

# PATIENT REGISTRATION



**BRASSFIELD**  
COSMETIC & FAMILY  
*Dental Center*

Robert M. Young, DDS

Phone (336) 545-5335

Fax (336) 545-5336

ID: \_\_\_\_\_

Chart ID: \_\_\_\_\_

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Patient Is: ☐ Policy Holder

Preferred Name: \_\_\_\_\_

☐ Responsible Party

Responsible Party (if someone other than the patient) \_\_\_\_\_

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Address: \_\_\_\_\_ Address 2: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Pager: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Ext: \_\_\_\_\_ Cellular: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Soc Sec: \_\_\_\_\_ Drivers Lic: \_\_\_\_\_

☐ Responsible Party is also a Policy Holder for Patient

☐ Primary Insurance Policy Holder

☐ Secondary Insurance Policy Holder

## Patient Information

Address: \_\_\_\_\_ Address 2: \_\_\_\_\_

City: \_\_\_\_\_ State / Zip: \_\_\_\_\_ Pager: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Ext: \_\_\_\_\_ Cellular: \_\_\_\_\_

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Soc. Sec: \_\_\_\_\_ Drivers Lic: \_\_\_\_\_

E-mail: \_\_\_\_\_ ☐ I would like to receive correspondences via e-mail.

## Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: \_\_\_\_\_ Pref. Dentist: \_\_\_\_\_

Employer ID: \_\_\_\_\_ Pref. Pharmacy: \_\_\_\_\_

Carrier ID: \_\_\_\_\_ Pref. Hyg.: \_\_\_\_\_

## Section 3

Referred By: \_\_\_\_\_

Previous Dentist: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Emergency Contact #: \_\_\_\_\_

## Primary Insurance Information

Name of Insured: \_\_\_\_\_ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: \_\_\_\_\_ Insured Birth Date: \_\_\_\_\_

Employer: \_\_\_\_\_ Ins. Company: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

Address 2: \_\_\_\_\_ Address 2: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Rem. Benefits: \_\_\_\_\_ .00 Rem. Deduct: \_\_\_\_\_ .00

## Secondary Insurance Information

Name of Insured: \_\_\_\_\_ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: \_\_\_\_\_ Insured Birth Date: \_\_\_\_\_

Employer: \_\_\_\_\_ Ins. Company: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

Address 2: \_\_\_\_\_ Address 2: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Rem. Benefits: \_\_\_\_\_ .00 Rem. Deduct: \_\_\_\_\_ .00

## MEDICAL HISTORY

PATIENT NAME \_\_\_\_\_ Birth Date \_\_\_\_\_

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, please explain: \_\_\_\_\_
- Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No If yes, please explain: \_\_\_\_\_
- Have you ever had a serious head or neck injury? ☐ Yes ☐ No If yes, please explain: \_\_\_\_\_
- Are you taking any medications, pills, or drugs? ☐ Yes ☐ No If yes, please explain: \_\_\_\_\_
- Do you take, or have you taken, Phen-Fen or Redux? ☐ Yes ☐ No \_\_\_\_\_
- Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ☐ Yes ☐ No \_\_\_\_\_
- Are you on a special diet? ☐ Yes ☐ No
- Do you use tobacco? ☐ Yes ☐ No
- Do you use controlled substances? ☐ Yes ☐ No

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 ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs
- ☐ Other If yes, please explain: \_\_\_\_\_

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

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

Have you ever had any serious illness not listed above? ☐ Yes ☐ No \_\_\_\_\_

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 \_\_\_\_\_ DATE \_\_\_\_\_



This notice describes how information about you may be used and disclosed and how you can gain access to this information. Please review it carefully.

