How did you hear about us?

Patient Name:_____

Today's Date:_____

I have been a patient here, before today: (circle one) Yes No

Please check all that apply.

Recommended by a friend, family member, or colleague (name):

_____

Social Media (e.g. Facebook, Instagram, Twitter)

Our website

Search engine (e.g. Google, Bing) - If so, which keywords were used to search?

_____

Advertisement (e.g. Radio, Newspaper):_____

Reviews Site (e.g. Google Reviews, Yelp):_____

Other (e.g. Insurance):_____

Office Use Only

TP		
TC		

Continue to next page ⟶

PERSONAL INFORMATION - Please complete all fields that are highlighted in yellow

CIRCLE MR. MRS. MS. DR.	First Name	Last Name	Preferred Name
	Best Contact Number	Date of Birth (mm/dd/yyyy)	Social Security #	Email
Address		City, State, Zip	
Emergency contact name		Relation	Emergency Contact's Phone Number
Previous dentist		Last dental visit	Previous Dentist's Phone Number
Dental insurance provider			Did you have x-rays taken? YES NO
Employer		Subscriber name	
Subscriber date of birth	ID number	Group number	Customer service number

HIPAA POLICY

*** If you have filled out this form digitally, you will receive a copy of this office's Notice of Privacy Practices upon arrival. You may also refuse to sign this acknowledgment .***

I acknowledge that I have received and read a copy of this office's Notice of Privacy Practices.

Printed name: _____ Signature: _____ Date: _____

Office use only: Individual refused to sign Communications barriers prohibiting acknowledgment

Emergency situation Other:_____

Parents / Legal Guardians, please give your NAME AND DATE OF BIRTH below:

_____ _____

CONSENT TO DISCUSS TREATMENT

In the event of a spouse, parent, or child who calls our office or is present with you at your appointment; we are not able to give out any information regarding your treatment, when your next appointment is scheduled, etc. Unless you list them as someone we are allowed to discuss this with below.

I do not wish to have my dental appointments or treatment discussed with anyone.

I hereby give consent to this dental practice to have my dental treatment or appointments discussed in front of or over the phone with _____.

Patient Signature: _____ Date: _____

Continue to next page ⟶

DENTAL HISTORY

YES or NO

1. Do your gums bleed when you brush or floss? 1.
2. Are your teeth sensitive? 2.

   If yes, explain_____
3. Does food or floss catch between your teeth? 3.
4. Is your mouth dry? 4.
5. Have you had any gum treatments? 5.
6. Have you had braces? 6.
7. Have you ever had any issues with dental treatment? 7.
8. Are you currently experiencing any pain? 8.
9. Do you have ear or neck pain? 9.
10. Do you have clicking or popping in your jaw? 10.
11. Have you ever had a serious head or mouth injury? 11.

    If yes, explain_____
12. Do you have any loose teeth? 12.
13. Do you have dentures or partial dentures? 13.

MEDICAL HISTORY

Primary physician's name:_____ Phone #:_____

Are you currently under the care of a physician? YES NO If yes, for what _____

Date of your last physical exam:_____

It is recommended by the ADA to have antibiotics prior to any dental treatment, including cleanings, if you have any history of Congenital Heart Disease (CHD), artificial/prosthetic valves or any previous infective endocarditis.

As office policy, if you have had any full joint replacement surgery within the last year of your appointment date, we require a clearance letter from your surgeon, as antibiotics may be recommended before treatment.

Do you use controlled substances (drugs)? YES NO

Do you use any form of tobacco? Vaping Products? YES NO If yes, what type? _____, frequency? _____

Do you drink alcohol? YES NO If yes, how often? _____

Do you take or have you ever taken Phen-Fen or Redux? YES NO If yes_____

Have you ever taken Fosamax, Boniva, Acetonel or any other medications containing Biphosphonates? YES NO If yes_____

Are you on a special diet? YES NO If yes_____

Has a doctor or dentist ever recommended you to take antibiotics before dental appointments? YES NO

If yes, for what condition? _____ For how long? _____

Women Only: Pregnant? YES NO Number of weeks: _____ Taking birth control pills or hormone replacement? YES NO

Continue to next page ⟶

MEDICAL HISTORY

		YES or NO
1.	Do you have unhealed oral injuries, growths, or spots in your mouth?	1.
2.	Have you been hospitalized within the past 5 years?	2.
3.	Is there any condition concerning your health that the doctor should be told?	3.
4.	Do you currently take any blood thinners?	4.
5.	Have you had or have any of the following conditions?	5.

