DURHAMDDS
Office Of Dr. Bill Argersinger

Welcome Checklist

Please find the checklist below to assist you in completing your new patient paperwork.

This packet may seem long but it includes just a few forms that require being filled out, and the rest is either required by law to provide or information for your review.

Forms to complete and bring with you before your first visit:

- ☐ Yellow form: Medical & Dental History Form
- ☐ White form: General Financial Agreement (understanding options and policies document)
- ☐ White form: Authorization for Release of Information (HIPAA)

Note: If you've downloaded these forms off www.durhamdds.com then the forms will all be white.

Other information to bring:

- ☐ Your up-to-date dental insurance card if you have one.
- ☐ List of all medicines you take (prescriptions, over-the-counter, and supplements.)

Office of Dr. Bill Argersinger
1212 Broad St, Durham, NC, 27705

919 286 0779
info@durhamdds.com

DURHAMDDS

Enter todays date (xx/xx/xxxx):

Name:	Email Address:
Home Address *(including city/st/zip)*	Occupation/Employer:
Telephone (Home):	Telephone (Mobile):
Date of Birth: (xx/xx/xxxx)	Marital Status:
Male / Female:	Emergency Contact Name / Mobile Phone Number:
How did you hear about DurhamDDS?	Primary care doctor name:

DENTAL HISTORY	*(write in your answer or circle your answer)*		
Reason for today's visit?			
Do you have any dental related pain?	No	Yes but it's ok now	Yes it's killing me
When was your last visit to the dentist?	In the last year	Emergencies only	Been a long time
Do you receive regular dental cleanings?	Twice a year	Sometimes	Been a long time
Ever received periodontal (gum) therapy?	Yes, recently	yes, in the past	Never
Anyone in your family have dentures/partials?	No	Yes (who:	)
Any problem being reclined in the dental chair?	No	Yes (Reason:	)
Any persistent dry mouth concerns?	No	Yes (nighttime)	Yes (all the time)
Is your water supply fluoridated?	Yes (city water)	Do not know	No (Well or Rural)
Please share the name of your last dentist:			

MEDICAL HISTORY	
Do you smoke or use tobacco products regularly?	No Yes (Cigarettes Cigars Pipe Chewing Tobacco)
Circle all allergies you have:	Latex Band-aid adhesive Metals (Nickel) Penicillin Aspirin Codeine Sulfites Other:
Have you visited a healthcare provider for any exams or care in the last year?	No Yes (please describe doc and visit reason):
Any history of surgeries where you were put to sleep (general anesthesia)?	No Yes (please describe what and when):
Are you on blood thinners such as Coumadin, or have you ever had any bleeding problems?	No Yes (please describe):
Do you have any joint replacements?	No Yes (please name joint, year and surgeon):
Do you have a pacemaker, heart surgeries or congenital heart issues?	No Yes (please specify):
Please list all medications you take (or add a list):	Circle all of the following that pertain to you:

Diabetes	Heart valve replaced	Joint replacement
HPV	CPAP / Sleep apnea	Hepatitis
Liver problems	Bleeding problems	Kidney problems
Cancer history	Blood pressure issues	AIDS / HIV
Stroke history	History facial trauma	Fainting
Seizures	Asthma / lung Issues	Radiation treatment
Depression	Severe headaches	Steroids (Cortisone)
Sinus trouble	Heart attack history	Rheumatic fever

I understand the above information is necessary to provide me with safe and efficient dental care. I have answered all questions truthfully and to the best of my knowledge.

Patient Signature: Doctor Signature: @

DURHAMDDS
Office of Dr. Bill Argersinger

General Financial Agreement

Thank you for choosing Dr. Argersinger and our team at DurhamDDS for your dental care services. This document describes our policies for service payment options, missed appointment fees, and insurance payment guidelines. We are committed to providing you with comprehensive dental care using only the highest quality materials and technology. We will always recommend treatment based on your needs not your insurance coverage.

Patient Name	
Date of Agreement	

Please initial each square below signifying that you have read and understand each section.

