NORTH CAROLINA
CENTER FOR ADVANCED DENTISTRY
DR. CHRISTOPHER J. GUDGER, DDS, PLLC

On behalf of all my staff I welcome you to our office. We are pleased that you have selected us to help with your dental care. We want you to know that we pride ourselves on making dentistry a pleasant experience for you.

Our commitment is to provide you with the best comprehensive dental treatment available. We offer a wide range of dental services, including preventive, cosmetic, restorative and reconstructive dentistry. Our dental team prides itself on our patient-centered practice and believes that co-diagnosis with you and other specialists is an integral part of our patient care.

In accordance with that philosophy we work in partnership with other dentists and specialists in the community to help ensure comprehensive care for our patients. Our goal is to help patients achieve the highest level of oral health possible at an affordable cost so they may enjoy the benefits of a functional, attractive mouth and smile.

We feel strongly that it is not in your best interest to rush through an examination and try to help you understand your condition in the same day, which is why your new patient experience with us is typically done in two appointments. **On your first visit with us a thorough examination will be completed**. This exam will include the necessary x-rays as well as the use of other aids including intra-oral photography which may be necessary in order to make an accurate diagnosis of the condition of your mouth, teeth, and gums. In most instances, your dental condition will be determined after a thorough review of the information collected for a second consultation appointment at no charge. **It is at this second appointment that you will receive your cleaning (pending no gum disease present) along with a thorough discussion of your current dental condition.** We appreciate the trust you have shown in us by selecting our office to provide your dental care.

Patient Information

Patient Name: ____ Date:_________________
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other_________________

Social Security #: _____________ Birth Date:________ Phone (Home): _________(Work): _______ (Cell): _____

Best way to contact you during the day:________________

Email Address (for email appointment reminders): ____

Address: ____
Street Apartment #

____
City State Zip Code

Preferred appointment times: ☐ Morning ☐ Afternoon ☐ Any Time ☐M ☐T ☐W ☐T ☐F ☐S

What is your profession: ____

Interests and hobbies outside of work: ____

What do you hope to accomplish in today's appointment? ____

Referral Information

How did you hear about our practice? ☐Another patient ☐ Yellow Pages ☐ Radio ☐ Newspaper

☐ School ☐ Work ☐ Other_________________

Please list the name of person or office referring you to our practice so we may properly thank them:
____

Insurance Information

Name of Insured: ____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _________________ ID #: _____________________ Group #:_____________________

Insured's Address: ____
Street City State Zip Code

Insured's Employer Name: ____

Address: ____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other___________________

Insurance Plan Name and Address: ____
____
____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid in full at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 2% per month (24% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree to allow Christopher J. Gudger DDS, PLLC to use any photographs taken for marketing or educational purposes.

I understand that this office uses composite (tooth colored) filling material to restore teeth and amalgam (silver) is not available. I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

____ Date: _____________ Relationship to Patient: ___________________
Signature of patient, parent or guardian

____ Date: _____________ Relationship to Patient: ___________________
Signature of guarantor of payment/responsible patient

HEALTH HISTORY

Name ____ Date ______________________________

Date of last health care exam: ________________What was this exam for?__________________________

Have you been hospitalized in the last 5 years? (Please circle) No Yes

If yes, reason:____

Are you currently receiving care? No Yes If yes, nature of care: __________________________

Please list all the names and phone numbers of the physicians who are currently providing you care:

1. ____
2. ____
3. ____
4. ____

For the following questions circle yes or no. Your answers are for our records only and will be confidential. Please note that during your initial visit you will be asked some questions about your response. Our team may ask additional questions concerning your health.

Anemia or Blood Disorder?	No	Yes	Hepatitis, Any Form	No	Yes
Arthritis, Rheumatism or other inflammatory disease?	No	Yes	Joint Replacement? When placed?	No	Yes
Asthma	No	Yes	Kidney Disease	No	Yes
Abnormal Bleeding from a cut?	No	Yes	Liver Disease (including Jaundice)	No	Yes
Cancer or Tumor?	No	Yes	Sore/Enlarged Lymph Nodes	No	Yes
Diabetes	No	Yes	Psychosis/Mental Illness	No	Yes
Emphysema or other Respiratory/Lung Illnesses	No	Yes	Previous Biopsies	No	Yes
Epilepsy	No	Yes	Radiation or Chemotherapy Treatment	No	Yes
Fainting or Dizzy Spells	No	Yes	Slow-Healing Mouth Sores	No	Yes
Glaucoma	No	Yes	Unintentional Weight Loss/Gain	No	Yes
Abnormal Heart or Previous Bacterial Endocarditis	No	Yes	H.I.V. Infection/AIDS or ARC	No	Yes
Heart Valve (artificial) or Heart Transplant	No	Yes	Venereal Disease	No	Yes
Heart Disease, Heart Attack, Heart Surgery	No	Yes	Other Conditions	No	Yes
Recurrent Illnesses	No	Yes			

Are you taking any of these medications?

