Thomas W. Farley, DDS

Cosmetic & General Dentistry

Thank you for joining our practice. We welcome you as a patient and appreciate the opportunity to provide you with the highest quality dental care in a kind and caring manner. As a patient in our practice, you will receive the best diagnosis, treatment, and advice that we are able to provide. Please assist us in this process by completing this information sheet.

○ Single
○ Married
○ Divorced
○ Widowed

Patient Name _____
(Miss / Mrs. / Ms. / Mr. / Dr.) First Initial Last

Residence Address _____
Street

_____
City State Zip Code

Residence Phone _____ Work Phone _____

Cell Phone _____ E-Mail Address _____

Date of Birth _____ Social Security Number _____

Occupation _____ Name of Employer _____

Person responsible for payment (if different than above) _____

Name of **EMPLOYER** providing Dental Insurance _____

Covered Employee _____ Employee's Date of Birth _____
(self, husband, wife)

Employee's SS# _____ ****Subscriber ID #** _____

Name of **DENTAL Insurance Carrier** _____

Group Number _____ Mailing Address _____

_____

Person to call in case of emergency _____
Last First Initial

Address _____ Phone No. _____
Street, City, State & Zip Code

Whom may we thank for recommending you to us? _____

PAYMENT OF CHARGES	PLEASE		CASH
IS DUE AT THE TIME	INDICATE		CHECK
SERVICE IS RENDERED	METHOD		CREDIT CARD

It is the stated financial policy of our office that responsibility for payment of Dental Services provided for the patient or his/her dependents is theirs, due and payable at the time services are rendered. Please note that a 1.5% finance charge per month (18% annually) will be added to any balance over 60 days. In the case of default of payment, the responsible party promises to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection on this account.

My signature below indicates I have read and understand the above.

Signature of Patient or Responsible Party _____ Date _____

(OVER, PLEASE >>>)

The following information will allow us to provide the best possible dental care in a manner that is compatible with your general health.

Medical History

Name of Physician_____ Phone_____

Address_____

Date of last visit_____Reason for last visit_____

Are you currently under the care of a physician? If yes, for what reason or condition?_____

_____

Are you currently taking any medication? (including birth control pills, aspirin,etc.) If yes, what

medication and for what reason?_____

_____

Do you have any drug allergies? If yes, please list._____

_____

Women: Are you pregnant? If yes for how long?_____

Have you ever been treated for any one of the following (please circle):

Rheumatic heart disease	Excessive bleeding	Liver disease	Diabetes
Heart murmur	Stomach/Intestinal disease	Hepatitis	Arthritis or Rheumatism
Congenital heart disease	Shortness of breath	Kidney problems	Joint replacement
Heart attack	Asthma	Venereal disease	AIDS/HIV+
Angina	Tuberculosis	Stroke	Anemia
Heart surgery	Cancer		
Abnormal blood pressure	Chemotherapy	Other_____	

Please explain any items circled above:_____

_____

Dental History

Do you at the present time have any dental complaints?_____	yes	no
Are any teeth sensitive to biting pressure, cold, hot, or sweets?_____	yes	no
Do your gums bleed when you brush or eat?_____	yes	no
Does food catch between your teeth?_____	yes	no
Would you like to improve the appearance of any of your teeth?_____	yes	no
Have you ever had an unpleasant experience in a dental office?_____	yes	no
Do you clench or grind your teeth during the day or night?_____	yes	no

When were your last dental x-rays taken?_____

Is there anything else about having dental treatment that you would like us to know?_____

_____

Patient Signature_____ Date_____

Parent or Responsible Party_____ Relationship to Patient_____

HIPAA RELEASE FORM & Legal Disclosure Information

I have read and I understand this office's Notice of Privacy Practices (see below)

SIGNATURE: _____

My information may be shared with the following people:

1.

2.

3.

Notice of Patient Information Practices – Privacy Policy
This notice describes how dental and health information about you may be used and disclosed and how you can get access to this information. Please read it carefully.
The privacy of your personal information is important. We want you to understand our privacy practices and procedures.

