Good Smiles

Nurica N. Good, DDS
603 S. Ayersville Road
Mayodan, NC 27027
Phone: (336) 427-8544

APPOINTMENT POLICY

Our office makes every effort to stay on schedule. This saves your time as well as ours. Please try to be on time for your appointment. If you are more than 10 minutes late for your appointment we may ask that you reschedule so we may remain on time for patients scheduled after you. We do ask that you notify our office **24 hours** in advance of your appointment if you need to cancel. If you do not cancel 24 hours in advance or simply fail to show up for your appointment this will be considered a broken appointment. Multiple broken appointments will lead to dismissal from the practice and you will be asked to seek treatment at another office. (If you are covered by Medicaid for dental treatment please see appointment policy under "Medicaid Coverage").

FINANCIAL POLICY

Payment for dental services should be made at the time services are rendered. No further appointments will be made until your account is paid unless alternate financial arrangements are made in advance. We accept Cash, Checks, Debit Cards, Visa, American Express, MasterCard, and Discover. A $35 fee will be charged for returned checks.

DENTAL INSURANCE

You will be responsible for payment of your yearly deductible and any copayment at each visit. Copayments are estimated at about 20% of routine services and 50% of major restorative such as crown, bridges, and dentures. As a service to our patients, our office will file your insurance claim with your primary insurance company. You will be responsible for filing your claim with any secondary insurance you may have. After 60 days, any disputed claims will be billed to the patient or responsible party and subsequently paid. Any disputed claims should be discussed between the insured person and the insurance company.

MEDICAID COVERAGE

Patients covered for dental care under the Medicaid program and over the age of 21 years must pay a $3.00 copayment for each visit. We do not accept credit card charges less than $10.00, please have cash or check to pay copays. Children under the age of 21 do not pay this fee. You will not be allowed to make advance appointments if you fail to cancel your appointment 24 hours in advance. Please bring your Medicaid card to each appointment and show this to the receptionist.

MONTHLY PAYMENTS

Financing for dental services is provided through Care Credit. After the initial exam you must fill out a finance application which upon approval will provide a 6 month interest free loan to cover dental treatment. Payments will be made to Care Credit.

I fully understand and agree to the above appointment and financial policies and agree to maintain my account in good standing. I further understand and agree to pay a 1.5% finance charge added to any balance over 30 days old. I also agree to pay a 20% collection fee and/or legal fees incurred to collect any balances 120 days overdue. I accept full financial responsibility for all charges not covered by insurance.

_____ _____

Signature Date

INFORMATION FOR PATIENT'S RECORD

Patient _____ Preferred Name _____
First Middle Last

Age _____ Date of Birth _____ Place of Birth _____

Address _____ Phone _____
Street City or County State

Father _____ Mother _____
Full Name Full Name

Father's Occupation _____ Business Address _____
If self, please state business here.

Mother's Occupation _____ Business Address _____

Person responsible for payment of account _____

Child's Physician _____

Family Dentist _____

Who may we thank for referring you to us? _____

Do you desire complete regular dental treatment, including regular follow-up examination: Yes ❑ No ❑

Do you desire only a specific or emergency treatment at this time: Yes ❑ No ❑

NOTE: Parents are requested to remain in waiting room when children are being treated. We have found that they respond much better when parents are not present.

PLEASE ANSWER EACH QUESTION

	Check YES	One NO
Does your child have regular medical examinations?	❑	❑
Has your child had any history of heart trouble, allergies, diabetes, asthma, kidney or liver trouble, epilepsy, rheumatic fever? (If answer yes, please underline the condition(s))	❑	❑
Has your child had a cerebral or spastic condition?	❑	❑
Has your child experienced any unfavorable reaction to medicine?	❑	❑
Is your child undergoing medical treatment at present?	❑	❑
Is your child presently taking any medicine?	❑	❑
Is this your child's first trip to the dentist?	❑	❑
Has your child had fluoride treatments?	❑	❑

Please use the reverse side for any additional helpful information.

Date _____ Please Sign: _____

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance with _____
Name of Insurance Company (ies)

and assign directly to **DR. NURICA GOOD** all benefits. If any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

_____
Date *Signature*

ASSIGNMENT AND RELEASE

I, being the parent or guardian of _____ do hereby request

and authorize the dental staff to perform necessary dental services for my child, including but not limited to X-rays and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.

