



Welcome To Our Practice

We would like to thank you for choosing us as your dental care provider. We are pleased to meet any dental needs you or your family have. We will always do our best to give you the most up to date and professional care available. To avoid any confusion, we have listed below some of our policies and procedures.

Regarding Payment

Payment for services is due at the time services are rendered unless prior arrangements have been made with the practice manager.

We accept the following forms of payment: Cash, Check, Visa, Discover & MasterCard.

Checks that are returned to our office from your financial institution are subject to a \$50.00 returned check fee. This fee covers the processing fees that are charge to our office.

You are responsible to pay the cost of collecting any debt owed on your account. This includes all attorney's fees, late fees and interest to be charged at 1.5% per month.

Regarding Insurance

As a courtesy, we will file your dental insurance claim. **Your insurance policy is a contract between you and your insurance company.** We are not a party to that contract. In the event we do accept assignment of benefits and your insurance company has not paid your account in full within 60 days, the balance may be transferred to your account. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and customary under the terms of your insurance policy. Our practice is committed to providing the best treatment for our patients and we charge what is the usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Your complete insurance information must be presented at the time services are provided. Most benefits will be verified before your insurance company can be billed. All insurance co-pays and deductibles must be paid at the time of service.

Regarding Appointments

Broken appointments are very costly and inconvenient. Please inform us at least 1 business day in advance if you are unable to keep your appointment. Our normal business hours are Monday-Thursday from 8:00am-5:00pm. Appointments that are canceled without this notice are subject to a broken appointment fee of \$50.00. Excessive broken appointments will lead to you and your family being dismissed from our practice.

Late arrivals cause schedule delays for those patients who arrive promptly at their appointment time. Late arrivals will be worked into the schedule if time allows or re-appointed to another day.

All patients under the age of eighteen (18) will not be seen or treated, in the absence of a parent or legal guardian, without a signed consent form.

I have read, understand and agree to the policies explained above.

Patient Name (please print)

Signature of patient or Responsible Party

Date

OFFICE GUIDELINES REGARDING DENTAL INSURANCE

Thank you for understanding that we file dental insurance as a courtesy to our patients. We are not responsible for how your insurance company handles its claims or for what benefits they pay on a claim. We can provide assistance with **estimating** your portion of the cost of treatment. However, we cannot guarantee what your insurance company will or will not cover in regards to each filed claim.

If we have received all of your insurance information on the day of your appointment, we will be happy to file the claim for you. Please become familiar with your insurance benefits, as on the date of service we will collect your estimated portion. If we are unable to verify insurance benefits due to insufficient or inaccurate information, you will be responsible for paying the full amount of your visit. By law your insurance company is required to pay claims within 30 days of receipt. We file most insurance electronically so your insurance company should receive each claim within several days of your treatment. You will be responsible for any balance remaining on your account after 30 days, whether insurance has paid or not. We will be glad to send you a refund once your insurance has paid us.

Please carefully read the following information that will help you understand some general guidelines about dental insurance benefits.

- No insurance pays 100% of ALL procedures – many patients assume their insurance pays 90%-100% of all dental fees. Most plans only pay between 50%-80% of the average total fee. Some pay more, some pay less.
- The percentage paid is usually determined by how much you or your employer has paid for coverage or the type of contract your employer has set up with the insurance company.
- Sometimes your dental insurer reimburses you or the dentist at a lower rate than the dentist's actual fee. Frequently, insurance companies state that the reimbursement was reduced because your dentist's fee has exceeded the usual, customary, or reasonable fee (UCR) used by the company. A statement such as this gives the impression that any fee greater than the amount paid by the insurance company is unreasonable or well above what most dentists in the area charge for a certain service. This can be very misleading and simply is not accurate. Insurance companies set their own schedules and each company uses a different set of fees they consider "allowable".
- Our dental material of choice for "fillings" is a white filling, also known as composite resin. Some insurance companies do not pay for a white filling (composite resin) at the same level as a silver filling (amalgam). The difference between the two fees will be your responsibility.
- Some dental insurers will not reimburse the provider (Dr. Sninski/Dr. Schmitt) directly for treatment but rather the subscriber. In this case, you are responsible for paying the full amount for treatment rendered on the day of service.

The following checklist is to assist you in preparing for your visit with Dr. Sninski or Dr. Schmitt. Your verification of this information will greatly help with filing your claim and speed up any refund you may be owed.

