Charlotte
Dental Implant Center

How did you hear about us?

Patient Name:_____

Today's Date:_____

I have been a patient here, before today: (circle one) Yes No

Please check all that apply.

- ☐ Recommended by a friend, family member, or colleague (name):

  _____

- ☐ Social Media (e.g. Facebook, Instagram, Twitter)
- ☐ Our website
- ☐ Search engine (e.g. Google, Bing) - If so, which keywords were used to search?

  _____

- ☐ Advertisement (e.g. Radio, Newspaper):_____
- ☐ Reviews Site (e.g. Google Reviews, Yelp):_____
- ☐ Other (e.g. Insurance):_____

Office Use Only

TP		
TC		

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PERSONAL INFORMATION - Please complete all fields that are highlighted in yellow

CIRCLE	First Name	Last Name	Best Contact Number
MR. MRS. MS. DR.			
	Date of Birth (mm/dd/yyyy)	**Social Security #**	Email
Address		**City, State, Zip**	
Emergency contact name		Relation	Emergency Contact's Phone Number
Previous dentist		Last dental visit	Previous Dentist's Phone Number
Dental insurance provider			Did you have x-rays taken? YES ☐ NO ☐
Employer		Subscriber name	
Subscriber date of birth	ID number	Group number	Customer service number

HIPAA POLICY

*** If you have filled out this form digitally, you will receive a copy of this office's Notice of Privacy Practices upon arrival. You may also refuse to sign this acknowledgment .***

I acknowledge that I have received and read a copy of this office's Notice of Privacy Practices.

Printed name: _____ Signature: _____ Date: _____

Office use only: ☐ Individual refused to sign ☐ Communications barriers prohibiting acknowledgment

☐ Emergency situation ☐ Other:_____

Parents / Legal Guardians, please give your NAME AND DATE OF BIRTH below:

_____ _____

CONSENT TO DISCUSS TREATMENT

In the event of a spouse, parent, or child who calls our office or is present with you at your appointment; we are not able to give out any information regarding your treatment, when your next appointment is scheduled, etc. Unless you list them as someone we are allowed to discuss this with below.

☐ I do not wish to have my dental appointments or treatment discussed with anyone.

☐ I hereby give consent to this dental practice to have my dental treatment or appointments discussed in front of or over the phone with _____.

Patient Signature: _____ Date: _____

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DENTAL HISTORY

		YES	NO
1.	Do your gums bleed when you brush or floss?	☐	☐
2.	Are your teeth sensitive?	☐	☐
	If yes, explain_____		
3.	Does food or floss catch between your teeth?	☐	☐
4.	Is your mouth dry?	☐	☐
5.	Have you had any gum treatments?	☐	☐
6.	Have you had braces?	☐	☐
7.	Have you ever had any issues with dental treatment?	☐	☐
8.	Are you currently experiencing any pain?	☐	☐
9.	Do you have ear or neck pain?	☐	☐
10.	Do you have clicking or popping in your jaw?	☐	☐
11.	Have you ever had a serious head or mouth injury?	☐	☐
	If yes, explain_____		
12.	Do you have any loose teeth?	☐	☐
13.	Do you have dentures or partial dentures?	☐	☐

MEDICAL HISTORY

Primary physician's name:_____ Phone #:_____

Are you currently under the care of a physician? YES ☐ NO ☐ If yes, for what _____

Date of your last physical exam:_____

It is recommended by the ADA to have antibiotics prior to any dental treatment, including cleanings, if you have any history of Congenital Heart Disease (CHD), artificial/prosthetic valves or any previous infective endocarditis.

As office policy, if you have had any full joint replacement surgery within the last year of your appointment date, we require a clearance letter from your surgeon, as antibiotics may be recommended before treatment.