_____
Date *Signature of Insured/Guardian*

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY MATTERS

I, _____, have read this office's Notice of Privacy Practices.
Please Print Name

_____
Date *Signature*

CONSENT FOR TREATMENT

I hereby authorize Dr. Good or designated staff to take X-rays, study models, photographs, and other diagnosis aids deemed appropriate by Dr. Good to make a thorough diagnosis of _____'s dental needs.
Patient's Name

Upon diagnosis, I authorize Dr. Good to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required providing proper care.

_____
Date *Signature*

ADDITIONAL MEDICATION:

Medication	Dosage	Frequency	Reason

DATE	TOOTH	PROGRESS NOTES

PATIENT REGISTRATION AND MEDICAL HISTORY

Date:_____

Patient Name: _____ Preferred Name: _____
First Middle Last

Date of Birth: _____ SS# _____ Gender: ❒ M ❒ F Status: ❒ Single ❒ Married ❒ Other

Address: _____ City: _____ State: _____ Zip Code: _____

Phone: _____ Circle Preferred #: Home / Mobile / Work
Home Mobile Work

Email address: _____

Would you like to receive appointment reminders by e-mail, text or phone? _____

Spouse's Name _____ Spouse's Phone: _____

In case of emergency, who should be notified? Please provide name and phone number below:

_____

EMPLOYER INFORMATION

Employer Name _____ Occupation _____

Business Address _____ Business Phone _____

RESPONSIBLE PARTY INFORMATION

Who is responsible for this account? _____ Relationship to Patient _____

Responsible Party SSN: _____

PRIMARY DENTAL INSURANCE INFORMATION

Name of Insurance Company _____ Group Number _____

MEDICAL HISTORY INFORMATION

Do you have any CURRENT HEALTH PROBLEMS? ❒ Yes ❒ No _____

Are you under a PHYSICIANS care now? ❒ Yes ❒ No For what? _____

Are you currently taking any medication? ❒ Yes ❒ No List additional medication on back.

Are you pregnant? ❒ Yes Due Date _____ ❒ No Do you smoke? ❒ Yes ❒ No

Family Physician's Name _____ Phone # _____

Date of Most Recent Physical: _____

Check mark any of the following which you have had or have at present

❒ Heart Attack
❒ High Blood Pressure
❒ Congenital Heart Lesions
❒ Heart Pacemaker
❒ Heart Disease
❒ Heart Murmur
❒ Heart Surgery
❒ Heart Problems
❒ Angina Pectoris
❒ Rheumatic Fever
❒ Artificial Heart Valve
❒ Anemia
❒ Ulcers
❒ Hepatitis ❒ A ❒ B ❒ C
❒ Blood Transfusion
❒ Fever Blisters
❒ Glaucoma
❒ Tuberculosis (TB)
❒ Thyroid Disease
❒ Scarlet Fever
❒ Stroke
❒ Liver Disease
❒ Nervousness
❒ Drug Addiction
❒ Alcoholism
❒ Psychiatric Treatment
❒ Epilepsy or Seizures
❒ Allergies or Hives
❒ Cortisone Medication
❒ Bleeding Problems
❒ Emphysema
❒ Chemotherapy (Cancer/Leukemia)
❒ Asthma
❒ Kaposi's Sarcoma
❒ Kidney Trouble
❒ Yellow Jaundice
❒ Hemophilia
❒ Fainting or Dizzy Spells
❒ Sickle Cell Disease
❒ Diabetes
❒ Venereal Disease (Syphilis, Gonorrhea, etc.)
❒ Arthritis
❒ Pain in Jaw Joints
❒ Pneumonia
❒ HIV Positive

Medical Alerts

❒ Allergic to Aspirin
❒ Allergic to Codeine
❒ Allergic to Lidocaine
❒ Allergic to Penicillin
❒ Allergic to Latex
❒ Artificial Joint/Hip/Knee
❒ Pre-medication Required
❒ Other (list below)

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for the benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date_____ Signature_____

ASSIGNMENT AND RELEASE

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