North Raleigh Dentistry

WE LOVE TO SEE YOU SMILE!

PATIENT INFORMATION

Date _____ Birthdate _____

Patient Name _____
Last First Middle

Address _____
Street City State Zip

Preferred Telephone Number _____ Check One ○ Home ○ Work ○ Mobile

Social Security # _____ Email Address _____

If patient is a minor, parent or guardian's name _____

How did you hear about our office? _____

RESPONSIBLE PARTY INFORMATION

Name _____
Last First Middle Marital Status

Mailing Address _____
Street City State Zip

Social Security # _____ Birthdate _____ Relationship to patient _____

Employer _____ Occupation _____

Employer Address _____

DENTAL INSURANCE INFORMATION

PRIMARY

Insured's Name _____ Insured's SS# or ID# _____

Insured's Birthdate _____ Insured's Employer _____

Insurance Co. _____ Group No. _____

Insurance Co. Address _____

Insurance Co. Phone # _____

Do you have dual coverage? Circle One Yes No If yes, please fill out secondary information below

SECONDARY

Insured's Name _____ Insured's SS# or ID# _____

Insured's Birthdate _____ Insured's Employer _____

Insurance Co. _____ Group No. _____

Insurance Co. Address _____

Insurance Co. Phone # _____

EMERGENCY CONTACT INFORMATION

Whom should we contact in case of emergency? _____

Complete Address (if not the same) _____

Phone Number _____

SMILE EVALUATION

When was your last visit to a dentist? Check One ○ 6 months ○ 1-2 years ○ 3-5 years ○ 5+ years

What is your main concern today? Check all that apply

○ Tooth Pain	○ Sensitivity	○ Broken/Cracked Teeth	○ Cavities/Decay	○ Cosmetic Dentistry
○ Cleaning	○ Missing Teeth	○ Implants	○ Gum Disease	○ Orthodontics
○ Dentures	○ Whitening	○ Sedation Dentistry	○ Gum Recession	

Other:

_____

If you are in pain or our doctors find a challenge that should be addressed immediately, are you interested in having treatment done today? Check One ○ Yes ○ No

Do you like the appearance of your smile and the look of your teeth? Check One ○ Yes ○ No

If no, what would you most like to change about your smile?

_____

_____

Check Yes or No Below

○ Yes	○ No	Are you aware of clenching/grinding your teeth?
○ Yes	○ No	If yes, do you wear a bite appliance?
○ Yes	○ No	Have you been diagnosed with sleep apnea?
○ Yes	○ No	Have you ever had periodontal gum treatment (deep cleaning or gum grafting)?
○ Yes	○ No	Have you ever had orthodontic treatment (braces)?
○ Yes	○ No	Have you had your wisdom teeth removed?
○ Yes	○ No	Do you have any pain or bleeding when you brush or floss?
○ Yes	○ No	Are you concerned about bad breath?
○ Yes	○ No	Have you ever had trouble getting numb or had reactions to local anesthetic?
○ Yes	○ No	Do we have your permission to administer dental x-rays in order to provide you with an accurate diagnosis?

How many times a day do you brush? _____ How many times a week do you floss? _____

Is there anything else you would like for us to know about you?

_____

_____

MEDICAL HEALTH HISTORY

PATIENT NAME _____ Date _____

A. CHECK YOUR ANSWERS (leave BLANK if you do not understand the question)

1. ○ Yes ○ No Are you in good health?
2. ○ Yes ○ No Has there been a change in your health within the last year? If yes, please explain

_____

3. ○ Yes ○ No Have you been hospitalized or had a serious illness in the last 5 years? If yes, please explain

