CAROLINA DENTAL CARE

WELCOME TO OUR OFFICE

Today's Date _____

Name _____ Date of Birth _____ S.S.# _____
Last First M.I.

Address _____ Marital Status _____ Sex ❑ M ❑ F

_____ Home Phone _____

Place of Employment _____ Work Phone _____

Email: _____ Cell # _____

Full Name of Spouse/Parent _____ Spouse/Patient Cell # _____

Who may we thank for referring you to our office? _____

Dental Insurance Company _____

Medical Physician's Name _____ Drug Store Name _____

In Case of Emergency Notify _____ Phone _____

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? ☐ Yes ☐ No If yes, _____

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No If yes, _____

_____

Have you ever had a serious head or neck injury? ☐ Yes ☐ No If yes, _____

Are you taking any medications, pills, or drugs? ☐ Yes ☐ No If yes, _____

_____

Do you take, or have you taken, Phen-Fen or Redux? ☐ Yes ☐ No If yes, _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ☐ Yes ☐ No If yes, _____

Are you on a special diet? ☐ Yes ☐ No If yes, _____

Do you use tobacco? ☐ Yes ☐ No If yes, _____

Do you use alcohol or recreational drugs? ☐ Yes ☐ No If yes, _____

Do you use controlled substances? ☐ Yes ☐ No If yes _____

Are you currently taking blood thinners? ☐ Yes ☐ No If yes, _____

Do you have to premedicate with an antibiotic prior to dental visits? ☐ Yes ☐ No If yes, _____

Women: Are you...

Pregnant/Trying to get pregnant? ☐ Yes ☐ No Nursing ☐ Yes ☐ No Taking oral contraceptives? ☐ Yes ☐ No

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 ☐ Yes ☐ No	Diabetes ☐ Yes ☐ No	Hepatitis B or C ☐ Yes ☐ No	Recent Weight Loss ☐ Yes ☐ No
Alzheimer's Disease ☐ Yes ☐ No	Drug Addiction ☐ Yes ☐ No	Herpes ☐ Yes ☐ No	Renal Dialysis ☐ Yes ☐ No
Anaphylaxis ☐ Yes ☐ No	Easily Winded ☐ Yes ☐ No	High Blood Pressure ☐ Yes ☐ No	Rheumatic Fever ☐ Yes ☐ No
Anemia ☐ Yes ☐ No	Emphysema ☐ Yes ☐ No	High Cholesterol ☐ Yes ☐ No	Rheumatism ☐ Yes ☐ No
Angina ☐ Yes ☐ No	Epilepsy or Seizures ☐ Yes ☐ No	Hives or Rash ☐ Yes ☐ No	Scarlet Fever ☐ Yes ☐ No
Arthritis/Gout ☐ Yes ☐ No	Excessive Bleeding ☐ Yes ☐ No	Hypoglycemia ☐ Yes ☐ No	Shingles ☐ Yes ☐ No
Artificial Heart Valve ☐ Yes ☐ No	Excessive Thirst ☐ Yes ☐ No	Irregular Heartbeat ☐ Yes ☐ No	Sickle Cell Disease ☐ Yes ☐ No
Artificial Joint ☐ Yes ☐ No	Fainting Spells/Dizziness ☐ Yes ☐ No	Kidney Problems ☐ Yes ☐ No	Sinus Trouble ☐ Yes ☐ No
Asthma ☐ Yes ☐ No	Frequent Cough ☐ Yes ☐ No	Leukemia ☐ Yes ☐ No	Spina Bifida ☐ Yes ☐ No
Blood Disease ☐ Yes ☐ No	Frequent Diarrhea ☐ Yes ☐ No	Liver Disease ☐ Yes ☐ No	Stomach/Intestinal Disease ☐ Yes ☐ No
Blood Transfusion ☐ Yes ☐ No	Frequent Headaches ☐ Yes ☐ No	Low Blood Pressure ☐ Yes ☐ No	Stroke ☐ Yes ☐ No
Breathing Problems/Respiratory ☐ Yes ☐ No	Genital Herpes ☐ Yes ☐ No	Lung Disease ☐ Yes ☐ No	Swelling of Limbs ☐ Yes ☐ No
Bruise Easily ☐ Yes ☐ No	Glaucoma ☐ Yes ☐ No	Mitral Valve Prolapse ☐ Yes ☐ No	Thyroid Disease ☐ Yes ☐ No
Cancer ☐ Yes ☐ No	Hay Fever ☐ Yes ☐ No	Nervous Disorders ☐ Yes ☐ No	Tonsillitis ☐ Yes ☐ No
Chemotherapy ☐ Yes ☐ No	Heart Attack/Failure ☐ Yes ☐ No	Osteoporosis ☐ Yes ☐ No	Tuberculosis ☐ Yes ☐ No
Chest Pains ☐ Yes ☐ No	Heart Murmur ☐ Yes ☐ No	How many years?_____	Tumors or Growths ☐ Yes ☐ No
Cold Sores/Fever Blisters ☐ Yes ☐ No	Heart Pacemaker ☐ Yes ☐ No	Pain in Jaw Joints ☐ Yes ☐ No	Ulcers ☐ Yes ☐ No
Congenital Heart Disorder ☐ Yes ☐ No	Heart Trouble/Disease ☐ Yes ☐ No	Parathyroid Disease ☐ Yes ☐ No	Venereal Disease ☐ Yes ☐ No
Convulsions ☐ Yes ☐ No	Hemophilia ☐ Yes ☐ No	Psychiatric Care ☐ Yes ☐ No	Yellow Jaundice ☐ Yes ☐ No
Cortisone Medicine ☐ Yes ☐ No	Hepatitis A ☐ Yes ☐ No	Radiation Treatments ☐ Yes ☐ No	