- ✓ Be sure you can currently receive benefits from your dental insurance policy and that there are no waiting periods.
- ✓ For each visit to our office please bring a current insurance card that includes the following: ID number, Group number, and the address and phone number for the insurance company. Some dental insurance plans do not issue a card; therefore we will need the social security number and date of birth for the person who carries the policy.
- ✓ The person who carries the insurance is the subscriber and we will need the subscriber's date of birth and employer information to expedite the processing of the claim.
- ✓ You may choose to contact your insurance company, in advance, to verify benefits, deductibles and benefit period maximums. This will enable you to become familiar with your particular plan and allow you to anticipate your level of benefits.

We know that filing insurance can be a time-consuming and somewhat confusing process. That is why we are happy to file your insurance for you. Thank you for reading our policy and familiarizing yourself with your insurance plan and the coverage you have.

Signature: _____

Date: _____

Dental Insurance Information

Name of Primary Dental Insurance Company:
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Insurance Company Phone Number:

Group Plan Name:

Group Number:

Policy Number:

Subscriber Information (Complete if the policy holder is not the patient)
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Subscriber Name:

Subscriber Date of Birth:

Subscriber Social Security Number:

Member ID Number:

Subscribers Address:

Name of Secondary Dental Insurance Company:
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Insurance Company Phone Number:

Group Plan Name:

Group Number:

Policy Number:

Subscriber Information (Complete if the policy holder is not the patient)
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Subscriber's Name:

Subscriber's Date of Birth:

Subscriber's Social Security Number:

Member ID Number:

Subscribers Address:

Authorization to Release Dental Information

Expires upon one time release

Patient Information:

Name of Patient _____ Date of Birth _____

Address _____

City, State, Zip _____

I authorize the practice below to release my health information: (your last dentist)

Please forward/release my dental information to:

Sninski & Schmitt Family Dentistry
100 Ridgeview Drive
Suite 103
Cary, NC 27511
cary@ssfamlydentistry.com
919-467-2203

The information below is provided at the request of the patient.

Any current x-rays along with the dates of any crowns, bridges, or extractions done in your office.

This authorization shall be in effect until the information has been forwarded as requested.

Patient Information

I understand that my treatment will not be conditioned on signing this authorization and that I have the right to refuse to sign this authorization. *I understand that information 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 understand that I have the right to revoke this authorization by sending a written notification to the address below and that a revocation is not effective if the information has already been disclosed but will be effective going forward.

I understand that I have the right to inspect or copy the protected health information as described in this document. I can do this by written notification to Sninski & Schmitt Family Dentistry.

Date _____
Signature of Patient or Personal Representative

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

Authorization for Release of Information

Name of Patient _____	Date of Birth _____
<p>Sninski & Schmitt Family Dentistry is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.</p>	

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.
<input type="checkbox"/> Voice Mail	<input type="checkbox"/> Results of lab tests/x-rays <input type="checkbox"/> Other _____
<input type="checkbox"/> Spouse	<input type="checkbox"/> Financial <input type="checkbox"/> Medical as follows: _____ _____
<input type="checkbox"/> Parent (provide name) _____	<input type="checkbox"/> Financial <input type="checkbox"/> Medical as follows: _____ _____
<input type="checkbox"/> Other (provide name) _____ _____	<input type="checkbox"/> Financial <input type="checkbox"/> Medical as follows _____ _____

<p>Patient Information</p> <p>I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.</p> <p>I understand that 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.</p> <p><i>I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.</i></p>

Date: _____

 Signature of Patient or Personal Representative

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

Sninski & Schmitt Family Dentistry

100 Ridgeview Drive Suite 103 Cary, NC 27511
919-467-2203

**Acknowledgement of Receipt
Of Notice of Privacy Practices**

Patient Name & 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 _____

Health History Form



American Dental Association
www.ada.org

E-mail: _____ Today's Date: _____

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name: Last First Middle	Home Phone: <i>Include area code</i> ()	Business/Cell Phone: <i>Include area code</i> ()		
Address: Mailing address	City:	State: Zip:		
Occupation:	Height:	Weight:	Date of birth:	Sex: M F
SS# or Patient ID:	Emergency Contact:	Relationship:	Home Phone: ()	Cell Phone: ()

Include area codes

If you are completing this form for another person, what is your relationship to that person?

