



# Tar Heel Periodontics and Implant Dentistry



Proud Partners of the Carolina Hurricanes

PATIENT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_  
Last First MI (Preferred Name)

BIRTH DATE: \_\_\_\_\_ AGE: \_\_\_\_\_ SOCIAL SECURITY #: \_\_\_\_\_

MALE: \_\_\_\_\_ FEMALE: \_\_\_\_\_ SINGLE: \_\_\_\_\_ MARRIED: \_\_\_\_\_ WIDOW(ER): \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
Street Apartment #  
\_\_\_\_\_  
City State Zip Code

TELEPHONE (HOME): \_\_\_\_\_ (WORK): \_\_\_\_\_ (CELL): \_\_\_\_\_

EMPLOYER: \_\_\_\_\_

## HEALTH INFORMATION

1. Do you premedicate before a dental visit?  Yes  No If yes, for what reason: \_\_\_\_\_  
What do you premedicate with? \_\_\_\_\_
2. Are you allergic to any medications?  Yes  No If yes, please list: \_\_\_\_\_
3. Are you currently taking any medications?  Yes  No If yes, please list: \_\_\_\_\_  
\_\_\_\_\_
4. Are you currently under the care of a physician?  Yes  No If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_  
Name of physician: \_\_\_\_\_ Phone #: \_\_\_\_\_
5. Have you ever had any type of joint replacement?  Yes  No If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_
6. Do you have or have you ever had Hepatitis A, B or C?  Yes  No
7. Have you ever been told you could not donate blood?  Yes  No If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_
8. Have you ever had a blood test for AIDS?  Yes  No Results were:  Positive  Negative
9. Do you use any tobacco products?  Yes  No If yes, please list: \_\_\_\_\_

## HEALTH INFORMATION (CONT'D)

10. Have you ever had any complications from dental treatment?  Yes  No If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

11. FEMALES: Are you pregnant?  Yes  No If yes, expected due date is: \_\_\_\_\_

12. Circle Yes or No to the following:

AIDS	Y	N	High Blood Pressure	Y	N
Diabetes	Y	N	Hepatitis A, B or C	Y	N
Epilepsy	Y	N	Arthritis	Y	N
Rheumatic Fever	Y	N	Prolonged Bleeding	Y	N
Heart Disease	Y	N	Cancer	Y	N
Mitral Valve Prolapse	Y	N	Asthma	Y	N
Heart Attack	Y	N	Fainting Spells	Y	N
Liver or Kidney Disease	Y	N	Tuberculosis	Y	N
Heart Murmur	Y	N	Anemia	Y	N
Stroke	Y	N	Stomach Ulcers	Y	N
Organ Transplant	Y	N	Thyroid Problems	Y	N
Chest Pain/Angina	Y	N	Latex Allergy/Reaction	Y	N

Reason for this visit: \_\_\_\_\_ Date of last dental visit: \_\_\_\_\_

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail. My signature authorizes treatment.

\_\_\_\_\_ Date: \_\_\_\_\_

Signature of patient, parent or guardian

## REFERRAL INFORMATION

Whom may we thank for referring you to our practice?  Another patient, friend or relative

Dental Office  Yellow Pages  Newspaper  School  Work  Other \_\_\_\_\_

Name of person or office referring you to our practice: \_\_\_\_\_

Who is your general dentist? \_\_\_\_\_

How long have you been a patient with your general dentist? \_\_\_\_\_

## RESPONSIBLE PARTY INFORMATION

NAME: \_\_\_\_\_

Male  Female

Married  Single  Other: \_\_\_\_\_

BIRTH DATE: \_\_\_\_\_ AGE: \_\_\_\_\_ SOCIAL SECURITY #: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

Street

Apartment #

City

State

Zip Code

PHONE (HOME): \_\_\_\_\_ (WORK): \_\_\_\_\_

## EMPLOYMENT INFORMATION

EMPLOYER NAME: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

EMPLOYER ADDRESS: \_\_\_\_\_

Street

Suite #

City

State

Zip Code

EMPLOYER PHONE: \_\_\_\_\_

## DENTAL INSURANCE INFORMATION

### Primary

Name of Insured: \_\_\_\_\_ Is insured a patient?  Yes  No

Insured's Birth Date: \_\_\_\_\_

Subscriber Social Sec. #: \_\_\_\_\_

Subscriber ID #: \_\_\_\_\_

Subscriber Group #: \_\_\_\_\_

Subscriber Address: \_\_\_\_\_

Street

City

State

Zip Code

Subscriber's Employer Name: \_\_\_\_\_

Address: \_\_\_\_\_

Street

City

State

Zip Code

Patient's relationship to insured:  Self  Spouse  Child  Other: \_\_\_\_\_

DENTAL INS. CO: \_\_\_\_\_

Full Name of Dental Insurance Carrier

DENTAL INSURANCE: \_\_\_\_\_

MAILING ADDRESS Street Suite #

City

State

Zip Code

DENTAL CLAIMS PHONE #: \_\_\_\_\_

DENTAL CLAIMS FAX #: \_\_\_\_\_ (IF AVAILABLE)

## 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 for at the time services are preformed.

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 patient's 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.

I understand that the fee estimate listed for this dental care can only be extended for a period of three 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 at the time said services are rendered. I further agree that the reasonable value of said services shall be as billed.

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.

Signature \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to Patient: Self \_\_\_\_\_ Spouse \_\_\_\_\_ Parent \_\_\_\_\_ Child \_\_\_\_\_ Other: \_\_\_\_\_

Please explain