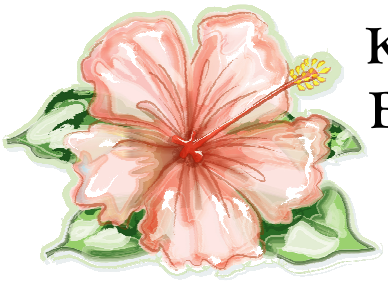

Karen J. Armstrong, D.M.D.
Bethany K. Tant, D.D.S.

3160 Henderson Drive
Jacksonville, NC 28546
Phone: (910)346-5600

Dear New Patient,

Welcome and thank you for choosing our office over the many that are available to you. Our entire team is dedicated to making your experiences with us positive and enjoyable. Modern dentistry provides many alternatives for your comfort and the longevity of your dental health. To help you feel more comfortable and at home, we have provided you with some information about your first visit.

One of our quality goals is to provide you with the most thorough dental examination possible. The examination includes necessary dental films (x-rays), an Oral Cancer Screening, an exam for early signs of any gum disease, and an evaluation of your bite and jaw joint. If any type of gum disease is diagnosed you may be asked to return for additional customized treatment. Our registered dental hygienist provides a thorough professional cleaning and works with you to develop a personalized home care routine. Whatever your goals are concerning your dental health, we are here to assist you.

We follow your examination with a consultation about your goals and your dental needs. All questions and concerns are completely covered. If treatment planning is complex, we may ask you to return for a more comprehensive consultation with the Doctor. Then, the time and investment for the treatment you choose is outlined. Financial arrangements, including answers to questions about any insurance coverage you might have, are made with our Treatment Coordinator before any treatment is begun.

Once any necessary treatment is completed, we will place you on a preventive program of care including a professional cleaning at recommended intervals. Research studies show that regular preventive care leads to fewer problems and, therefore, less cost.

We look forward to meeting you. Please arrive at least 15 minutes before your scheduled appointment time to avoid having a portion of your appointment rescheduled. We ask that you allow our office 90 minutes for this appointment from the time that you arrive. It is also recommended that child care arrangements be made for this first appointment only, as the visit is lengthy and requires your full participation.

Welcome to the first step in better dental health!

Karen J. Armstrong, DMD
Bethany K. Tant, DDS

Karen J. Armstrong, D.M.D.
Bethany K. Tant, D.D.S.

3160 Henderson Drive • Jacksonville, NC 28546 • 910-346-5600

Patient Information

Patient Name: _____ Preferred Name: _____
☐ Male ☐ Female First MI Last ☐ Married ☐ Single ☐ Child

Social Security #: _____ Birth Date: _____ Occupation: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Phone (Home): _____ (Work): _____ ext.: _____ Cellular #: _____

Whom may we thank for referring you to our practice? _____

Email address: _____ Would you like to receive email and/or text msg. confirmations? ☐ Yes ☐ No

Health Information

Have you ever had any of the following? Please check those that apply:

☐ AIDS/HIV	☐ Eating Disorder	☐ Liver Disease	**List Medications Below**
☐ Acid Reflux	☐ Epilepsy	☐ Mental/Nervous Disorder	_____
☐ Allergies	☐ Excessive Bleeding	☐ Mitral Valve Prol.	_____
☐ Antibiotic Allergy	☐ Fainting/Dizziness	☐ Pacemaker	_____
☐ Artificial Joints/Val.	☐ Headaches	☐ Pregnant; Due:_____	_____
☐ Aspirin Allergy	☐ Head Injuries	☐ Radiation Treatment	_____
☐ Asthma	☐ Heart Murmur	☐ Respiratory Problem	_____
☐ Autism	☐ Heart Disease	☐ Rheumatic Fever	_____
☐ Blood Disease	☐ Hepatitis	☐ Sleep Apnea/Snoring	_____
☐ Cancer	☐ Herpes	☐ Stroke	_____
☐ Chemical Depend.	☐ High/Low Blood Pressure	☐ Thyroid Problems	_____
☐ Codeine Allergy	☐ Iodine/Nickel Allergy	☐ Tobacco Habit	☐ **Medication List Attached**
☐ COPD	☐ Kidney Disease	☐ _____	☐ **No Conditions Apply**
☐ Diabetes	☐ Latex Allergy	☐ _____	

