Welcome to Dentistry of the Carolinas! Please tell us about yourself.

DOC
DENTISTRY OF THE CAROLINAS

Patient's Last Name: _____ First Name: _____ MI: ____ Title: _____

Preferred Name: _____ Birth Date: _____ Gender: _____

Billing Address: _____ Apt/Unit#: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

SSN: _____ - _____ - _____ Email: _____

Employer: _____ Occupation: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Domestic Partnership

How did you hear about our office? _____

How do you prefer to be contacted for appointment confirmation? ☐ Email ☐ Phone

Have you been seen at any of our other locations at any time? ☐ Yes ☐ No If yes, where? _____

How can we help you today? _____

Are you experiencing dental pain? ☐ Yes ☐ No If yes, where? _____

Person Responsible for Account (if other than yourself/patient)

Name: _____ Relationship to Patient: _____

Birth Date: _____ SSN: _____ - _____ - _____ Currently a patient in our office? ☐ Yes ☐ No

Billing Address: _____ City _____ State _____ ZIP _____

Home/Cell Phone: _____ Work Phone: _____

Insurance Information

Subscriber Name: _____ Relationship to Patient: _____

Subscriber Birth Date: _____ Subscriber SSN/ID Number: _____

Subscriber Employer: _____

Insurance Company Name: _____ Insurance Company Phone: _____

Insurance Authorization

I authorize my insurance company to pay directly to Dentistry of the Carolinas and their associate dentists my insurance benefits that would otherwise be payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or for my dependents. I have received, read, understand and accept DOC's Explanation of Dental Insurance Benefits. In addition, by signing below I agree to receive calls from DOC staff at work, home, or by mobile phone to discuss matters related to my dental treatment, insurance and financial arrangements.

Patient/Legal Guardian Signature: _____

Authorization for Treatment

I consent to the procedure decided upon to be necessary or advisable in the opinion of the dentist.

Patient/Legal Guardian Signature: _____ Date: _____

HEALTH HISTORY FORM

DENTISTRY OF THE CAROLINAS

Office use only: ☐ Medical Alert ☐ Premedication ☐ Latex Allergy ☐ Drug Allergy ☐ Pregnant Date: _____

Patient's Last Name: _____ First Name: _____ Middle Name: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Address: _____ Apt/Unit #: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Height: _____ Weight: _____ Sex: ☐ Male ☐ Female

Social Security #: _____ Occupation: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

If you are completing this form for another person, what is your relationship to that person? _____

For the following questions, please (X) whichever applies. Your answers are for our records only and will be kept confidential in accordance with applicable laws. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

DENTAL INFORMATION

Date of your last dental exam: _____

Date of last dental x-rays: _____

What was done at that time? _____

How would you describe your current dental problem?

How do you feel about the appearance of your teeth?

	Yes	No	Unsure
Do your gums bleed when you brush your teeth?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets, or pressure?	☐	☐	☐
Do you have earaches or neck pain?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Do you wear removable dental appliances?	☐	☐	☐
Have you had a serious/difficult problem associated with any previous dental treatment? *If yes, please explain:* _____	☐	☐	☐

MEDICAL INFORMATION

Have you had any of the following diseases or problems?	Yes	No	Unsure
Active tuberculosis	☐	☐	☐
Persistent cough greater than a 3 week duration	☐	☐	☐
Cough that produces blood	☐	☐	☐

If you answered yes to any of the three (3) items above, please stop and return this form to the receptionist.

Are you in good overall health?	☐	☐	☐
Has there been any change in general health within the past year?	☐	☐	☐
Are you now under the care of a physician? *If yes, what is/are the condition(s) being treated?* _____	☐	☐	☐

Date of last physical examination: _____

Physician: _____

Phone #: _____

Address: _____

Have you had any serious illness, operation, or been hospitalized in the past 5 years? *If yes, what was the illness or problem?* _____	☐	☐	☐
Do you wear contact lenses?	☐	☐	☐
Are you hearing impaired?	☐	☐	☐

Are you taking or have you recently taken...	Yes	No	Unsure
Any medicine(s) including non-prescription medicine? *If yes, what medicines are you taking?* _____	☐	☐	☐
Anti-coagulants (blood thinners)? *If yes, which one(s)?* _____	☐	☐	☐
Intravenous Bisphosphanates (for osteoporosis)?	☐	☐	☐
Vitamins, natural, or herbal preparations and/or diet supplements? *If yes, which one(s)?* _____	☐	☐	☐
Any diet drugs such as: Pondimin (fenfluramine), redux (dexphenfluramine) or phen-fen (fenfluramine-phentermine combination)?	☐	☐	☐
Do you drink alcoholic beverages? *If yes, how much in the last 24 hours?* _____ *In the past week?* _____	☐	☐	☐
Are you alcohol and/or drug dependent?	☐	☐	☐
If yes, have you received treatment?	☐	☐	☐
Do you use drugs for recreational purposes? *If yes, please list:* _____ *Frequency of use (daily, weekly, etc.):* _____ *Number of years of recreational drug use:* _____	☐	☐	☐
Do you use tobacco (smoking, chew, snuff)?	☐	☐	☐
If yes, are you interested in stopping?	☐	☐	☐

