



Welcome to our Practice! We look forward to providing you with the highest quality dental care.

PATIENT INFORMATION

NAME _____
ADDRESS _____
CITY _____ STATE _____ ZIP _____
SEX: M F AGE _____ BIRTH DATE _____ MARITAL STATUS: S M D W
HOME PHONE _____
NOTIFY IN CASE OF EMERGENCY _____
HOME PHONE _____
WHOM MAY WE THANK FOR REFERRING YOU? _____

INSURANCE INFORMATION

POLICY HOLDER _____
RELATION TO PATIENT _____
D.O.B. _____ SSN _____
ADDRESS (IF DIFFERENT THAN PATIENT) _____
CITY _____ STATE _____ ZIP _____
PHONE _____ WORK PHONE _____
EMPLOYER _____
INSURANCE CO. _____

AUTHORIZATION

I authorize my dentist to release necessary information to secure payment of benefits. I understand that after 30 days, I am financially responsible for all charges whether or not paid by insurance.

We realize emergencies can occur. Should an unforeseen situation prevent you from making a pre-arranged appointment, please contact our office to avoid the possibility of a misunderstanding (and a \$75.00 per half-hour cancellation fee).

SIGNATURE _____
(PATIENT/PARENT/GUARDIAN)



CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

NAME _____
ADDRESS _____
CITY _____ STATE _____ ZIP _____
HOME PHONE _____
EMAIL _____

SECTION B: TO THE PATIENT - PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities (including filing insurance), and health operations.

Notice of Privacy Practice: By signing this form, you acknowledge receiving a copy of the Notice of Privacy Practices that gives a description of our treatment, payment activities, and health operations, the uses and disclosures we may make of your protected health information, and the important matters about your protected health information.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

To obtain more information regarding our privacy practices you may contact: Charlotte Hurt at 919-556-6200. Address: 1711 South Main Street, Wake Forest, NC 27587

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the contact person listed above. Please understand that revocation of the Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

SIGNATURE SECTION:

I _____ have had full opportunity to read and consider the comments of this Consent form and your Notice of Privacy Practices of which I have received a copy. I understand that, by signing this form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health operations.

SIGNATURE: _____ DATE: _____

If this Consent is signed by a personal representative or a parent/guardian on behalf of the patient, complete the following:

Personal Representative's Name: _____
Relationship to the Patient: _____



We place a high emphasis on helping you determine your present and future dental needs. Here are some things we are going to be talking about at your first visit. These are issues you may have never thought of. Please check what best expresses how you feel about the following questions:

- Are you having any areas of concern? _____
- Tell us in your opinion what you think the present state of health of your mouth is: _____

- How healthy do you want us to get your mouth? (please circle)
 "Don't really care" Average The best it can be
- Tell us about your good dental experiences... _____

- and the bad ones... _____
- What caused you to leave your last dental office? _____
- What would you like to change about your smile? _____

- What would it take for you to trust us to be your dentist? _____

- Do you have any family or friends that already come to our office? _____
- What do you already know about our office and what are your expectations? _____

- Has fear ever been an issue for you in a dental office? _____
- Has time ever been a factor in getting your dental work done? _____
- Has the cost of dental treatment been a concern for you? _____
What can we do to help you with this? _____
- We have the unique ability to look at your mouth from 3 different perspectives. What combination of these would you like us to use for you? (please circle)
 As a **general** dentist As a **cosmetic** dentist As a **functional** dentist
- At what point do you want us to initiate treatment? (please circle)
 When my tooth hurts or breaks When something is worsening When something isn't ideal
- What quality of dentistry do you want us to recommend? (please circle)
 "Just patch it" Average Ideal/the best
- Is there any additional information you would like us to know? _____



Have you been under the care of a medical doctor during the past two years?

If so, for what? _____

Physician's Name Phone# _____

Are you taking any medication now, including regular dosages of aspirin?

If so, please list name and dosage _____

Are you aware of having an allergic reaction to any medication or substance?

If so, please list _____

Indicate which of the following you have had, or have at present. Circle "Yes" or "No" to each item.

Heart Concerns	Y	N	Diabetes	Y	N
Congenital Heart Disease	Y	N	Headaches	Y	N
Heart Murmur	Y	N	Jaw Pain	Y	N
High Blood Pressure	Y	N	Jaw Popping	Y	N
Mitral Valve Prolapse	Y	N	Limited Opening	Y	N
Artificial Heart Valve	Y	N	Congested Ears	Y	N
Pacemaker	Y	N	Dizziness	Y	N
Stroke	Y	N	Ringling Ears	Y	N
Asthma	Y	N	Loose Teeth	Y	N
Liver Disease/jaundice	Y	N	Posture Problems	Y	N
Latex Sensitivity	Y	N	Clenching	Y	N
Artificial Joints	Y	N	Grinding	Y	N
Kidney Trouble	Y	N	Facial Pain	Y	N
Radiation/Chemotherapy	Y	N	Sensitive Teeth	Y	N
Epilepsy/Seizures	Y	N	Neck Pain	Y	N
Hepatitis	Y	N	Bell's Palsey	Y	N
AIDS/HIV	Y	N	Difficulty Swallowing	Y	N
Sickle Cell Disease	Y	N	Trigeminal Neuralgia	Y	N
Neruological Disorders	Y	N	Tingling in Arms/fingers	Y	N
Psychiatric/Psychological	Y	N	Insomnia/frequent waking	Y	N
Have you had braces?	Y	N	Do you see a Chiropractor	Y	N
Does floss shred when you use it?	Y	N	Does food pack/catch between your teeth?	Y	N
Do you smoke or chew tobacco?	Y	N	Do your gums bleed?	Y	N
Have you ever taken "Fen/Phen"?	Y	N	Does your breath concern you?	Y	N

Do you take or have you ever taken Bisphosphonates (Fosamax, Actenol, Aredia, and Zometa, Etc.)? Y N

Do you have any disease, condition or problem not listed? _____

Women: Are you Pregnant? Y N Nursing? Y N Taking Birth Control Pills? Y N

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider who may release such information to you. I will notify the doctor of any change in my health or medication.

Signature _____ Date _____

Social Security Number _____ Date of Birth _____

Email Address _____