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
  _____
- Name of Physician: _____ Phone: _____
- In Case of Emergency: _____ Phone: _____
- Have you had Heart Surgery? ☐ Yes ☐ No Joint Replacement Surgery? ☐ Yes ☐ No
- Do you have any health problems that need further clarifications (incl. any other known allergies)? ☐ Yes ☐ No
  If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any changes in my health, I will inform the doctor at the next appointment without fail. I will not hold my dentist or staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient, Parent or Legal Guardian Date

Signature of Doctor Date

Karen J. Armstrong, D.M.D.
Bethany K. Tant, D.D.S.
3160 Henderson Drive
Jacksonville, NC 28546
Phone: (910)346-5600

Name:_____

Dental Questionnaire and History

***Please circle Yes or No to indicate if you have any of the following: ***

Bad Breath	Yes	No	Lip or Cheek Biting	Yes	No
Bleeding Gums	Yes	No	Loose Teeth or broken fillings	Yes	No
Blisters on lips or mouth	Yes	No	Mouth Breathing	Yes	No
Burning Sensation on Tongue	Yes	No	Mouth Pain when Brushing	Yes	No
Chew on one side of mouth	Yes	No	Orthodontic Treatment	Yes	No
Clicking or Popping jaw	Yes	No	Oral Piercings	Yes	No
Dry Mouth	Yes	No	Pain around Ear	Yes	No
Fingernail biting	Yes	No	Periodontal Treatment	Yes	No
Food collection between teeth	Yes	No	Sensitivity to Cold	Yes	No
Grinding Teeth	Yes	No	Sensitivity to Heat	Yes	No
Gums Swollen or Tender	Yes	No	Sensitivity to Sweets	Yes	No
Jaw Pain or Tiredness	Yes	No	Sensitivity when Biting	Yes	No
How Often do you Floss? _____			Sores or Growths in Mouth	Yes	No
How Often do you Brush? _____					

Briefly tell us how you feel about your teeth, your smile and dental expectations.

What are your expectations from this office?_____

_____

Are you interested in keeping your natural teeth for the rest of your life? Yes No
If you are already missing some teeth, do you want them replaced? Yes No
Have you ever been told you have periodontal disease (gum disease)? Yes No
Do you like your smile? Yes No if the answer is No, what changes would you like to see?

_____

Rate your smile on a scale of 1-5 with 1 being the lowest: _____
Are you interested in whitening? Yes No
Are you interested in straightening your teeth? Yes No
Do you ever feel anxious or nervous about dental treatment? Never Sometimes Always
Have you ever had nitrous oxide (laughing gas), general anesthesia or "twilight sleep" during a dental appointment? Yes No
Are you aware of anything that might prevent you from having either basic or cosmetic dental treatment?
Have your past dental office experiences been positive?_____
If no, please explain:_____
Is there anything in particular you would always like us to do for you?_____
Explain:_____
Is there anything in particular you would like us never to do?_____
Explain:_____
Do you have any dental concerns not listed here that you would like to bring to our attention?
Explain:_____

Briefly tell us about your normal dietary habits.

Do you consume any of the following drinks? How many per day?

☐Sweet Tea ___ ☐Regular Soda___ ☐Diet Soda ___ ☐Sports Drinks ___

☐Juice ___ ☐Energy Drinks ___ ☐Sugar Sweetened Beverages ___ ☐Other_____

Do you chew gum? How often? ☐Sugar free _____☐Regular _____
Do you consume hard candy or mints? Yes No How Often? _____
Do you consume large amounts of starchy foods such as French fries, chips, bread? Yes No
Are there any other dietary habits you would like to make us aware of?_____

Karen J. Armstrong, D.M.D.
Bethany K. Tant, D.D.S.