## NOTICE OF INFORMATION PRACTICES

1. Dr. Robert M. Young, DDS, PA may use and disclose protected health information for treatment, payment and healthcare operations. Examples of these include, but are not limited to, requested preschool, or sports physicals, foster care homes, home health agencies and/or referral to other providers for treatment. Payment examples include, but are not limited to, insurance companies for claims including coordination of benefits with other insurers; collection agencies. Healthcare operations include, but is not limited to, internal quality control and assurance including auditing of records.
2. Dr. Robert M. Young, DDS, PA is permitted or required to use or disclose protected health information without the individuals written consent or authorization in certain circumstances. Two (2) examples of such are for public health requirements or court orders.
3. Dr. Robert M. Young, DDS, PA will not make any other use or disclosure of a patient's protected health information without the individual's written authorization. Such authorization may be revoked at any time. Revocation must be written.
4. Dr. Robert M. Young, DDS, PA will abide by the terms of this notice currently in effect at the time of the disclosure.
5. Dr. Robert M. Young, DDS, PA reserves the right to change the terms of its notice and to make new notice provisions effective for all protected health information that it maintains. Dr. Robert M. Young, DDS, PA will provide each patient with a copy of any revisions of its Notice of Information Practices at the time of their next visit, or at their last known address if there is a need to use or disclose any protected health information of the patient. Copies may also be obtained at any time at our offices.
6. Any patient, guardian or personal representative has the right to object to the use of their health information for directory purposes.
7. Any patient, guardian or personal representative has the right to inspect and obtain copies of their dental record.
8. Any patient, guardian or personal representative has the right to request amendments be made to their dental record.
9. Any patient, guardian or personal representative has the right to request a 6-year accounting of all disclosures of their medical record. The history will be provided within 60 days of the request and a reasonable charge may be assessed for any copies after the first requested in a 12-month period.
10. Any patient, guardian or personal representative has the right to request restrictions as to how their health information may be used or disclosed to carry out treatment, payment or healthcare operations. The Practice is not required to agree to the restrictions requested, but if the Practice does agree, the Practice must abide by those restrictions.
11. Any person/patient may file a complaint to the Practice and to the Secretary of Health and Human Services if they believe their privacy rights have been violated. To file a complaint with the practice, please contact the Privacy Officer at the following address and/or phone number Dr. Robert M. Young, DDS, PA, 3800 Robert Foreher Way, Suite 100, Greensboro, NC 27410, telephone (336) 545-5335. All complaints will be addressed and the results will be reported to the Privacy Officer.
12. It is the policy of Dr. Robert M. Young, DDS, PA that no retaliatory action will be made against any individual who submits or conveys a complaint of suspected or actual non-compliance of the privacy standards.

The effective date:

Name of Patient: \_\_\_\_\_

Signature of Patient or Legal Guardian: \_\_\_\_\_

Date: \_\_\_\_\_

**Dr. Robert Young, D.D.S., PA**  
**3800 Robert Porcher Rd, Suite 100**  
**Greensboro, North Carolina 27410**  
**(336) 545-5335**

### **financial policy**

Thank you for choosing our office for your dental needs. Obtaining dental treatment is very important for your overall health, but using dental insurance can be confusing. Our financial policies are designed to help patients maximize their insurance plan benefits, and make filing claims easy.

1. Payment is due on the day of treatment. If we accept assignment of insurance payment, the amount not covered by your insurance is due the day of treatment (your portion will be estimated). Total payment is due for first visits. You may find it more convenient to pay in full at the time of treatment, and we will direct your insurance company to pay you.

2. This office will file insurance claims for you. We are happy to help you by submitting insurance claims without charge. However, our office does not guarantee payment or coverage by your insurance company. Dental insurance usually pays only a portion of your charges and we urge you to be fully aware of the provisions of your dental plan's policy. You are responsible for your estimated portion at the time of service. A late charge will be added to your account on any unpaid balance 60 days from the date of treatment on all unpaid balances including outstanding amounts to be paid by your insurance company(s). We will not accept responsibility for your insurance company's delay of payment on your claims.

3. Cash, Check, VISA, MasterCard, American Express, or Discover are acceptable methods of payment.

4. In the event you are unable to make payment by any of the methods outlined above, you can ask for information about third-party lending institutions to assist you in paying for your dental treatment.

5. Since our time with our patients is very precious to us and lost time is irretrievable, we must charge for broken appointments when we have not been notified at least 24 hours in advance. Our charge for broken appointments is \$25. Our desire is never to find it necessary to make this charge. Please keep your appointment, we are waiting for you.

### **Payment Options**

Financial considerations should not be an obstacle to obtaining medical care. Several payment options are available to assist you in fulfilling your financial obligations:

1. Payment at time of service: This includes estimated payments by insurance plans, and your co-pay.

2. Monthly payment plans: Care Credit offers 3 or 6 month NO INTEREST financing for approved applicants. There are no hidden fees.

3. Prepayment courtesy: A 5% accounting discount for all treatment over \$300 that is paid in full by cash or check at the start of treatment.

---

*Please sign this policy signifying your acknowledgment of and agreement to our financial policies before dental services at Dr. Robert Young, DDS, P.A. are rendered.*

---

**We look forward to caring for your dental needs.**