Legal Duty
Thomas W. Farley, DDS PA is required by law to protect the privacy of your personal dental and health information, provide this notice about practices, and follow the information practices that are described herein.

Information We Collect
We collect information about you and your family as part of our registration process and during the course of your care. This personal information includes items such as your name, address, phone number, birth date, social security number, employer, health history, and insurance policy and coverage information. During the course of treatment, we will collect health information regarding diagnosis, treatment plans, progress, and any test results.

Uses and Disclosures of Health Information
Thomas W. Farley, DDS PA uses your personal dental and health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example, we will share our findings with your primary care or referring dentist, or other referring dental offices; send your diagnosis and treatment information to your insurance plan or review your record internally to review the care provided. We also use your personal dental and health information to contact you to provide appointment reminders, or information about treatment alternatives or other health benefits that could be of interest to you. We may contact you by telephone at home and leave a message on an answering machine, or with a household member, or send you a postcard regarding missed appointments, scheduling appointments, or the readiness of your case.
In any other situation, our policy is to obtain your written authorization before disclosing your personal dental and health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

Patient's Individual Rights
You have the right to review or obtain your personal dental records at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You have the right to have your communications with us remain confidential, except as where required by law. You also have the right to request a list of instances where we have disclosed your personal dental and health information for reasons other than treatment, payment, or other related administrative purposes.
You may also request in writing that we not use or disclose your personal dental and health information for treatment, payment, and administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. Thomas W. Farley, DDS PA will consider all such requests on a case-by-case basis, but the practice is not legally required to accept them.

Concerns and Complaints
If you are concerned that Thomas W. Farley, DDS PA may have violated your privacy rights, or if you disagree with any decisions we have made regarding access or disclosure of your personal dental and health information, please contact our Privacy Officer at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. This notice was published and became effective on December 1, 2012.

Privacy Officer
Kelly Robinette
704-332-6200

CONSENT FOR TREATMENT

I give permission for **THOMAS W. FARLEY, DDS, PA** to give me medical/dental treatment.

I allow **THOMAS W. FARLEY, DDS, PA** to file for insurance benefits to pay for the care I receive.

I understand that:

- **THOMAS W. FARLEY, DDS, PA** will have to send my medical/dental record information to my insurance company.
- I must pay my share of the costs.
- I must pay for the cost of these services if my insurance does not pay or I do not have insurance.

I understand that:

- I have the right to refuse any procedure or treatment.
- I have the right to discuss all medical/dental treatments with my clinician.

Patient Signature/Date _____

Thomas W. Farley, DDS
General and Cosmetic Dentistry

118 South Colonial Avenue
Charlotte, NC 28207
704.332.6200 FAX: 704-332-6299
Office@DrTomFarley.com

REQUEST FOR RECORDS RELEASE

Date:_____

Dear Dr._____ (Previous Dentist)

Phone #: _____

I request that all my dental records, including radiographs and any progress notes be released to:

Dr. Thomas Farley
118 S. Colonial Avenue
Charlotte, NC 28207

Kelly@DrTomFarley.com

Specifically, x-rays from years: ANY CURRENT

Patient Name & DOB: _____

Patient Signature: _____

This release is valid for 1year from date of signature.

Thomas W. Farley, DDS
General and Cosmetic Dentistry

Office Cancellation Policy

If you need to reschedule or cancel your appointment, please note that we require a **48-hour notification**.

If you are unable to keep your appointment and do not call or email to cancel the appointment, you will be considered a "no show". After (1) no show appointment, you will be charged $100 for any additional no show appointment. This charge is not covered by insurance and is the responsibility of the patient. The decision to charge a penalty is at the discretion of the office manager.

It is our office policy to dismiss a patient from our practice when they have failed to arrive for 2 appointments. Dr. Farley's office seeks to provide timely service and consideration to all of our patients. In addition, if you should arrive more than 15 minutes late, you may be asked to reschedule.

_____
Signature of patient or responsible party

118 S. Colonial Avenue ◊ Charlotte, NC 28207
704-332-6200 Fax 704-332-6299
www.drtomfarley.com