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Financial Policy

- Our office is a fee for service office, meaning we politely ask for your portion of payment **in full** at the time services are rendered.
- We accept Cash, Personal Check (if established), Visa, Mastercard, Discover Card, American Express and the CareCredit plan.
- If your dental treatment requires more than one visit, we will allow you to pay half at each visit. Ask your Treatment Coordinator if your visit is eligible.
- We charge a $25 returned check fee and a $25 collection fee for accounts sent to our outside collection agency.
- Accounts are considered delinquent after three (3) billing statements have been sent with no payment arrangements made.
- If your account is sent to collections, we reserve the right to suspend any future appointments and/or cancel any scheduled appointments until the delinquency is remedied.

Information for our Patients with Dental Insurance

As a courtesy to our patients, our office will assist you in obtaining the maximum benefit from your insurance.

- Our courtesy service to you includes electronically filing your insurance within 24 office hours of your appointment so that benefits may be paid quickly, researching your plan to advise you of benefits available to you and following the American Dental Association guidelines for coding and filing insurance claims.
- We ask that you understand that the policy belongs to you and we have no leverage to obtain payment from your insurance. With that, we ask that you take responsibility for payment of your visit should your insurance company not pay within 75 days of your appointment date. We ask that you keep our office informed of any changes in your insurance coverage or employment.
- Every dental insurance policy has a maximum benefit, which we are able to track for services rendered in our office. If you have received care by another office, we cannot be responsible for calculating your remaining benefits accurately. You may call your insurance company to receive an updated amount remaining after services have been paid to all office(s) involved.
- On the date of your office visit, you are responsible for the portion we estimate the insurance will not cover. However, if our estimates are inaccurate, there will be a need to send you a billing statement for the balance due. We ask that you remit payment upon receipt of this statement.
- At this time, we are participating providers for Metlife, Delta Dental Premiere, Tricare Retirees and Blue Cross Blue Shield of North Carolina. We will do our very best to inform you in advance should any of the above change.

For Your Information…

- Dental insurance pays based on the premium paid. Higher premium plans pay more of the fees for your dental care.
- Dental insurance is help in defraying costs of dental care and typically requires a patient copayment for most dental services.
- Dental insurance policies reduce payment for some services, use restricted fee schedules and exclude some procedures based on prior conditions or length of time on the plan. Every plan is written differently based on the request(s) of your employer.
- The type of treatment you need and receive from our office is based upon the Dentist's professional judgment, and not on the coverage you receive from a dental benefit plan. We do not believe it is in your best interest for us to compromise your recommended treatment in order to accommodate an insurance program.
- It is very important to understand that dental plans are not in business to make sure you receive the care you need – their only responsibility is to pay for the services your employer has purchased.

I have read and agree to this Financial Policy.

I hereby authorize benefits be paid directly to this office. I understand that the recommended treatment has been diagnosed as standard practice, and agree to the financial liability regardless of the necessity determined by my insurance carrier. If services are excludable from coverage, I have been made aware of their fee in the treatment plan presented.

Signature of Patient or Responsible Party **Today's Date**

Karen J. Armstrong, D.M.D.
Bethany K. Tant, D.D.S.

3160 Henderson Drive • Jacksonville, NC 28546 • 910-346-5600

Office Policy

High quality care and patient comfort is our highest mission. We pledge to provide the finest personal service and facilities for our patients who will always enjoy a warm, relaxed and comfortable environment. Within these walls dwell people dedicated to the total well being of each person who enters. By reaching out to people through ourselves, we can give them the understanding, compassions, and quality care they deserve.

Confirmation Policy

If our office is unable to confirm your dental appointment verbally or electronically with you, we do reserve the right to cancel your appointment and reappoint to another patient. Please be sure to keep us in mind when you change your phone, work or cellular phone numbers to avoid this situation.

Missed Appointment Policy

We reserve our time, facilities and equipment especially for you to receive high quality dental care. To keep our fees from rising, we politely request at least a 48 hour notice if you are unable to keep a reserved appointment. Without this notice, we reserve the right to charge a $30 broken appointment fee. After three missed or broken appointments per family we reserve the right to politely ask your family to receive dental care at another office. We ask that you please try to understand our position on this delicate situation and kindly confirm your reserved appointment with our office no later than 48 hours before your appointment time.

