Smile Cabarrus

5000 Hwy 49 South
Harrisburg, NC 28075

PATIENT INFORMATION

Patient Name:_____ Prefers: _____ Date: _____
LAST FIRST MI

❍ MALE ❍ FEMALE ❍ Married ❍ Single ❍ Child ❍ Other: _____ Birth Date: _____

Social Security #: _____ How did you hear about our office?_____

Address:_____
STREET APARTMENT # CITY, STATE ZIP CODE

Home Phone:_____ Cell Phone: _____ Accept Text Messages? YES NO EMAIL:_____

SPOUSE OR RESPONSIBLE PARTY INFORMATION

Name:_____ ❍ MALE ❍ FEMALE

Relationship to Patient: _____

Social Security #: _____ Birth Date: _____

Home Phone: _____ Cell Phone:_____

Address: _____
STREET APARTMENT # CITY, STATE ZIP CODE

EMPLOYMENT INFORMATION

Employer's Name: _____ Occupation: _____

Address of Employer: _____
STREET CITY, STATE ZIP CODE

DENTAL INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE Name of Policyholder: _____

Is insured a patient? ❍ YES ❍ NO Insured's Birth Date: _____ID#: _____ Group #: _____

Insured's Employer Name and Address: _____

_____

Patient's relationship to insured: ❍ Self ❍ Spouse ❍ Child ❍ Other _____

Insurance Plan Name and Address: _____

_____

CONSENT FOR SERVICES AND PRIVACY POLICY

I, the undersigned, hereby authorize the doctor to take radiographs, study models, photographs or any other diagnostic aids deemed appropriate to make a thorough diagnosis of my dental needs. I also authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I authorize and consent that the doctor employs any such assistance as deemed appropriate.

I further authorize the release of any information, including the diagnosis, radiographs and records of any treatments or examinations rendered to my insurance company, consulting professionals or others who may request my records. I understand that I am personally responsible for payment of all fees for dental services provided in this office for me or my dependents, regardless of insurance coverage. I understand that payment is due when services are rendered. Any other arrangements for payment must be made before treatment begins.

By signing below, I am testifying that the above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of the staff responsible for any errors omissions that I may have made in the completion of this form.

DATE: _____ SIGNATURE: _____

ACKNOWLEDGE OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I HAVE READ THE NOTICE OF PRIVACY PRACTICES FOR THE ABOVE NAMED PRACTICE.

DATE: _____ SIGNATURE: _____

MEDICAL HISTORY INFORMATION

Physician's Name:_____ Phone#:_____

*Are you under a doctor's care now? ❍YES ❍NO If yes, please describe: _____

*Any illnesses/operations/hospitalizations in past 2 years? ❍YES ❍NO If yes, please describe: _____

*(Women) Are you pregnant? ❍YES ❍NO Due Date: _____ Nursing? ❍YES ❍NO Taking birth control? ❍YES ❍NO

*Do you take, or have you taken, Phen-Fen or Redux? ❍YES ❍NO _____

*Have you ever taken Fosamax, Boniva, Actonel or any other bisphosphonates? ❍ YES ❍ NO_____

*List any medications you are currently taking _____

*Please list any allergies to drugs, medications, anesthetics, or latex_____

IF YOU HAVE ANY OF THESE MEDICAL CONDITIONS, PLEASE CHECK THE APPROPRIATE BOX. IF MORE THAN ONE IS LISTED, PLEASE CIRCLE THE SELECTION THAT APPLIES TO YOU:

- □ Alzheimer's Disease
- □ Alcoholism/Drug Addiction
- □ Asthma
- □ Autism
- □ Neurological Problems
- □ Epilepsy/Seizures
- □ Diabetes
- □ Kidney Problems
- □ Dialysis
- □ Liver Problems
- □ Eye Disorder/Glaucoma
- □ Arthritis/Rheumatism
- □ Sleep Disorders: Snoring/ Sleep Apnea/Insomnia
- □ Hives or Skin Condition
- □ ADD/ADHD
- □ High Blood Pressure
- □ Low Blood Pressure
- □ High Cholesterol
- □ Stroke _____ year
- □ Thyroid Problems
- □ AIDS/HIV/ARC
- □ Tonsilitis
- □ Tobacco Use: cigars, cigarettes, smokeless
- □ Respiratory Problem
- □ Hay Fever
- □ Sinus Problems
- □ Persistent Cough
- □ Tuberculosis
- □ Bacterial Endocarditis
- □ Blood Disease
- □ Sickle Cell
- □ Anemia/Blood Problems
- □ Hemophilia
- □ Hepatitis A / B / C
- □ Blood Transfusion ____ year
- □ Sexually Transmitted Disease
- □ Psychiatric Problems/Care
- □ Cancers/Tumors/Leukemia
- □ Radiation Treatments
- □ Chemotherapy
- □ Cataracts
- □ Sudden Weight Gain/Loss
- □ Yellow Jaundice
- □ Heart Murmur/Mitral Valve Prolapse
- □ Heart Attack _____ year
- □ Angina/Chest Pain
- □ Rheumatic Heart Fever/Disease
- □ Heart Pacemaker _____ year
- □ Heart Surgery _____ year
- □ Artificial Heart Valves _____ year
- □ Congenital Heart Disorder
- □ Congestive Heart Failure
- □ GI Disorders: IBD/GERD/Celiac/ Ulcers/Colitis/Reflux/Bypass/Crohn's
- □ ANY Artificial: Knee, Hip, Joints, Pins, Plates _____ year
- □ Circulatory Problems
- □ Frequent Headaches or Migraines

DENTAL HISTORY INFORMATION

Date of Last Dental visit/x-rays:_____ Previous Dental Provider Name & phone number: _____

If you could change one thing about your smile, what would it be? _____

How often do you brush?_____ floss? _____Have your wisdom teeth been removed? ❍ YES ❍ NO

PLEASE CHECK IF YOU HAVE, OR EVER HAD ANY OF THE FOLLOWING:

- □ Clenching or Grinding Teeth
- □ Bleeding Gums
- □ Bad Breath/Bad Taste in Mouth
- □ Sensitive to Hot
- □ Clicking or popping Jaw/TMJ
- □ Loose teeth
- □ Periodontal Treatment
- □ Sensitive to Cold
- □ Muscle soreness in face
- □ History of dental decay
- □ Sores in Mouth
- □ Sensitive to Sweet
- □ Food collection between teeth
- □ Broken fillings and/or chipped teeth
- □ Mouth breathe while sleeping
- □ Sensitive to Pressure/Biting/Chewing

Have you lost any teeth or have any teeth been removed? ❍ YES ❍ NO If yes, are you interested in dental implants? ❍ YES ❍ NO

Have you ever experienced any head/face injury or trauma? ❍ YES ❍ NO If yes, please describe _____

Have you had any orthodontic work? ❍ YES ❍ NO If yes, please give Orthodontist and year of treatment _____

If we find something that needs to be done in your mouth, do you want ❍ Details OR ❍ Big Picture/Overview

Any other questions or concerns not addressed on this form?_____

_____ _____

Patient's (Guardian's) Signature Date