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):_____

EMAIL: _____

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