(continued on following page)

MEDICAL INFORMATION (continued)

Are you allergic to/have had a reaction to any of these?	Yes	No	Unsure
Local Anesthetics	☐	☐	☐
Aspirin	☐	☐	☐
Penicillin or other Antibiotics	☐	☐	☐
Barbiturates, Sedatives, or Sleeping Pills	☐	☐	☐
Sulfa Drugs	☐	☐	☐
Codeine or other Narcotics	☐	☐	☐
Latex	☐	☐	☐
Iodine	☐	☐	☐
Animals	☐	☐	☐
Food (*specify:* _____)	☐	☐	☐
Metals (*specify:* _____)	☐	☐	☐
Other (*specify:* _____)	☐	☐	☐

To yes responses, specify type of reaction:

_____

	Yes	No	Unsure
Have you had an orthopedic total joint (hip, knee, elbow, or finger) replacement? *If yes, when was the operation done?* _____	☐	☐	☐
If you answered yes to the above question, have you had any complications/difficulties with your prosthetic joint?	☐	☐	☐
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? *Name of physician or dentist:* _____ *Phone #:* _____	☐	☐	☐

WOMEN ONLY: ***Are you...***

Pregnant? *If yes, # of weeks:* _____	☐	☐	☐
Nursing?	☐	☐	☐
Taking birth control pills or hormonal replacement?	☐	☐	☐

ADDITIONAL INFORMATION

Have you had any of the following diseases or problems?	Yes	No	Unsure
Abnormal/Prolonged Bleeding (*Platelet Count:* _____)	☐	☐	☐
AIDS or HIV infection (*CD4 Count:* _____)	☐	☐	☐
Anemia	☐	☐	☐
Arthritis	☐	☐	☐
Rheumatoid Arthritis	☐	☐	☐
Asthma	☐	☐	☐
Blood Transfusion. *If yes, date:* _____	☐	☐	☐
Cancer/Chemotherapy/Radiation Treatment	☐	☐	☐
Cardiovascular Disease. *If yes, specify below:*	☐	☐	☐

☐ Angina
☐ Arteriosclerosis
☐ Artificial Heart Valves
☐ Congenital Heart Defects
☐ Congestive Heart Failure
☐ Coronary Artery Disease
☐ Damaged Heart Valves
☐ Heart Attack
☐ Heart Murmur
☐ High Blood Pressure
☐ Low Blood Pressure
☐ Mitral Valve Prolapse
☐ Pacemaker
☐ Rheumatic Heart Disease
☐ Rheumatic Fever

Chest Pain/Angina	☐	☐	☐
Chronic Pain	☐	☐	☐
Disease, Drug, or Radiation-Induced Immunosupression	☐	☐	☐
Diabetes. *If yes, specify below:* ☐ Type I (insulin dependent) ☐ Type II	☐	☐	☐
Dry Mouth	☐	☐	☐
Eating Disorders. *If yes, specify:* _____	☐	☐	☐
Emphysema	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting Spells or Seizures	☐	☐	☐
Gastrointestinal Disease	☐	☐	☐
G.E. Reflux/Persistent Heartburn	☐	☐	☐
Gastrointestinal Disease	☐	☐	☐

Have you had any of the following diseases or problems?	Yes	No	Unsure
Glaucoma	☐	☐	☐
Hemophilia	☐	☐	☐
Hepatitis, Jaundice or Liver Disease	☐	☐	☐
Recurrent Infections. *If yes, indicate type of infection:* _____	☐	☐	☐
Kidney/Bladder problems	☐	☐	☐
Mental health disorder (psychiatric care)	☐	☐	☐
Malnutrition	☐	☐	☐
Night Sweats	☐	☐	☐
Neurological Disorders	☐	☐	☐
Osteoporosis	☐	☐	☐
Persistent Swollen Glands in Neck	☐	☐	☐
Respiratory Problems. *If yes, specify below:* ☐ Emphysema ☐ Bronchitis	☐	☐	☐
Severe Headaches/Migranes	☐	☐	☐
Severe or Rapid Weight Loss	☐	☐	☐
Sexually Transmitted Disease	☐	☐	☐
Sinus Trouble	☐	☐	☐
Sleep Disorder	☐	☐	☐
Sores or Ulcers in the Mouth	☐	☐	☐
Stroke	☐	☐	☐
Systemic Lupus Erythematosus	☐	☐	☐
Tuberculosis	☐	☐	☐
Thyroid problems. *If yes, specify below:* ☐ Hypo ☐ Hyper	☐	☐	☐
Ulcers	☐	☐	☐
Excessive Urination	☐	☐	☐
Do you have any disease, condition, or problem not listed above that you think we should know about? *If yes, please explain:* _____	☐	☐	☐

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to any dental treatment.