Do you use controlled substances (drugs)? YES ☐ NO ☐

Do you use any form of tobacco? Vaping Products? YES ☐ NO ☐ If yes, what type? _____, frequency? _____

Do you drink alcohol? YES ☐ NO ☐ If yes, how often? _____

Do you take or have you ever taken Phen-Fen or Redux? YES ☐ NO ☐ If yes_____

Have you ever taken Fosamax, Boniva, Acetonel or any other medications containing Biphosphonates? YES ☐ NO ☐ If yes_____

Are you on a special diet? YES ☐ NO ☐ If yes_____

Has a doctor or dentist ever recommended you to take antibiotics before dental appointments? YES ☐ NO ☐

If yes, for what condition? _____ For how long? _____

Women Only: Pregnant? YES ☐ NO ☐ Number of weeks: _____ Taking birth control pills or hormone replacement? YES ☐ NO ☐

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MEDICAL HISTORY

		YES	or	NO
1.	Do you have unhealed oral injuries, growths, or spots in your mouth?	☐		☐
2.	Have you been hospitalized within the past 5 years?	☐		☐
3.	Is there any condition concerning your health that the doctor should be told?	☐		☐
4.	Do you wish to speak with the doctor privately about anything?	☐		☐
5.	Have you had or have any of the following conditions?	☐		☐

☐ Abnormal / Excessive Bleeding	☐ Congestive Heart Failure	☐ Heart Surgery	☐ Psychiatric Treatment / Care
☐ AIDS or HIV infection	☐ Contagious Disease	☐ Heart Trouble / Disease	☐ Recent Weight Loss
☐ Alzheimer's Disease	☐ Convulsions	☐ Hemophilia	☐ Recurrent Infections
☐ Anaphylaxis	☐ Cortisone Medicine	☐ Hepatitis A	☐ Renal Dialysis
☐ Anemia	☐ Damaged Heart Valves	☐ Hepatitis B or C	☐ Rheumatic Fever
☐ Angina	☐ Delay in healing	☐ Herpes / Cold Sores / Fever Blisters	☐ Rheumatism
☐ Arthritis / Gout / Joint Disease	☐ Diabetes	☐ High Blood Pressure	☐ Scarlet Fever
☐ Artificial Heart Valve	☐ Dialysis	☐ High Cholesterol	☐ Shingles
☐ Artificial Joints	☐ Drug Addiction	☐ Hives or Rash	☐ Sickle Cell Disease / Traits
☐ Asthma	☐ Eating Disorder	☐ Hypoglycemia	☐ Sinus Problems
☐ Autoimmune Disease	☐ Emphysema	☐ Immune System Problems	☐ Spina Bifida
☐ Blood Disease	☐ Epilepsy	☐ Irregular Heartbeat	☐ Stomach Disease
☐ Blood Transfusion	☐ Excessive Thirst	☐ Joint Replacements	☐ Swelling of Limbs
☐ Breathing Problems / Difficulty	☐ Fainting Spells / Seizures	☐ Kidney Disease / Problems	☐ Thyroid Problems / Disease
☐ Bronchitis, Chronic Cough	☐ Frequent Diarrhea	☐ Leukemia	☐ TMJ, Jaw Pain
☐ Bruise Easily	☐ Frequent Headaches	☐ Liver Disease	☐ Tonsillitis
☐ Cancer	☐ Gallbladder Trouble	☐ Low Blood Pressure	☐ Tuberculosis (TB)
☐ Cardiovascular Disease	☐ Genital Herpes	☐ Low Blood Sugar	☐ Tumors or Growths
☐ Chemo / Radiation Therapy	☐ GERD / Heartburn	☐ Lung Disease	☐ Ulcers
☐ Chest Pains	☐ Glaucoma	☐ Mitral Valve Prolapse	☐ Venereal Disease
☐ Chronic Fatigue	☐ Hay Fever	☐ Mononucleosis	
☐ Cold Sores / Fever Blisters	☐ Heart Attack / Stroke / Failure	☐ Osteoporosis	
☐ Congenital Heart Disorder	☐ Heart Murmur	☐ Pacemaker	

Do you have any disease, condition or problem that was not listed above? YES ☐ NO ☐ If yes_____

What medications are you currently taking? _____

ALLERGIES - Are you allergic to or have you had any type of reaction to:

		YES	or	NO	SPECIFIC TYPE OF REACTION:
1.	Local Anesthetics	☐		☐	_____
2.	Aspirin	☐		☐	_____
3.	Penicillin or other antibiotics	☐		☐	_____
4.	Barbiturates, sedatives or sleeping pills	☐		☐	_____
5.	Sulfa drugs	☐		☐	_____
6.	Codeine or other narcotics	☐		☐	_____
7.	Latex	☐		☐	_____

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Authorization, Release, and Agreement to Pay for Services Rendered

I understand that with dental insurance, the copay of total fee is expected at the time services are rendered. I also understand that for my convenience the dentist accepts cash, check or credit card and I hereby agree to pay the copay today for the services rendered to me. Without dental insurance, fees are due when service is rendered; afterwards it is the patient's responsibility to return if treatment is not completed on the first visit.

If I have dental insurance, the consultation fee for my visit will not be payable today, but will be filed on my insurance claim. I authorize the dentist to **release any information** including the diagnosis and records of any treatment rendered me during the period of dental care to third party payers and/or referring practitioners. I **authorize** and hereby request my insurance company to pay directly to the dentist any benefits otherwise payable to me. I would like your office to file all insurance claims to the best of their ability as a courtesy to me. I am aware an "estimated" portion is due at the time of service and I understand that I, the patient and/or subscriber, am responsible for all amounts not covered by my insurance carrier (see disclaimer below) and that any balance due on the account after 45 days must be paid in full, regardless of insurance still being processed. I will be responsible for contacting my insurance company for further explanation.

Insurance Disclaimer

It is our pleasure to estimate your insurance coverage and file claims on your behalf to all dental insurance companies. Since we are not a Medicare provider, a receipt with all the necessary information can be provided in order for you to file your own claim to medicare. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for **full payment** of all services rendered on my behalf or on behalf of my dependents regardless of what my insurance company may/may not cover. Note: We are in-network with Aetna, Ameritas, Assurant, BCBSNC, Cigna, Delta Dental, Dentemax, Guardian, Humana, MetLife, United Health Care.

We do our best to research online and call directly to a representative to give us accurate information. Please keep in mind that our estimates are only as accurate as the information provided to us by your insurance representatives. Because of human error, there is always an insurance disclaimer stating payment is not a guarantee and final payment will be determined upon receipt of the claim for actual services rendered. We are not responsible for any unforeseen balances incurred due to incorrect information or policy changes. Based on the occasional inaccurate information supplied to us by insurance companies, **we encourage everyone to get involved and verify their own insurance coverage prior to treatment.**

Despite such expansive research there are times insurance companies may change coverage based on individual situations. In this case they may deny the coverage that had originally been approved. This decision comes from the insurance company directly. There could also be procedures performed that are subject to being downgraded by your insurance company. In such circumstances, the insurance portion of the fee becomes my responsibility.

Our office understands that sometimes unexpected circumstances may prohibit you from keeping your scheduled appointment. However, we ask that you notify us at least 24 hours prior to your scheduled appointment time. Any no-show or cancelled appointments without a 24 hour notice will be charged a $50 fee for hygiene appointments and $100 for treatment appointments. Any outstanding balances not paid at the time services are rendered, will be turned over to a collection agency by this dental office after 90 days. I will be responsible to pay any administrative fees, attorney fees, court fees, or any cost of collection.

NOTE: Root canal therapy does not guarantee restoration of the tooth. Rarely, after root canal treatment, the tooth may still fracture or become infected, requiring further treatment. Treatment of a crowned, infected tooth will be performed at no cost to the patient within six months from the date of original treatment. After six months, the patient will be responsible for the re-treatment fee. **NO REFUNDS WILL BE GIVEN** for fractured teeth left unprotected by crown.

To the best of my knowledge, the questions on this form have been accurately answered. I understand providing incorrect information can be dangerous to my and other patients' health. It is my responsibility to inform the dental office of any changes in medical status.

Patient, parent or legal guardian Signature: _____ Date: _____