. For your convenience we do offer information for financing your dental visits from 2 months to 5 years. Please feel free to ask someone about this service.

Appointments: We make every effort to provide dental service in a timely manner. We understand that your time is valuable and want your visit to be as convenient as possible. In order to give you the most efficient care, we work within an appointment system and your appointment times are reserved especially for you. Our office hours are Mondays 9:30a-6p, Tuesday/Thursday 7a-4:30p, Wednesday 7a-7p and Friday 8a-2p. We make every effort to honor all time commitments and expect that patients extend the same courtesy to us. We aim to give you the time and attention you need when in our office. Please help us achieve this goal by being punctual for your appointment. If you are more than 15 minutes late for your appointment we may need to reschedule you to allow enough time for your treatment. For all operative appointments scheduled, a scheduling deposit will be required.

Cancellation Policy: I understand that if I am unable to keep my scheduled appointment for any reason, **I will notify the office at least forty-eight (48) hours in advance of my scheduled appointment time. I understand that I will need to call the office and confirm my appointment within forty eight (48) hours. I understand that if I do not call the office to confirm my scheduled appointments, my appointment may be released to another patient.** Please note schedule changes will be accepted only during regular office hours. **I am aware that I may be charged a fee if I do not provide forty-eight (48) hours notice of cancellation or do not show up for the appointment. The fee will vary depending on the amount of time scheduled and will not be less than $25.00.** If you fail to show up for two (2) appointments, we may not be able to schedule you for any more appointments.

Insurance: We would like for all of our patients to better understand their dental insurance. The first thing to know is that dental insurance is not insurance at all. Insurance originated as, and is by definition, *a pooling of funds to pay for a rare, but catastrophic event*. Fire insurance is an excellent example. Originally, medical insurance was also designed this way. Payment for routine office visits, basic medications, and low deductibles are a relatively recent modification in medical policies to create additional employee benefits that are not true insurance but "tax-free" benefits.

At our office, we believe that you deserve the best in dental care. That is why we always present you with the best dental solution possible to treat your personal situation. Each year we provide outstanding dental care to thousands of people. Some have dental benefits, but most do not. If you have dental benefits, congratulations! You are very fortunate. Here are some important things you should know:

- Your dental benefits are based upon a contract made between your employer and insurance company. If you have any questions regarding your dental benefits please contact your employer or the insurance company directly.
- Dental benefits differ greatly from medical benefits. In 1959, most dental benefit plans had a yearly maximum cap of $1,000 & you will be surprised to know that the average dental benefit plan today still has a yearly maximum cap of $1,000. There has been no significant increase in the yearly maximum cap in over 40 years! However, there have been significant increases in your premiums. Dental benefit plans will never pay for completion of your dental care. It is only meant to assist you.
- Many people receive notification from their insurance company that dental fees are "above usual and customary". An insurance company determines their reimbursement level by surveying a geographical area, calculating the average fee, then determines that 80% of the average fee is customary. Included in the survey are discount dental clinics and managed care facilities, which have severely reduced dental fees that bring down the average. Any doctor in private practice will have fees that insurance companies define as "higher than usual and customary".
- Many dental benefit plans tell their participants that they will be covered "**up to** 80% or 100%" but do not clearly specify the plan fee schedule allowance, annual maximums or limitations. It is more realistic to expect dental benefits to cover between 25%-60% of dental services. Remember that the amount a plan reimburses is determined by how much your employer has paid for your dental benefit plan. You will only get back what your employer has put in, less the insurance company's profit margin.
- Insurance companies do not recognize many routine and newer dental services. Our team will gladly assist you in filling out the necessary forms to maximize your dental benefits and discuss your financial options. Excellent dental care is available with or without dental benefits. We hope you choose the best dentistry has to offer.
- Many plans try to confuse participants by giving the In-network as opposed to out-of-network benefits. After reviewing many plans, the benefits only slightly vary between in-network and out-of-network. Before deciding on going to an in-network provider of your insurance, you need to evaluate the level of treatment and patient care you will be receiving.
- Dental Oasis of Clayton only offers composite (white) fillings. We do not provide amalgam (silver/metal) fillings. Most insurance companies allow an alternative treatment or downgrade to silver amalgam fillings on molar and sometimes pre-molar teeth. If your insurance company downgrades, the difference in cost of a composite restoration & an amalgam restoration would not be paid for by the insurance company and you would be responsible for this cost. This cost if typically between $8-$40 per filling depending on the size of the filing and your insurance company.

If you understand and agree to the above guidelines for our office, please sign below.