Clinical Area

Our treatment rooms are a sterile environment and must remain in sanitary condition for the duration of your dental visit. For that reason, we do not allow food or beverage items in any treatment area. We also ask that you do not bring small children with you to your dental visit unless they can be supervised in our Waiting Area. We kindly ask that you limit your cellular phone use to the Waiting Room only as our Clinical area has sensitive equipment and technology. We prefer that only the patient be in the treatment room, but can allow one additional person at the Doctor's discretion.

Minor/Child Fee and Payment Policy

The adult, parent(s), or legal guardian accompanying a minor child are responsible for the family's portion not covered by Dental Benefits at the time services are rendered. For unaccompanied minors, we require a note from the parent or guardian stating any changes in medical history, medications, and form of payment for the family's portion not covered by Dental Benefits. For unaccompanied minors, non-emergency treatment will be denied unless an arrangement for payment on a pre-authorized credit card, cash, or check is brought in before or at the time of the dental appointment.

Late Arrivals

We attempt to schedule our patients as efficiently as possible to reduce your wait time in our reception area. Due to this method of scheduling, it is imperative that we are able to start your appointment at the time we have scheduled for you. If you arrive for your appointment more than 10 minutes late, we do reserve the right to reschedule your appointment for another day and time. As always, we will try our very best to honor your appointment to the best of our abilities. With this policy in mind, if our office runs behind for your appointment more than 10 minutes, we will allow you to reschedule your appointment with no penalty to your record.

I, the undersigned, assign all dental benefits, if any, otherwise payable to me for services rendered.
I understand that I am financially responsible for all charges regardless of my Dental Benefits.

Signature_____seal Date_____

Thank you for understanding our Office Policy and please feel free to ask any questions you may have.
This "signature" will expire two (2) years from the date above.

Karen J. Armstrong, D.M.D.
Bethany K. Tant, D.D.S.
3160 Henderson Drive • Jacksonville, NC 28546 • 910-346-5600

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective April 14, 2003 Last Revision: December 1, 2013

Karen J. Armstrong, DMD, & Bethany K. Tant, DDS, PLLC is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). We realize that these laws are complicated, but we must provide you with the following important information.

Uses and Disclosures of Health Information

Federal law provides that we may use your protected health information ("PHI") for treatment, payment and health care operations without specific notice to you, or written authorization by you. Please review the following statements that explain this in more detail.

Treatment. We may use and disclose health information for your treatment and to provide you with treatment-related health care services. For example, we may disclose health information to doctors, dentists, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care. This will also include if our office refers you to another provider. We will furnish that provider with your medical information that relates to that problem so that you will receive proper medical care.

Payment. We may use and disclose your health information so that we or others, may bill and receive payment from you, an insurance company, or a third party for the treatment and services you received. For example, we may give your health plan information so they will pay for your treatment, such as a diagnosis code for your visit and a description of the services rendered.

Health Care Operations. We may use and disclose your health information for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the medical care you receive is of the highest quality. These activities include, but are not limited to, third party "business associates" that perform various activities for the practice such as billing and transcription services, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. This information may also be used for risk reduction or quality assurance purposes. We may also use a sign-in sheet at the registration desk and we may call you by name in the waiting room when your provider is ready to see you.

We may use or disclose your PHI, without further notice to you, or specific authorization by you, where:

1. Required by law;
2. Required for public health purposes;
3. Required by law to report abuse or neglect;
4. Where required by a health oversight agency for oversight activities authorized by law, such as the Department of Health, Office of Professional Discipline or Office of Professional Medical Conduct;
5. Required by law in judicial or administrative proceedings;
6. Required by law enforcement purposed by a law enforcement official;
7. Required by a coroner or medical examiner
8. Permitted by law to a funeral director;
9. Permitted by law for organ donation purposes;
10. Permitted by law to avert a serious threat to health or safety;
11. Permitted by law and required by military authorities if you are a member of the U.S. armed forces.