I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquires set forth above have been answered to my satisfaction. I will not hold DOC, my dentist, or any other member of DOC staff, responsible for any action they take or do not take because of errors or omissions that I have made in the completion of this medical history form.

Patient/Legal Guardian Signature: _____ Date: _____

FOR COMPLETION BY DENTIST OR HYGIENIST

Comments concerning health history: _____
Significant findings: _____
Dental management considerations: _____

On a regular basis, the patient should be questioned about any medical changes. Dates and changes should be noted along with signatures.

Date: _____ Changes: _____ Signatures: _____

DENTISTRY OF THE CAROLINAS
WWW.DENTISTRYOFTHECAROLINAS.COM

Notice of Privacy Practices

We understand that your medical and dental information is personal and we are committed to protecting it. We create a record of the care and services you receive at our office. We need this record to provide you with quality dental care and to comply with certain legal requirements. This notice will tell you about the way we may use and share your Protected Health Information (PHI).

We Have a Legal Duty to:

1. Keep your personal health information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the current notice.

We Have the Right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices:

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following describes different ways that we use and disclose your medical information. Not every use or disclosure will be listed. However, we have listed all the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us

1. **For treatment:** We may use your PHI to provide you with dental treatment or services. We may disclose medical information about you to healthcare providers who may be involved in your treatment both directly and indirectly.

2. **For Payment:** We may use and disclose your PHI for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your medical information.

3. **For Health Care Operations:** We may use and disclose your PHI for our health care operations including quality assessments, evaluating the performance of employees and conducting training.

I understand that I may request in writing that you restrict how my private health information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name (Print): _____

Relationship to Patient: _____

Patient/Legal Guardian Signature: _____

Date: _____

DENTISTRY OF THE CAROLINAS
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Practice Policies

- We require 24hr prior notice if you are unable to keep your scheduled appointment. We reserve the right to charge you a cancellation fee and/or dismiss you from the practice if you fail to comply with this policy.

- When we call to confirm our appointments, we ask our patients to confirm their appointment (by return phone call, e-mail, or text message) within 24hrs after receiving your confirmation notification. Failure to comply with this policy will mean you will be scheduled as an unconfirmed "stand-by" patient and you may or may not be seen if you show for your appointment.

- Medicaid recipients are responsible for a $3.00 co-payment for each visit to the dentist. The following are exempt from the $3.00 copay:
  1. Services for individuals under the age of 21.
  2. Services provided to Medicaid for pregnant women.
  3. Services delivered in a hospital emergency department.
  4. Services provided to residents of nursing facilities, intermediate facilities for mental retardation.
  5. Services provided to participants in a Community Alternatives Program.
  6. Services covered by both Medicare and Medicaid.

- There is a $30.00 fee for transfer or release of patient's records; including x-rays.

- Children may not be left alone in the waiting room and may not accompany you to the treatment rooms/area. Please arrange for child care prior to your appointment or we reserve the right to reschedule your appointment.

- Only patients are allowed in the treatment area/rooms. If the patient is a minor, the parent or legal guardian will be allowed to accompany the patient to the treatment room, where the treating doctor will explain the diagnosis, planned treatment, and risks and benefits of the treatment. When it comes time to deliver the treatment to the patient, it will be at the discretion of the treating dentist whether they will allow the parent or legal guardian to remain in the treatment room for the remainder of the appointment.

- Parent, legal guardian or nursing home staff must remain at the office during treatment if the patient is younger than 18 or is a resident or in the care of a group home, assisted living facility, nursing home, or any other type of guardian care.

- Cell phone use is not permitted in the waiting area or operatories. Please step outside to use your cell phone.

- Food and beverage is not permitted in the waiting area or operatories.

- Smoking is not permitted inside or within fifty (50) feet of the patient entrance.

- Weapons of any type (guns, knives, batons, etc.), concealed or unconcealed are not permitted inside.

- Please be considerate of others when talking. Patients who talk loudly or use inappropriate language may be asked to leave.

I understand and agree to conform to the above practice policies.

