Tar Heel Periodontics
AND IMPLANT DENTISTRY

PROUD PARTNER OF THE

CAROLINA HURRICANES

We are happy to have you join our great family of patients and friends. The benefits of a healthy, beautiful smile are never-ending, and our goal is to provide a safe and comfortable environment while providing you the highest quality of care.

Please complete this form to the best of your ability so we can provide the best possible care.

Dental Health History Form

PATIENT NAME:_________________________________ DATE: ____________________
LAST FIRST (PREFERRED NAME)

BIRTHDATE: ___________ AGE: _______ SOCIAL SECURITY # : _______________________

MALE: _____ FEMALE: _____ SINGLE: _____ MARRIED: _____ WIDOW: _____

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: ____

5. Have you ever had any type of joint replacement? ☐ Yes ☐ No

   If yes, please explain: ____

PROUD PARTNER OF THE

CAROLINA HURRICANES

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 explain: ______________________________

10. Have you ever had any complications from dental treatment? ☐ Yes ☐ No

    If yes, please explain: ______________________________

11. FEMALE PATIENTS: 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
Sleep Apnea	Y	N			

Reason for this Visit : ______________________ Date of last dental visit: __________

To the best of my knowledge, all 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 ☐ School ☐ Social Media ☐ Other ________________________________

Name of the person or office referring you to our practice: ____________________________

Who is your general dentist? ____

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

DENTAL INSURANCE INFORMATION

Primary

Name of insured: ______________________________ is the insured a patient? ☐ Yes ☐ No

Insured's Birth Date: ____________________________

Subscriber's Social Sec. # : ____________________________

Subscriber ID #: ____________________________

Subscriber Group #: ____________________________

Subscriber Address: ____

Street City State Zip Code

Subscriber's Employer Name: ____

Address: ____

Street City State Zip Code

Patients relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other: ____________________

DENTAL INS. CO. : ____

Full Name of Dental Insurance Carrier

DENTAL INSURANCE: ADDRESS: ____
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 performed.

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)

Your Health. Your Life. Our Passion.