Abnormal / Excessive Bleeding	Congestive Heart Failure	Heart Surgery	Psychiatric Treatment / Care
AIDS or HIV infection	Contagious Disease	Heart Trouble / Disease	Recent Weight Loss
Alzheimer's Disease	Convulsions	Hemophilia	Recurrent Infections
Anaphylaxis	Cortisone Medicine	Hepatitis A	Renal Dialysis
Anemia	Damaged Heart Valves	Hepatitis B or C	Rheumatic Fever
Angina	Delay in healing	Herpes / Cold Sores / Fever Blisters	Rheumatism
Arthritis / Gout / Joint Disease	Diabetes	High Blood Pressure	Scarlet Fever
Artificial Heart Valve	Dialysis	High Cholesterol	Shingles
Artificial Joints	Drug Addiction	Hives or Rash	Sickle Cell Disease / Traits
Asthma	Eating Disorder	Hypoglycemia	Sinus Problems
Autoimmune Disease	Emphysema	Immune System Problems	Spina Bifida
Blood Disease	Epilepsy	Irregular Heartbeat	Stomach Disease
Blood Transfusion	Excessive Thirst	Joint Replacements	Swelling of Limbs
Breathing Problems / Difficulty	Fainting Spells / Seizures	Kidney Disease / Problems	Thyroid Problems / Disease
Bronchitis, Chronic Cough	Frequent Diarrhea	Leukemia	TMJ, Jaw Pain
Bruise Easily	Frequent Headaches	Liver Disease	Tonsillitis
Cancer	Gallbladder Trouble	Low Blood Pressure	Tuberculosis (TB)
Cardiovascular Disease	Genital Herpes	Low Blood Sugar	Tumors or Growths
Chemo / Radiation Therapy	GERD / Heartburn	Lung Disease	Ulcers
Chest Pains	Glaucoma	Mitral Valve Prolapse	Venereal Disease
Chronic Fatigue	Hay Fever	Mononucleosis	
Cold Sores / Fever Blisters	Heart Attack / Stroke / Failure	Osteoporosis	
Congenital Heart Disorder	Heart Murmur	Pacemaker	

Do you have any disease, condition or problem that was not listed above? YES NO If yes_____

What medications are you currently taking? _____

ALLERGIES - Are you allergic to or have you had any type of reaction to:

		YES or NO	SPECIFIC TYPE OF REACTION:
1.	Local Anesthetics		_____
2.	Aspirin		_____
3.	Penicillin or other antibiotics		_____
4.	Barbiturates, sedatives or sleeping pills		_____
5.	Sulfa drugs		_____
6.	Codeine or other narcotics		_____
7.	Latex		_____

Continue to next page ⟶

Authorization, Release, and Agreement to Pay for Services Rendered

I understand that with dental insurance, the copay of total fee is expected at the time services are rendered. I also understand that for my convenience the dentist accepts cash, check or credit card and I hereby agree to pay the copay today for the services rendered to me. Without dental insurance, fees are due when service is rendered; afterwards it is the patient's responsibility to return if treatment is not completed on the first visit.

If I have dental insurance, the consultation fee for my visit will not be payable today, but will be filed on my insurance claim. I authorize the dentist to **release any information** including the diagnosis and records of any treatment rendered me during the period of dental care to third party payers and/or referring practitioners. I **authorize** and hereby request my insurance company to pay directly to the dentist any benefits otherwise payable to me. I would like your office to file all insurance claims to the best of their ability as a courtesy to me. I am aware an "estimated" portion is due at the time of service and I understand that I, the patient and/or subscriber, am responsible for all amounts not covered by my insurance carrier (see disclaimer below) and that any balance due on the account after 45 days must be paid in full, regardless of insurance still being processed. I will be responsible for contacting my insurance company for further explanation.