Print Name: _____ Date: _____

Patient/Legal Guardian Signature: _____

DENTISTRY OF THE CAROLINAS
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Insurance and Financial Policy

At **Dentistry of the Carolinas**, we believe that you deserve the very best care. That's why we always present you with the best dental solution possible to treat your personal situation. Each year we provide outstanding dental care to thousands of patients. While some have dental benefits, others do not. If you have dental benefits, congratulations! You are very fortunate. Here are some important things you should know:

Please Initial On The Line Before Each Statement

_____ ■ Your dental benefits are based upon a contract made between your employer and an insurance company. **If you have any questions regarding your dental benefits please contact your employer or insurance company directly. Dental benefit plans will never pay for completion of your dental care. It is only meant to assist you.**

_____ ■ We work with many different insurance companies. We must see your insurance card at each visit. Although we can maintain computerized histories of payment by a given company, they do change; therefore it is impossible to give you a guaranteed quote at the time of service. We estimate your portion based on the most up-to-date information we have, but it is **ONLY AN ESTIMATE**. If you would like to know your insurance benefit, we will be happy to file a "pre-treatment authorization" with your insurance company prior to treatment. Please keep in mind this is not a guarantee of coverage. This does delay treatment but will give you a more accurate out of pocket figure you may require.

_____ ■ We will bill your insurance as a courtesy. If insurance does not pay within 60 days, the treatment exceeds your yearly maximum benefit, your insurance company denies treatment, your insurance benefits are less than what was indicated on your pre-estimate, or if you fail to complete treatment which results in non-payment from your insurance company, **Dentistry of the Carolinas** reserves the right to request payment in full for services from you and let you collect the insurance funds that are due to you. This is rare, but it is important that you recognize that the insurance you have is a legal contract between you and your insurance company. Our office is not, and cannot be a part of that legal contract. Ultimately, you are responsible for all charges incurred in our office.

_____ ■ **Dentistry of the Carolinas** does require payment in full for your portion at the time of service. We accept MasterCard, Visa, money orders, and cash. **We do not accept checks for any patient**. If you receive a check from your insurance company for your dental services, it is your responsibility to forward this payment to the office. If you are in need of an extended finance option, some of our locations work with "CareCredit", who offers 3, 6, 12 or 18 month "same as cash" or longer terms with an interest bearing revolving charge designed to meet your treatment plan needs on approved credit.

_____ ■ A specific amount of time is reserved especially for you and we strongly encourage all patients to keep their appointments. If you must change your appointment, we require at **least 24 hour** notice to avoid a **$55/hour cancellation fee** (emergencies are an exception).

_____ ■ In the event of an emergency after regular business hours a **$100 emergency fee** will be charged for established patients in addition to the necessary treatment fees. Patients who are not established in the practice will be charged a **$250 after hours emergency fee** in addition to the necessary treatment fees.

I agree with the above conditions.

Print Name: _____ Date: _____

Patient/Legal Guardian Signature: _____

DENTISTRY OF THE CAROLINAS
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No-Show and Broken Appointment Policy

At Dentistry of the Carolinas, our number one priority is our patients and our commitment to provide ideal dental healthcare. Providing services in a timely manner is critical to accomplish this goal. Additionally, we work to keep this timely service as affordable as possible. When we make your appointment, we are reserving a room for you and your particular treatment needs. When you fail to keep your appointment without providing us adequate notice, you are adding to the overall cost of healthcare as trained professionals and dental facilities are not being utilized. These broken appointments also result in lost time that could have been used to treat other patients. We ask that if you must change an appointment, please give us at least 24 hours notice. This courtesy makes it possible to give your reserved room to another patient who would like it.

Due to an increase in the number of broken appointments at our offices, it is necessary to implement a Broken Appointment Policy effective October 13, 2014.

To continue being treated as a patient of DOC, you must adhere to the following:

1. Confirm your appointment. Failure to respond to our confirmation call by text message, phone call, or e-mail within 24 hours of your scheduled appointment may forfeit your appointment. Forfeited appointments are considered Broken Appointments. Please also remember, that it is **your responsibility to make sure we have your current phone number on file.**
2. Arrive on-time. We reserve the right to reschedule your appointment if you arrive late. If we reschedule your appointment due to your tardiness it will be considered a Broken Appointment.
3. Cancel 24-hours in advance of appointment. When sufficient notice is not given to cancel your appointment, it does not give us enough time to contact another patient on our waiting list who would benefit from coming in earlier. Canceling the "day of" your scheduled appointment will be considered a Broken Appointment.
4. "No-shows" and Broken Appointments**.** After three broken appointments, patients will no longer be permitted to schedule dental appointments in advance. Instead a patient will be required to call "day of" desired day of treatment to determine availability. Patient will be treated only if schedule permits.
5. Dismissal from DOC. If a patient is only permitted to be seen on a 'same-day' appointment basis, and forfeits the appointment by breaking the appointment or tardiness, patient will be dismissed from the practice and will need to seek treatment at another dental office.

I have read and understand the above policies and will adhere to them to remain a patient of Dentistry of the Carolinas.

_____ _____

Patient/Parent/Guardian (printed name) Date Patient/Parent/Guardian (signature) Date