Have you ever had any serious illness not listed ☐ Yes ☐ No If yes _____

_____

CERTIFICATION: I certify that the answers given are correct to the best of my knowledge. We are NOT in any networks. However we will file all insurance for you. I fully understand that my insurance benefit is an arrangement between myself and the insurance company and I am responsible for the entire balance. I understand I will be charged 1.5% interest monthly if my account is over 90 days.

TREATMENT AUTHORIZATION: I hereby grant authority to the Carolina Dental Care who is in charge of the patient whose name appears on this health history form, to obtain any and all health information from any physician(s) and/or pharmacy(s), to administer any treatment and to administer such X-rays, anesthetics, sedatives, or nitrous oxide, and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient.

NOTICE OF PRIVACY PRACTICES:

I have received and/or read a copy of this office's Notice of Privacy Practices and Acknowledgement of Receipt of Notice of Privacy Practices

X_____ _____ _____

SIGNATURE ***Relationship to Patient*** ***Date***

Our Financial and Appointment Policies

Thank you for choosing Carolina Dental Care for your dental care, where we are committed to the success of your treatment. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial and Appointment Policies. PLEASE READ AND SIGN THAT YOU UNDERSTAND EACH OF OUR OFFICE'S EXPECTATIONS FROM YOU.

- **Co-Payments: All applicable deductibles, co-insurance amounts, and non-covered service is rendered. For your convenience our office accepts cash, personal checks, Care Credit, and any major credit card.**

- **Dental Insurance: As a courtesy, we file any dental insurance claim as long as you provide us with the correct insurance information, a copy of the insurance card, the insured's social security number and date of birth. Our office will attempt to call your insurance company prior to any treatment to verify dental benefit coverage. The benefits you receive are based on the contract between you and/or your employer and the dental insurance company, not our office. Some services you may need or want may not be covered by your dental plan.**

- **Unpaid Insurance Balances: Every effort is made to process your dental claim efficiently and quickly as well as to calculate your patient co-insurance amounts for each date of service. However, they are still estimates based on the current information you and your dental benefit plan provided to our office. The exact amounts are not known until the claim has been paid. YOU ARE RESPONSIBLE AND WILL BE REQUIRED TO PAY FOR ANY REMAINING ACCOUNT BALANCE AFTER YOUR INSURANCE HAS PAID THEIR PORTION.**

- **NO SHOW/APPOINTMENT CANCELLATIONS: We make every effort to accommodate you when scheduling an appointment. Thus, we trust that no change in your appointment will be necessary. However, if this becomes necessary we require a 24 hour notice to make changes in your reserved appointment time. We recognize that emergencies do occur and adequate notice is not possible. These situations will be considered on a case by case basis. We reserve the right to NOT reschedule your appointment.**

- **NO SHOW/CANCELLATION FEES: We reserve the right to charge $25.00 for any appointment missed or not canceled within 24 business hours.**

We will be glad to discuss any question you may have about our financial or appointment policies. We hope by presenting our policies we will avoid any misunderstandings and therefore have more time to dedicate to your dental care.

I hereby authorize all claims to be filed on myself or my dependents' behalf, for the use of "my signature on file" for all insurance claims and for the benefits to be assigned to Carolina Dental Care. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. I authorize the use of my healthcare information for the purpose of obtaining payment for services rendered and determining benefits. This consent will remain in effect for as long as I or my dependents are a patient of record.

_____ _____

Patient/Guardian Signature **Date**