Insurance Disclaimer

It is our pleasure to estimate your insurance coverage and file claims on your behalf to all dental insurance companies. Since we are not a Medicare provider, a receipt with all the necessary information can be provided in order for you to file your own claim to medicare. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for **full payment** of all services rendered on my behalf or on behalf of my dependents regardless of what my insurance company may/may not cover. Note: We are in-network with Aetna, Ameritas, Assurant, BCBSNC, Cigna, Delta Dental, Dentemax, Guardian, Humana, MetLife, United Health Care.

We do our best to research online and call directly to a representative to give us accurate information. Please keep in mind that our estimates are only as accurate as the information provided to us by your insurance representatives. Because of human error, there is always an insurance disclaimer stating payment is not a guarantee and final payment will be determined upon receipt of the claim for actual services rendered. We are not responsible for any unforeseen balances incurred due to incorrect information or policy changes. Based on the occasional inaccurate information supplied to us by insurance companies, **we encourage everyone to get involved and verify their own insurance coverage prior to treatment.**

Despite such expansive research there are times insurance companies may change coverage based on individual situations. In this case they may deny the coverage that had originally been approved. This decision comes from the insurance company directly. There could also be procedures performed that are subject to being downgraded by your insurance company. In such circumstances, the insurance portion of the fee becomes my responsibility.

Our office understands that sometimes unexpected circumstances may prohibit you from keeping your scheduled appointment. However, we ask that you notify us at least 24 hours prior to your scheduled appointment time. Any no-show or cancelled appointments without a 24 hour notice will be charged a $50 fee for hygiene appointments and $100 for treatment appointments. Any outstanding balances not paid at the time services are rendered, will be turned over to a collection agency by this dental office after 90 days. I will be responsible to pay any administrative fees, attorney fees, court fees, or any cost of collection.

NOTE: Root canal therapy does not guarantee restoration of the tooth. Rarely, after root canal treatment, the tooth may still fracture or become infected, requiring further treatment. Treatment of a crowned, infected tooth will be performed at no cost to the patient within six months from the date of original treatment. After six months, the patient will be responsible for the re-treatment fee. **NO REFUNDS WILL BE GIVEN** for fractured teeth left unprotected by crown.

To the best of my knowledge, the questions on this form have been accurately answered. I understand providing incorrect information can be dangerous to my and other patients' health. It is my responsibility to inform the dental office of any changes in medical status.

Patient, parent or legal guardian Signature: _____ Date: _____

X-Ray Policy

At our dental practice, your dental health is our priority! To make an appropriate dental diagnosis, adequate x-rays must be taken of your teeth and surrounding structures. We adhere to the following protocol to maintain quality of care:

1. All new patient comprehensive exams will require **(4) Bitewing X-Rays**, a **Panoramic X-Ray** or of equal value, and a **Full Mouth Series (FMX)** set of X-Rays.
2. Existing patients will require a minimum of **(4) Bitewing X-Rays** each year and a **Panoramic X-Ray** every 3 to 5 years. Periodontal conditions, extent of existing dental work, and other factors may necessitate the need for additional x-rays.
3. X-Rays taken prior to your initial visit may not be satisfactory depending on when they were taken at the previous office. *If you have already had x-rays taken within the last year, it is your responsibility to have those x-rays transferred to yourself and/or our office prior to your initial visit, or we will require our own so we may properly diagnose.* ***Please let us know in advance if you need assistance from us to get those records transferred.****

Please note: Required x-rays must be taken in order to continue treatment with us, regardless of your insurance coverage. It is a violation of State Law to treat a patient without adequate x-rays. State Law also dictates that a patient cannot consent to negligent treatment. Therefore, the refusal of necessary x-rays will constitute termination of the doctor-patient relationship. We appreciate your understanding of this policy. Staff members will be able to answer any questions that you may have.

I accept the recommended X-Ray procedures.

Signature:_____ Date: _____