Patient's Signature:_____ **Date:**_____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient:_____ Print Name:_____

Source of Authority:_____

DENTAL OASIS
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Authorization for the Request of Records & X-Rays

I, _____(patient name) request my dental records be sent via email to Dental Oasis of Clayton. I do herby authorize the doctors and staff of _____ (previous dental practice) to release records or knowledge concerning my dental health. I specifically request that you release copies of:

All X-Rays & Images All Treatment Notes

Signed: _____ (patient name/guardian name)

Printed name: _____ (patient name/guardian name)

Records can be sent to:

Email: recordsrequest@dentaloasisclayton.com

Dental Oasis of Clayton

45 Shotwell Road

Clayton, NC 27520

tel: 919.550.5200 fax: 919.550.5240

Welcome to Dental Oasis of Clayton! Please complete this dental history form so that we may provide you with the best possible dental care.

What is your main reason for todays visit? _____

Do you have any dental problems or concerns? Yes/No. If yes, please describe: _____

Are you happy with the way that your teeth look? Yes/No. If no, please describe: _____

Have you ever had an upsetting dental experience? Yes/No. If yes, please describe: _____

When was your last dental cleaning? _____

When was your last dental visit? _____

What was done at your last dental visit? _____

How often do you have a dental cleaning and exam? _____

How many times a day do you brush? _____ How many times a week do you floss? _____
Have you ever or do you now use a topical fluoride? Yes/No.

What tools or aides do you use to help clean your teeth currently (ex. Waterpik, toothpicks etc.). _____

Are your teeth sensitive to:

Hot or Cold? □yes □no

Sweets? □yes □no

Biting or chewing? □yes □no

Have you ever had:

Braces or orthodontic treatment? □yes □no

Oral surgery? □yes □no

Periodontal treatment. □yes □no

A night guard? □yes □no

A serious injury to the mouth/teeth/head? □yes □no.
If yes, please describe: _____

Do you:

Clench or grind your teeth? □yes □no

Hold foreign items with your teeth (pens/pipes etc.) □yes □no

Have difficulty chewing on either side of the mouth? □yes □no

Snore of have any other sleep disorder □yes □no

Have bleeding or sore gums? □yes □no

Bite your cheeks or lips? □yes □no

Breath through your mouth, while awake or asleep? □yes □no

Have sore jaws, especially in the morning? □yes □no

Get cold sores, blisters or any oral lesions? □yes □no

Have any loose teeth? □yes □no

Have a family history of gum disease or tooth loss? □yes □no

Smoke/vape/chew tobacco? □yes □no. If yes, how often? _____

Have you experienced:

Clicking or popping of the jaw: □yes □no

Head/neck/shoulder aches? □yes □no

Difficulty opening or closing the mouth? □yes □no

Sore muscles (neck/shoulder). □yes □no

Pain. (joint/ear side of the face)? □yes □no If yes, please describe: _____

Have you noticed any mouth odors or bad tastes? □yes □no

Have you noticed a change in your bite? □yes □no

Does food get caught between your teeth? □yes □no If yes, where? _____

Would you like to keep all of your teeth all of your life? □yes □no

Do you feel nervous or have anxiety about having dental treatment? □yes □no.

If yes, what are your biggest concerns? _____

Have you ever been told to take a pre-medication prior to treatment? □yes □no

Is there anything else about you would like for us to know? □yes □no. If yes, please describe: _____

DENTAL OASIS OF CLAYTON

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of Dental Oasis of Clayton's HIPAA Notice of Privacy Practices.

PLEASE NOTE IT IS YOUR RIGHT TO REFUSE TO SIGN THIS ACKNOWLEDGEMENT.

______________________________	______________________________	____________________
Patient Name (please print)	Patient Signature	Date

OR

______________________________	______________________________	____________________
Name of Personal Representative	Signature of Personal Representative	Date

Relationship to patient:

☐ Parent ☐ Guardian ☐ Power of Attorney ☐ Other: ____________________

- -

Dental Oasis Use Only

I tried to obtain written acknowledgement by the individual noted above of receipt of our Notice of Privacy Practices, but it was not obtained because:

___ An emergency prevented us from obtained acknowledgment.

___ A communication barrier prevented us from obtained acknowledgment.

___ The patient/representative was unwilling to sign.

___ Other: ____

___________________________	___________________________	__________________
Staff Member Name (please print)	Staff Member Signature	Date

DENTAL OASIS
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Authorization for Release of Information – Compound Release

Patient Name: _____ Date of Birth: _____

Dental Oasis of Clayton is authorized to release protected dental health information about the above-named patient in the following manner and to selected

Entity to Receive Information. Check each person/entity 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	☐ Appointments ☐ Other _____
☐ Other person(s) (provide name and phone number) _____	☐ Financial ☐ Dental
☐ Email communication-provide email address* _____ *For email communications to occur, accept the disclosure below:	☐ Financial ☐ Dental ☐ Appointment reminders ☐ Breach notification
☐ Text communication-provide cell phone number _____ *For text communications to occur, accept the disclosure below:	☐ Financial ☐ Dental ☐ Appointment Reminders ☐ 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	☐ May be posted in the office
☐ Photo taken by staff (example pre/post treatment)	☐ May be posted on website/social media
☐ 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.

_____ _____

Signature of Patient or Personal Representative (and relationship to patient) Date