_____

4. ○ Yes ○ No Are you being treated by a physician now? For what? _____

Name of your physician _____ Date of last Medical Exam _____

B. HAVE YOU EVER EXPERIENCED...

5. ○ Yes ○ No Chest Pains
6. ○ Yes ○ No Swollen Ankles
7. ○ Yes ○ No Shortness of breath
8. ○ Yes ○ No Recent weight loss, fever, night sweats
9. ○ Yes ○ No Persistent cough, coughing up blood
10. ○ Yes ○ No Bleeding problems, bruising easily
11. ○ Yes ○ No Sinus Problems
12. ○ Yes ○ No Difficulty swallowing
13. ○ Yes ○ No Joint pain, stiffness
14. ○ Yes ○ No Jaundice
15. ○ Yes ○ No Dizziness
16. ○ Yes ○ No Ringing in ears
17. ○ Yes ○ No Frequent Headaches
18. ○ Yes ○ No Fainting spells
19. ○ Yes ○ No Blurred Vision
20. ○ Yes ○ No Seizures
21. ○ Yes ○ No Excessive thirst
22. ○ Yes ○ No Frequent urination
23. ○ Yes ○ No Dry Mouth
24. ○ Yes ○ No Sleep apnea or chronic snoring

C. DO YOU HAVE OR HAVE YOU HAD...

25. ○ Yes ○ No Heart disease
26. ○ Yes ○ No Heart attack/heart defects
27. ○ Yes ○ No Heart murmur/challenges
28. ○ Yes ○ No Rheumatic fever
29. ○ Yes ○ No Stroke, hardening of arteries
30. ○ Yes ○ No High Blood Pressure
31. ○ Yes ○ No TB, emphysema or other lung diseases
32. ○ Yes ○ No Hepatitis ○ A ○ B ○ C
33. ○ Yes ○ No Stomach problems, ulcers
34. ○ Yes ○ No Diabetes
35. ○ Yes ○ No Mitral Valve Prolapse
36. ○ Yes ○ No HIV positive or AIDS-ARC
37. ○ Yes ○ No Tumors, Cancer
38. ○ Yes ○ No Arthritis, rheumatism
39. ○ Yes ○ No Eye disease
40. ○ Yes ○ No Skin disease
41. ○ Yes ○ No Anemia
42. ○ Yes ○ No VD (syphilis or gonorrhea)
43. ○ Yes ○ No Herpes
44. ○ Yes ○ No Kidney, bladder diseases
45. ○ Yes ○ No Thyroid, adrenal diseases
46. ○ Yes ○ No Diabetes/Cancer

D. DO YOU HAVE OR HAVE YOU HAD...

47. ○ Yes ○ No Surgeries
48. ○ Yes ○ No Blood Transfusions
49. ○ Yes ○ No Artificial Joint
50. ○ Yes ○ No Contact Lenses
51. ○ Yes ○ No Psychiatric Care
52. ○ Yes ○ No Radiation Treatments
53. ○ Yes ○ No Chemotherapy
54. ○ Yes ○ No Prosthetic heart valve
55. ○ Yes ○ No Pacemaker
56. ○ Yes ○ No Birth Control Pills
57. ○ Yes ○ No Pregnant or nursing

E. DO YOU TAKE OR HAVE TAKEN...

58. ◯ Yes ◯ No Recreational drugs
59. ◯ Yes ◯ No Alcohol
60. ◯ Yes ◯ No Tobacco in any forms
61. ◯ Yes ◯ No Bisphosphonates (i.e. Fosamax or other osteoporosis medication like Prolia)

62A. PLEASE LIST ALL ALLERGIES BELOW (i.e. drugs/medications, food, latex, metals, jewelry, acrylics, etc.)

_____

62B. PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING

_____

_____

DENTAL HEALTH HISTORY

63. ◯ Yes ◯ No Do you have or have you had any other diseases or medical problems NOT listed on this form?
If yes, please explain

_____

64. ◯ Yes ◯ No Have you ever been told by a physician or dentist that you need to pre-medicated prior to any dental treatment? If yes, please explain

_____

65. ◯ Yes ◯ No Does having dental treatment make you afraid or nervous?