We may contact you by mail or phone, including cell phone, at your residence or work place, in reference to your appointment scheduling, billing issues, test results or other medical information that we may need to provide proper medical care. Unless you instruct us otherwise in writing, we may leave a message for you on any answering device or with any person who answers the phone at your residence. You can make reasonable requests, in writing, for us to use alternative methods of communicating with you in a confidential manner.

Other uses or disclosures of your medical information will be made only with your written authorization. You have the right to revoke any written authorization that you give, at any time, in writing, except to the extent that **Karen J. Armstrong, DMD, & Bethany K. Tant, DDS, PLLC** has already taken an action relying on the use of your previously signed authorization.

Rights That You Have

You have the right to request restrictions on certain uses or disclosures described above. Except as stated below, we are not required to agree to such restrictions. **For details, see the long form of this Notice of Privacy Practices.**

We must agree to your request to restrict disclosures of PHI to a health plan if: (i) the disclosure is for purposes of payment or health care operations and is not otherwise required by law, and (ii) the PHI pertains solely to health care items or services for which you, or another person on behalf of you (other than the health plan), has paid in full.

You have the right to inspect and obtain copies of your medical information (a reasonable fee will be charged). You must make this request in writing to our Office and allow a reasonable amount of time for us to prepare.

You have the right to request amendments to your medical information. Such requests must be in writing, and must state the reason for the requested amendment. We will notify you as to whether we agree or disagree with the requested amendment. If we disagree with any requested amendment, we will further notify you of your rights.

You have the right to request an accounting of any disclosures we make of your medical information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to our Privacy and Security Officer.

You have the right to obtain a paper copy of this notice from our office.

Obligations That We Have

We are required by law to maintain the privacy of health information and to provide individuals with notice of our legal duties and privacy practices. We are required to abide by the terms of this notice as long as it is currently in effect.

We reserve the right to revise this notice and to make a new notice effective for all health information we maintain. Any revised notice will be posted in our office and copies will be available there.

If you are not satisfied with how our office handled your complaint, you may also submit a written complaint to:

Secretary of the Department of Health and Human Services
200 Independent Avenue, S.W.
Washington, D.C. 20201

We support your right to the privacy of your protected health information. We will not retaliate or penalize you in any way if you choose to file a complaint with us, or the Department of Health and Human Services. Your medical health and privacy rights will always be important to us.

You may also file a complaint with us. Complaints should be directed to **Jane Collins,** our **Privacy and Security Officer.** You can contact her at **(910) 346-5600**, if you desire further information, or have any questions or concerns.

Karen J. Armstrong, D.M.D.
Bethany K. Tant, D.D.S.
3160 Henderson Drive • Jacksonville, NC 28546 • 910-346-5600

Acknowledgement of Receipt of Notice of Privacy Practices

By signing below, I am acknowledging that I have been provided with a copy of **Karen J. Armstrong, DMD, & Bethany K. Tant, DDS, PLLC**'s Notice of Privacy Practices dated **December 1, 2013** pursuant to the Health Information Portability and Accountability Act of 1996 (HIPAA).

_____ _____
Signature of Patient or Representative Date

_____ _____
Printed name of Patient or Representative Relationship of Representative to Patient

Evidence of the authority of the patient's representative must be attached to this acknowledgment

If patient is unable to sign please document the reason and initial: _____
_____

☐ I hereby give **Karen J. Armstrong, DMD, & Bethany K. Tant, DDS, PLLC** permission to leave messages on my telephone answering machine/voicemail or to whomever answers the telephone regarding appointment, billing and/or medical information.

☐ I do not give **Karen J. Armstrong, DMD, & Bethany K. Tant, DDS, PLLC** permission to leave messages on my telephone answering machine/voicemail or to whomever answers the telephone regarding appointment, billing and/or medical information.

_____ _____
Signature of Patient or Representative Date

_____ _____
Printed name of Patient or Representative Relationship of Representative to Patient