Pre-medication before dental treatment?	No	Yes	Tagamet® (cimetidine) or Prilosec® (omeprazole)?	No	Yes
Antacids?	No	Yes	Cardizem® (diltiazem) or Calan, Isoptin® (Verapamil)?	No	Yes
Dilantin® or Tegretol®	No	Yes	Serzone® (nefazodone)	No	Yes
Barbiturates (any)	No	Yes	Diflucan® (fluconazole) or Sporonox® (itraconazole)	No	Yes
St. John's Wort or Kava-Kava?	No	Yes	Biaxin® (clarithromycin)	No	Yes
Have you been treated with Bisphosphonate drugs (Fosamax®, Aredia®, Zometa®, Actonel®, Boniva®)? If so, when did the treatment begin? When did the treatment end?				No	Yes
Have you ever taken any prescription drugs such as fen-phen for weight loss?				No	Yes
Do you consume grapefruit juice, grapefruits or grapefruit extract?				No	Yes

Please list any medications you are currently taking:

1. ____________________________ 2. ____________________________
3. ____________________________ 4. ____________________________
5. ____________________________ 6. ____________________________

Please list any dietary or herbal supplements you are taking, and for what purpose:

7. ____________________________ 8. ____________________________
9. ____________________________ 10. ____________________________
11. ____________________________ 12. ____________________________

Women: Are you pregnant? No Yes

If no, are you planning a pregnancy in the near future? No Yes

Are you a nursing mother? No Yes

Are you taking birth control pills? No Yes

Abnormal Blood Pressure? (Please circle) No Yes

Have you ever received a diagnosis of "high blood pressure"?
What is your normal blood pressure? S /D Today: ________________/_________

Are you allergic or have you had a reaction to:

a. Local anesthetics ………………………………………………………... No Yes
b. Penicillin or other antibiotics …………………………………………… No Yes
c. Aspirin, Ibuprofen or Tylenol …..……………………………………… No Yes
d. Codeine, Valium® or other sedatives…………………………………… No Yes
e. Latex or Metals
f. Other (please specify)____

Tobacco, Alcohol, Drugs

Do you use tobacco? If yes, circle type: smoke chew How much per day? For how long?	No	Yes
Do you want to quit using tobacco?	No	Yes
Do you consume alcohol? If yes, approximately how many alcoholic beverages per week?	No	Yes
Do you use any mood altering drugs other than those previously listed?	No	Yes

Weight and Diet considerations

Weight	Meals per Day	Dietary Restrictions	Food Allergies
Sugar in your diet (circle one): *none* *slight* *moderate* *high*			

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health and medication.

Patient (Print Name) ___________________ **Patient Signature** __________________ **Date**______

Doctor (Print Name) ____________________ **Doctor Signature** __________________ **Date**______

Our Financial Policy

Thank you for choosing us for your dental care. We are proud to be part of a team whose primary mission is to deliver the finest, longest lasting and most comprehensive oral health care available today. In addition, we are also dedicated to making top-quality care as cost-effective as possible.

Our professional treatment is rendered to you, not the insurance company. **Please remember that you have a contract with the Insurance Company and our office has a contract with you, therefore, we look to you for payment if your insurance does not pay within 30 days.** As a courtesy, we will submit your insurance claim along with any necessary diagnostic/narrative records to the insurance company for you and will do our best to help you derive the maximum benefits available, for no additional charge. However, we are not responsible for determining what those benefits might be. This is an agreement entered into by you, your employer and the Insurance Company.

Please understand that the amount to be paid by your particular policy is pre-determined and agreed to by your employer and the insurance company. Most of these fees are determined by outdated surveys taken 3-7 years ago and often in different area codes or even different cities than what you currently live in. Please be aware that because of the random manner in which insurance companies set their fees some of the services provided may not be covered or considered above the "usual and customary" fee arbitrarily derived by the Insurance Companies. Our practice is committed to providing the best treatment for our patients, while charging what is reasonable and customary for our area. If you have any questions about the amount the plan will pay or the treatments your plan will cover, we will be happy to help you determine what portion your insurance policy will cover to the best of our ability. **We believe that it is not in your best interest for us to compromise our recommended treatment to accommodate a dental plan's maximum benefits. By doing so this almost always compromises your health.** It is better to spread out the optimum treatment over several years than compromising the treatment plan to accommodate insurance benefits or financial concerns. We will be more than happy to discuss a treatment plan's advantages and disadvantages with you to accommodate you in the health care decision-making process.

In order for our office to accept assignment of benefit (accept your insurance as payment) on your behalf we require keeping a credit card on file, which any under collection of fees will be debited to accordingly. This card will only be used to charge unpaid balances if we receive no payment from the insurance company at the 60 day mark after doing a procedure or at which time we receive your insurance payment and there is an outstanding balance after processing the insurance claim in our system. You may also use this card to sign up for our VIP program and receive a 5% bookkeeping reduction off all regularly priced dental services to be charged when treatment is scheduled with the insurance reimbursement being sent directly to you. Those patients that do not have insurance may still benefit from our VIP program by signing up for our 5% off bookkeeping reduction program.