F. HAVE YOU EVER EXPERIENCED....

66. ◯ Yes ◯ No Bleeding Gums
67. ◯ Yes ◯ No Bad Breath or sour taste in mouth
68. ◯ Yes ◯ No Burning sensations in mouth
69. ◯ Yes ◯ No Soreness in jaw
70. ◯ Yes ◯ No Challenge to open wide
71. ◯ Yes ◯ No Clicking/popping in jaw
72. ◯ Yes ◯ No Wearing braces
73. ◯ Yes ◯ No Sensitivity to Hot & Cold
74. ◯ Yes ◯ No Snoring
75. ◯ Yes ◯ No Food getting stuck in teeth
76. ◯ Yes ◯ No Clenching/Grinding of teeth
77. ◯ Yes ◯ No Pain/Soreness on face, ears
78. ◯ Yes ◯ No Stiff Neck Muscles
79. ◯ Yes ◯ No Oral Surgery

80. At North Raleigh Dentistry , our top priority has always been the safety and comfort of our patients while offering gentle, compassionate care. When considering your dental health decisions, which of the following are most important... Check all that apply

○ Convenience	○ Appearance	○ Relationship with Dental Team
○ Finances	○ Time	○ Quality of care
○ Insurance Coverage	○ Health	○ Detailed treatment explanations
○ Fear or Anxiety	○ Comfort	○ Technology

Other _____

_____

_____

Patient Signature _____ Date _____

TO OUR PATIENTS

What is HIPAA? The Health Insurance Portability and Accountability Act

Why? 1. HIPAA protects you and the privacy of your health information.

- This permits us to file your electronic insurance claims which protects the privacy of your information and allows for faster reimbursement.
- This is required by law.

Attached:

- Notice of Privacy Practices - at your leisure please read the complete explanation of HIPAA
- Acknowledgement of Receipt of Notice of Privacy Practices – please complete & give to a staff member

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Your signature states that you have received this 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
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

_____

_____

PATIENT FINANCIAL POLICY

Your dental health is important to us and we want to ensure that you receive the gentle, compassionate care necessary. We realize that every person's financial situation is different. For this reason, we offer the following payment options from which you may choose.

Cash or Check
MasterCard, Visa, Discover or American Express
Payment Plan agreement between patient and North Raleigh Dentistry

INSURANCE FILING

We may accept assignment of your insurance benefits; however, we require that your estimated portion and deductible be paid at the time of service. Since your insurance policy is an agreement between you and your insurance company, please realize that it is your responsibility to follow up on claims and payments. We will send a statement to you each month your account has an outstanding balance. Payment in full is appreciated on all statements.

Our staff will file your claims with your insurance provider on your behalf. If we are contracted with your insurance company, we will accept the negotiated rate.

I have read, understand and agree to the payment terms of this financial policy. I agree to allow North Raleigh Dentistry to file my insurance on my behalf and be paid directly by aforementioned insurance company.

_____ _____

Date Patient or Responsible Party Signature

NOTE A 1.5% finance charge per month will be assessed on all balances over 60 days old. All accounts over 120 days past due will be forwarded to our collection service. All fees and costs associated with the collections process (including all legal fees) will be the responsibility of the patient.

PAYMENT IS EXPECTED AT TIME OF SERVICE

Please give us a minimum of 48 hours' notice to cancel your appointment. Failure to do so may result in a $50 cancellation fee.

REQUEST RELEASE OF DENTAL RECORDS

Date _____ Birthdate _____

Patient Name _____

Last First Middle

I hereby request release of my dental records from the office of

_____

_____

_____

Phone _____ BWX _____ Panoramic _____ FMX _____

***Please include date all x-rays were taken and attach via email in JPEG format. To avoid repeat requests, please contact us immediately if the patient does not have current records at your office.**

PLEASE SEND TO

North Raleigh Dentistry

1111 Prince George Ln
Raleigh ,NC 27615

info@nraleighdentistry.com

_____

PATIENT AUTHORIZATION