Initials	Section Topic
	Optimizing Your Dental Insurance Reimbursements -- Should you have dental insurance; we offer the courtesy of working directly with your insurance carrier to maximize your benefits reimbursements. Every patient's benefits vary greatly from carrier to carrier. It is important to understand that we have no control over what your dental insurance provides for benefits.
	Balances Remaining After the Insurance Payment Are the Patients Responsibility -- Patients are ultimately responsible for their account balance no matter how much their dental insurance reimburses. If your insurance company has not made payment within 30 days of billing, the balance becomes your responsibility. Insurance coverage and benefits levels are a contractual agreement between the insurance company and you or your employer.
	When Insurance Sends You the Reimbursement Check -- Some insurance companies send your dental benefits checks directly to our office to put towards your balance owed. A small number of companies send checks directly to you. When your insurance company does this, we expect payment in full at the time of service from you.
	Lateness, No-Show, and Late Cancellations • If you must cancel, please call us with at least 48 hours advance notice and we can assist with rescheduling. • We charge $40 for late cancellations or no-shows for hygiene and $80 for doctor appointments that are missed or late cancelled. • Habitually late, or repeat 'no-show', or 'late cancel' offenders may continue to receive services but with contingencies. We do not make appointments without your consent. We also confirm your appointment several days in advance via email and phone. We understand "life happens" and emergencies occur, and work with you when they do.
	Payment Due At Time Of Service -- In the interest of offering our quality services at the lowest price, payments are due at the time of service.
	Options To Pay For Your Care -- To help patients choose the best care, we offer flexible payment options. Options include incentives for paying for care in full in advance, short term payment plans with a credit card or bank account automatic draft on file, or longer term payment plans using CareCredit.
	Payment Flexibility: Cash, Check, Credit Card, CareCredit -- We accept most credit cards, cash, check and CareCredit financing.
	Minor Patients -- The adult accompanying the minor patient is responsible for the payment on the account.

	Statements And Overdue Balances -- All patients with an overdue balance will receive a statement each month. An annual finance charge of 18% is added to all balances over 60 past due.
	Returned Checks Fee of $35 -- A fee of $35 will be charged for any returned or bounced checks.
	Collections Agency -- Statement balances over 90 days past due are subject to collection through a collection agency. If your account balance is referred to any agency or attorney(s) for collection purposes, you may be charged reasonable attorney's fees and expenses or costs relating to the collection proceeding, including court costs.
	Suspension of Care -- If you elect to no longer receive care with DurhamDDS, all fees for prior professional services rendered will be immediately due for payment in full.

I assign directly to DurhamDDS all insurance benefits, if any, otherwise payable to me for services rendered. I authorize and release information and payment of my dental benefits directly to the practice. I understand that I am financially responsible for all charges whether or not paid in full or in part by insurance. I authorize the use of my signature on all insurance claims submissions. The above-named dental practice may use my health care information and may disclose such information to the above-named insurance company and their agents for the purpose of obtaining payments for services and determining insurance benefits or the benefits payable for related services.

I have read, initialed and fully understand the financial policies of DurhamDDS and Dr. Argersinger. I understand my financial obligations and options available to meet those obligations. I understand that in the event my account becomes delinquent I will be responsible for any collections, legal fees and any other charges incurred to collect my account. Additionally, by signing this form I authorize DurhamDDS to process credit card transactions initiated by me either by mail or phone and I authorize my credit institution to pay.

Thank you for giving us the opportunity to serve your oral health and dental needs. If you have any questions about this form, please let us know before signing below so that we may address them.

PRINT FULL NAME: _____

SIGNATURE OF PATIENT: _____

DATE: _____

Authorization for Release of Information (Omnibus HIPAA)

Name of Patient _____ ***Date of Birth*** _____

Dr. William E Argersinger DDS PA is authorized to release protected health information (PHI) 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. By signing this form you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations. You have the right to read of Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the use and disclosures we may make. We encourage you to read the notice carefully and completely before signing this consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our practice practices, we will issue a revised Notice. Those changes may apply to any of your PHI that we maintain. **You may obtain a copy of our Notice of Privacy Practices at any time through our website at www.durhamdds.com or at our office at 1212 Broad St, Durham, NC, 27705 (919-286-0779).** You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to our office. Please understand that revocation of this consent will not affect any action we took in reliance on the consent before we received your revocation and that we may decline to treat you or to continue treating you if you revoke this consent.

Check each person/entity below that you approve to receive information:	***Description of information to be released. Check what can be given to person/entity at left in the same section.***
❑ Email	❑
❑ Voice Mail	❑ Results of lab tests/x-rays
❑ Spouse (provide name & phone number below)	❑ Financial ❑ Medical
❑ Parent (provide name & phone number below)	❑ Financial ❑ Medical
❑ Other (provide name & phone number below)	❑ Financial ❑ Medical
❑ For email communication, I understand that if email is not sent in an encrypted manner, there is a risk it could be accessed inappropriately. I still elect to receive email communication.	

Patient Information -- 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. 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. *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 have had full opportunity to read and consider this consent form and the Notice of Privacy Practices. I understand that by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operations, in addition to specific protected health information (PHI) permissions noted above by checkmark.

Signature: _____ ***Date of Consent:*** _____

If this consent is signed by a personal representative on behalf of the patient, complete the following:
Personal representatives name: _____ ***Relationship to patient:*** _____