Tar Heel Periodontics
AND IMPLANT DENTISTRY

# Welcome to The Premier Periodontal Practice in The Triangle!

It is with the greatest pleasure that we welcome you to our periodontal practice here in The Triangle. On behalf of the entire team at Tar Heel Periodontics and Implant Dentistry, we welcome you to our family! For more than 20 years, Tar Heel Perio has been serving The Triangle with comprehensive, modern dental care and personalized periodontal disease and implant treatment.

Our doctors work as faculty for the UNC Department of Periodontology, and each doctor works closely with the residents in the training program. The doctors at Tar Heel Perio are the only full-time periodontists in the area currently serving as faculty for UNC Dental School and are glad to bring that experience to patient care here in The Triangle. Go Heels!

We also support local athletics and are proud to be a part of this growing community.

We appreciate your confidence and trust in our team in choosing Tar Heel Perio for your periodontal and surgical care and look forward to treating you like family.

-Your Friends at Tar Heel Perio

*Your Health. Your Life. Our Passion.*

RALEIGH/WAKE COUNTY DENTAL SOCIETY

SPEAR STUDY CLUB

UNC DENTISTRY

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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 : _____

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## HEALTH INFORMATION

1. Do You premedicate before a dental visit? ☐ Yes ☐ No

   If yes, for what reason: _____

   What do you premedicate with? _____

   Do you take anticoagulants (blood thinners) such as (Please circle):

   - Clopidogrel (Plavix)
   - Dipyridamole (Persantine)
   - Prasugrel (Effient)
   - Ticagrelor (Brilinta)
   - Vorapaxar (Zontivity)
   - Rivaroxaban (Xarelto)
   - Warfarin (Coumadin)
   - Aspirin
   - Dabigatran (Pradaxa)
   - Apixaban (Eliquis)
   - Enoxaparin (Lovenox)
   - Heparin

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: _____

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

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# OFFICE POLICY FOR FINANCIAL ARRANGEMENTS

We believe that every patient has the right to expect the very best professional care we can provide. In turn, we expect your cooperation in establishing a definite payment arrangement.

Fees quoted for periodontal services will be honored provided the treatment is initiated within **three months** from the consultation date.

Payment options:

1. **Cash and Personal Checks**: this includes money orders.
2. **MasterCard/Visa/AMEX/Discover**: we accept credit cards as payment for periodontal care as your limit allows.
3. **Payment Plan**: a separate line of credit to cover your entire family's dental needs. Approval takes less than 15 minutes. It does not affect current spending limits and balances of other credit cards. There is no annual fee and no interest if the balance is paid by the due date. Otherwise monthly payments need only be 3% of the total balance. Financing your treatment allows you to start your periodontal care immediately and spread the payments over a time period appropriate for you. Most importantly, it offers you the opportunity to enjoy the benefits of your periodontal health without financial strain.

As a courtesy to our patients with dental insurance, we will be happy to file your insurance if we are supplied with the necessary information for your plan. We will be willing to assist you in settling any insurance disputes with additional information if required. Any estimated insurance coverage given by this office is only an **estimate** of coverage and **not** a guarantee of insurance payment. The estimate is either based on our past history of benefits from your plan or on information supplied by you pertaining to your plan. Most insurance companies have their own schedule of what they consider "Usual and Customary" (UCR) fees. These fees can vary greatly among different plans. Many plans do not differentiate between fees charged by general dentists and the fees of a periodontist. Our fees are based solely on the amount of time, expertise and care required to treat your particular case and is not based on your insurance coverage. Therefore, it is not uncommon to find differences in our fees and insurance fee schedules. Please understand that your insurance is an agreement between you, your employer and your insurance carrier. We are not a party to that agreement.

I realize I am financially responsible for the charges indicated above. Procedures need to be paid in full at least seven days before treatment is performed. I have read, understand and agree to the above financial arrangements.

Signature of Patient, Parent or Guardian Date

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# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**You May Refuse to Sign This Acknowledgement**

I, _____, have received a copy of this office's Notice of Privacy Practices.

Please Print Name _____

Signature _____

Date _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

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*Optional*

# Photography Consent Form

I, _____, hereby grant Tar Heel Periodontics and Implant Dentistry permission to take photographs of myself, and to publish those photographs for any lawful purpose, including, but not limited to, their website, social media accounts, and promotional materials, either digital or in print, in perpetuity. I also grant permission to use my name.

By signing and dating this document I authorize Tar Heel Periodontics and Implant Dentistry to edit, alter, share, remix, tweak, build upon or in any way alter the photograph(s) mentioned above. I also waive any rights of privacy or compensation associated with the use of my image(s) and name(s) for the personal or commercial purposes outlined above.

I prefer that:

- ☐ My complete name be used
- ☐ My first name only be used
- ☐ No name be used

_____ _____

*Signature* *Date*

_____ _____

*Printed name* *THP witness*

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**COVID-19 Pandemic Emergency Dental Treatment Consent Form**

I, _____, knowingly and willingly consent to have dental treament completed during the COVID-19 pandemic. I understand the COVID-19 virus has a long incubation period during which carriers of the virus may not show symptoms and still be contagious. Screening procedures cannot be guaranteed to find all positive cases. Dental procedures carry the potential to spread viral particles.

I confirm that I am not presenting any of the following symptoms of COVID-19 listed below:

- Fever
- Shortness of Breath
- Dry Cough
- Runny Nose
- Sore Throat

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We are excited to offer an in-house membership plan for you!

## Tar Heel Periodontics and Implant Dentistry Membership Plan

### Perio 2

- 2 periodontal maintenance visits/year
- Oral cancer screening with cleaning
- 2 exams/year
- X-rays as determined necessary
- 1 emergency exam with X-ray/year
- Up to 15% off any needed treatment

**$55.00/mo** or **$589.00/yr**

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