LANDON A. POTEAT, D.D.S., P.A.

Welcome to the practice and thank you for choosing us to take care of your dental needs.

- Please complete these forms **prior** to your appointment and bring them with you to your first visit.

- Please sign the **Consent for the Release of Records** and send to your previous dentist to have x-rays e-mailed to our office **prior** to your appointment. If x-rays are not received, we will take new ones, which may result in additional out of pocket costs to you.

- Our office is out of network for all insurance companies, but we will file your claim for reimbursement as a courtesy. Please verify your coverage and bring a valid insurance card with you to your first visit.

- Payment in full is required for all new patient appointments.

CONSENT FOR THE RELEASE/TRANSFER OF RECORDS

Please complete this form and forward it to your previous dental office to have your records transferred to Dr. Landon A. Poteat's office prior to your appointment.

I, _____, do hereby consent to and authorize (PREVIOUS dentist) Dr._____, to disclose and/or transfer information contained in my dental records, including current and previous records from other practitioners, dental practices, hospitals or clinics. I request that such records be forwarded to:

Landon A. Poteat, DDS, PA

1257 Hendersonville Rd.

Suite B

Asheville, NC 28803

Phone: (828) 274-2265

Fax: (828) 274-8096

Email: info@poteatdentistry.net

**Please Email X-Rays and Treatment Notes in digital format whenever possible.

Print Name:_____ DOB:_____

Signature:_____

Relationship to Patient:_____

Today's Date:_____

TIME 03:44 PM DATE 5/5/2020

PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name:

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

Past Due Account

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: Rem. Deduct:

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: Rem. Deduct:

Eaglesoft Medical History 2020

Patient Name: Birth Date: Date Created:

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? Please name.	◯ Yes ◯ No	If yes
Have you ever had a serious head or neck injury, been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Are you taking any blood thinners?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Do you use tobacco?	◯ Yes ◯ No	If yes
Do you use controlled substances?	◯ Yes ◯ No	If yes
Are you taking any medications, pills or drugs? Please list.	◯ Yes ◯ No	

WOMEN: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics

Other? ☐ If yes

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

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

Have you ever had any serious illness not listed above? ◯ Yes ◯ No

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:

X Date:_____

LANDON A. POTEAT, D.D.S., P.A.

CONSENT FOR TREATMENT

- I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of dental conditions and needs.
- I hereby agree to the use of anesthetics, sedatives, and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand I may ask for a complete review of any possible complications.
- I hereby agree to be responsible for the payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service. In the event payment is not received by the agreed upon date, I understand that a 1.0% late charge (18% APR) may be added to my account. If services are not paid for by me, Landon A. Poteat, DDS, PA, may use methods to collect monies including the following, but not limited to: collection agencies, collection calls, and representation by a law firm with any fees being incurred payable by me.
- The diagnosis, proposed therapy, and other reasonable treatment alternatives have been explained to me, as well as the prognosis with and without the proposed therapies. The risk associated with treatment, including failures with some cases despite treatment, has also been explained. The costs may vary according to treatment.
- I understand this consent form covers any and all procedures performed in the office from this day forward.
- I hereby give consent to the doctor or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine, for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.

Patient Name:_____ Date:_____

Patient/Parent/Guardian Signature:_____

I hereby give permission for the following person(s) to assist me in the matters of scheduling appointments, discussing treatment recommendations, handling financial matters and other communications deemed necessary in my care. ****If you are 18 years old and above, please list anyone who may be scheduling appointments for you or is responsible for payment or insurance on your account:**

Name & Relationship to Patient:_____

Contact Number:_____

Name & Relationship to Patient:_____

Contact Number:_____

INSURANCE FILING

Please note: We do not participate with any insurance companies; therefore we are a NON-NETWORK provider.

We will file dental insurance claims as a courtesy.

However, you must provide a **valid insurance card** with all necessary information concerning your policy at each visit.

Please make any necessary calls to your insurance company, concerning any questions, **prior** to your appointment.

Due to privacy matters between you and your insurance company, we are no longer able to obtain information.

WRITTEN FINANCIAL POLICY

Our primary mission is to deliver the best and most comprehensive dental care available. An important part of our mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

NEW PATIENTS

***Payment in full is required for all initial new patient appointments.** Your dental insurance will be filed for reimbursement to be paid directly to you.

PAYMENT OPTIONS

Cash, Check, Visa, MasterCard, American Express, or Discover Card

CONVENIENT MONTHLY

Payment Plans from *CARE CREDIT* allow you to pay over time with no annual fees. **Available for treatment/payments of $1000 or more.** Payment terms are for 6 months, with no interest **IF** paid in full by end of term.

PLEASE NOTE:

Landon A. Poteat, D.D.S., PA requires payment prior to the completion of your treatment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case. We accept payment in thirds for treatments over $1000. For plans requiring multiple appointments, alternative payment arrangements may be provided. For larger, more comprehensive treatment plans of $2000 or more, a 1/3 deposit is required to secure your initial treatment appointment. For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment. ****HOWEVER, IF WE DO NOT RECEIVE PAYMENT FROM YOUR INSURANCE CARRIER WITHIN 30 DAYS, YOU WILL BE RESPONSIBLE FOR PAYMENT OF YOUR TREATMENT FEES AND COLLECTION OF YOUR BENEFITS DIRECTLY FROM YOUR INSURANCE CARRIER.**

***A FEE OF $50 MAY BE CHARGED FOR PATIENTS WHO MISS OR CANCEL AN APPOINTMENT WITHOUT 24 HR NOTICE.** OUR OFFICE CHARGES A $30 NSF FEE FOR RETURNED CHECKS.

*Account balances over 60 days, will incur a 1.0% interest charge. *Account balances over 90 days may be turned over to a collections agency.

Since we are not in network with any insurance company **SOME BCBS & DELTA DENTAL INSURANCE PAYMENTS WILL BE PAID TO THE SUBSCRIBER (patient) BY THE INSURANCE COMPANY, depending on which plan you have. Please be sure to check with your insurance provider prior to your appointment. **Payment is therefore due at the time of service if this applies.**

_____ _____

Patient, Parent or Guardian Signature Date