Your Name _____ Relationship _____

Do you have any of the following diseases or problems:	(Check DK if you Don't Know the answer to the question)			Yes	No	DK
Active Tuberculosis.....				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Persistent cough greater than a 3 week duration.....				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cough that produces blood.....				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Been exposed to anyone with tuberculosis.....				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

Dental Information For the following questions, please mark (X) your responses to the following questions.

	Yes	No	DK		Yes	No	DK
Do your gums bleed when you brush or floss?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have earaches or neck pains?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitive to cold, hot, sweets or pressure?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any clicking, popping or discomfort in the jaw?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does food or floss catch between your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you brux or grind your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your mouth dry?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have sores or ulcers in your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any periodontal (gum) treatments?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you wear dentures or partials?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had orthodontic (braces) treatment?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you participate in active recreational activities?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any problems associated with previous dental treatment?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had a serious injury to your head or mouth?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your home water supply fluoridated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Date of your last dental exam:			
Do you drink bottled or filtered water?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	What was done at that time?			
If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY				Date of last dental x-rays:			
Are you currently experiencing dental pain or discomfort?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
What is the reason for your dental visit today?							
How do you feel about your smile?							

Medical Information Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No	DK		Yes	No	DK
Are you now under the care of a physician?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you had a serious illness, operation or been hospitalized in the past 5 years?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physician Name: _____ Phone: <i>Include area code</i> ()				If yes, what was the illness or problem?			
Address/City/State/Zip:				Are you taking or have you recently taken any prescription or over the counter medicine(s)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you in good health?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements:			
Has there been any change in your general health within the past year?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____			
If yes, what condition is being treated?				_____			
Date of last physical exam:				_____			

Medical Information Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

(Check DK if you Don't Know the answer to the question)			Yes No DK				Yes No DK				
Do you wear contact lenses?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you use controlled substances (drugs)?.....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you use tobacco (smoking, snuff, chew, bidis)?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Date: _____ If yes, have you had any complications? _____						If so, how interested are you in stopping? (Circle one) VERY / SOMEWHAT / NOT INTERESTED					
Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you drink alcoholic beverages?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If yes, how much alcohol did you drink in the last 24 hours? _____					
Date Treatment began: _____						If yes, how much do you typically drink In a week? _____					
Allergies - Are you allergic to or have you had a reaction to:			Yes	No	DK				Yes	No	DK
To all yes responses, specify type of reaction.						Metals _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Local anesthetics _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Latex (rubber) _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Iodine _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin or other antibiotics _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hay fever/seasonal _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Barbiturates, sedatives, or sleeping pills _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Animals _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sulfa drugs _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Food _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Codeine or other narcotics _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.											
			Yes	No	DK				Yes	No	DK
Artificial (prosthetic) heart valve			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Autoimmune disease			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Previous infective endocarditis			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid arthritis			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Damaged valves in transplanted heart			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Systemic lupus erythematosus.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Congenital heart disease (CHD)						Asthma			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unrepaired, cyanotic CHD			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis.....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Repaired (completely) in last 6 months			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Repaired CHD with residual defects			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus trouble			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						Tuberculosis			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.</i>						Cancer/Chemotherapy/ Radiation Treatment			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						Chest pain upon exertion			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						Chronic pain			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						Diabetes Type I or II			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						Eating disorder.....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						Malnutrition			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						Gastrointestinal disease.....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						G.E. Reflux/persistent heartburn			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						Ulcers			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						Thyroid problems			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						Stroke.....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						Glaucoma			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						Hepatitis, jaundice or liver disease			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						Epilepsy			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						Fainting spells or seizures.....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						Neurological disorders.....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						If yes, specify: _____					
						Sleep disorder			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						Mental health disorders			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						Specify: _____					
						Recurrent Infections			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						Type of infection: _____					
						Kidney problems.....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						Night sweats.....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						Osteoporosis			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						Persistent swollen glands in neck			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						Severe headaches/ migraines			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						Severe or rapid weight loss			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						Sexually transmitted disease			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						Excessive urination.....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?											
Name of physician or dentist making recommendation:									Phone:		
Do you have any disease, condition, or problem not listed above that you think I should know about?											
Please explain:											

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
 I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: _____ Date: _____

FOR COMPLETION BY DENTIST

Comments: _____