Initials: _______

To assist you with your health care investment, we provide the following payment options:

1. VIP Dental Concierge Program that offers a 5% discount off all regularly priced dental fees along with other great services.

2. Cash/Checks

3. Visa/MasterCard --- we accept credit cards as payment for treatment.

4. Financing Options --- the monthly payment plan we offer is carried out by an outside company as a separate line of credit to cover you and your family members' healthcare needs credit approved financing endorsed by the ADA. With CareCredit:

   - Approval usually only takes a few minutes.
   - We offer an Interest Free Option up to 6 months: You can make monthly payments as low as 3% of the outstanding balance.
   - We also offer a low interest Extended Payment Plan option, for more time to pay your balance.
   - No annual fees or prepayment penalties.

If CareCredit is your preferred option, you can begin any necessary treatment immediately and spread the payment out over time.

We do not "double book" appointments and recognize the value of your time. Except in emergency situations, you can expect us to be on time for you. When we schedule an appointment, that time is reserved just for you. If you must change an appointment, please give us at least a 48-hour notice. **There is a fee of $100 for missed appointments without at least a 48-hour notice. If your appointment was confirmed and the appointment is a no-show without a courtesy phone call you will be responsible for the full scheduled fee for that missed appointment. Last minute cancellations deny other patients the benefits of treatment they need. This policy is implemented to allow us enough time to get those patients on our short call list in with reasonable notice. Please help us serve you better by keeping your scheduled appointments.**

Deposits made either in full via our VIP program thereby qualifying for the 5% discount or monies paid as a deposit to reserve the dental operatory, staff's professional services, and Dr. Gudger's time for future dental procedures are non-refundable. They can be transferred to a later date if needed to accommodate scheduling complications or illnesses.

Payment is due when services are rendered. There will be a 2% monthly finance charge for all balances unpaid after 60 days.

Thank you for reading and understanding our Financial Policy. Please let us know if you have any questions or concerns.

X ____ ___________

Signature of patient or responsible party Date

Credit Card On File Authorization Form

(for insurance patients wishing us to accept their insurance as payment AND our VIP patients wishing to save 5%)

Visa/Mastercard

Christopher J Gudger DDS, PLLC is authorized to maintain credit card payment information in our confidential files. Your signature authorizes us to review this information and deduct fees from the credit card below for services rendered, when you sign the applicable application.

Cardholder Name (as imprinted on credit card) ______________________________

Credit Card Visa/Mastercard # ______________________________

Expiration Date ______________________________

Please list names of any family members you would like to have procedures charged to this account below.

Name: ____________________ Relationship: ____________________

Name: ____________________ Relationship: ____________________

Name: ____________________ Relationship: ____________________

Name: ____________________ Relationship: ____________________

By signing below you authorize Christopher J Gudger DDS, PLLC to deduct fees from the credit card for the above family members for services rendered including them in the benefits of the VIP dental program or the program that allows us to accept your insurance as payment.

Cardholder Signature ______________________________

Date

Please read and initial which program you would like to enroll in below:

VIP PROGRAM 5% BOOKEEPING COURTESY

❑ _______ initials I would like to sign up for the VIP program that includes a 5% bookkeeping courtesy reduction off all regularly priced services by paying at the time of scheduling with my insurance being sent directly to me if applicable (recall visits will be charged out a month before the scheduled treatment date to benefit from this program.

INSURANCE ACCEPTANCE PROGRAM ONLY WITH NO 5% COURTESY

❑ _______ initials I would like your office to accept my dental insurance as payment from my insurance and to charge my credit card any under collection of payments for those family members or persons listed above.

NORTH CAROLINA

CENTER FOR ADVANCED DENTISTRY

DR. CHRISTOPHER J. GUDGER, DDS, PLLC

CHRISTOPHER J GUDGER DDS, PLLC

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect May 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available on request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment for you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If your are present, then prior to use or disclosure of your health information, we will provide you with opportunity to object to such uses or disclosures. In the even of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to

correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicable do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $25.00 for radiographs and basic medical clinical notes, if photographs are requested there will be a $3.00 charge per photograph printed, to locate and copy your health information, and postage will be added if you want the copies mailed to you or another provider. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing). Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended). We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclose of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Christopher J Gudger DDS
Telephone: (919) 846-8400
Fax: (919) 846-8398
Address: 8351 Standonshire Way Suite 121
Raleigh, NC 27615

NORTH CAROLINA

CENTER FOR ADVANCED DENTISTRY

DR. CHRISTOPHER J. GUDGER, DDS, PLLC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, ___________________________________, have received a copy of this office's Notice of Privacy Practices.

____

{Please Print Name}

____

{Signature}

____

{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

____

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