Welcome to Premier Dental Associates of the Carolinas

NEW PATIENT PACKET (ADULT)

PLEASE FILL OUT THE FORM COMPLETELY AND IN INK.

PATIENT INFORMATION

Last Name_________________________ First Name_____________________ Middle Name __________________

Birthdate_____/_____/_________ Age______ Sex_________ Social Security #________-_____-_________

Marital Status (Circle One): Single, Married, Divorced, Widowed, Separated Race:________________________

Street Address____ Apartment/Unit# (if Applicable)____________

City__________ State____ Zip Code__________ Email Address____

Home # (______)_______-__________ Work # (______)_______-________ Cell # (______)_______-_________

Employer ________________________ Occupation ___________________ Driver's License #_________________

GENERAL CONSENT FOR TREATMENT AND FINANCIAL POLICES

I, ____, give permission to Dr. Bill Connor, Dr. Jack Brinkley and their auxiliary staff to administer treatment as needed to ____ by providing preventative basic and major dental services. These services include dental exam and x-rays that may be performed on my first visit and any subsequent visits.

PATIENTS WITH INSURANCE: I further acknowledge that I am currently a covered member/dependent under a Dental Insurance plan with __________________________________. We will file insurance benefits on your behalf to assist you in maximizing your dental coverage. If, for any reason, the above insurance company refuses to pay this claim (or subsequent claims), I agree that I am completely financially responsible for any and all charges associated with my account.

PATIENTS WITHOUT INSURANCE: I understand that Dr. Connor requires payment in full at the time services are rendered. We offer several affordable payment options.

Estimated down payment is expected at the time of operative appointment. Customized payment plan options include cash, credit card, in-house draft plans with no interest, and third-party financing with Lending Club and Wells Fargo.

I certify that I have read and understand the above information.

Patient (sign)____ Date _____/_____/________

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Please make sure this information is your DENTAL INSURANCE and not your MEDICAL INSURNACE

INSURANCE INFORMATION (PRIMARY ONLY)

Patient's Name_______________________________ Insured's Name____________________________________

Relationship to Patient________________ DOB_____/_____/______ Social Security #________-_____-________

Employer_________________________________ Insurance Company___________________________________

Insurance Co. Address (either Full Address or P.O. Box info.)____

____

Claims Phone #: __(______)_______-__________

ID #____________________________ Group #__________________ Effective Coverage Date_____/_____/_____

Have you received previous <u>dental care</u> under this plan? **O** Yes **O** No

Patient (sign)____ Date _____/_____/________

- -

(FOR OFFICE USE ONLY: Copy front and back of insurance card)

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PLEASE FILL OUT THE FORM <u>COMPLETELY AND IN INK.</u> Patient's Name______________________ Patient's Age___

Please be specific by checking (✓) the circle that applies to you. Explanations can be written in the lines provided.

MEDICAL HISTORY

O AIDS/HIV Positive
O Hepatitis A
O Renal Dialysis
O High Blood Pressure
O Scarlet Fever
O Shingles
O Asthma
O Blood Disease
O Blood Transfusion
O Frequent Headaches
O Low Blood Pressure
O Lung Disease
O Mitral Valve Prolapse
O Osteoporosis
O Pain in Jaw Joints
O Convulsions
O Speech Disorders
O ADHD/ADD
O Hemophilia
O Anaphylaxis
O Anemia
O Rheumatism
O Artificial Heart Valve
O Artificial Joint
O Fainting Spells/Dizziness
O Frequent Cough
O Leukemia
O Liver Disease
O Swelling of Limbs
O Thyroid Disease
O Tonsillitis
O Tuberculosis
O Tumors or Growths
O Heart Trouble/Disease
O Hearing Disorders
O Radiation Treatments
O Drug Addiction
O Herpes
O Arthritis/Gout
O Hypoglycemia
O Irregular Heartbeat
O Kidney Problems
O Stomach/Intestinal Diseases
O Stroke
O Cancer
O Chemotherapy
O Chest Pains
O Cold Sores/Fever Blisters
O Congenital Heart Disorder
O Psychiatric Care
O Emotional Problems
O Diabetes
O Hepatitis B or C
O Rheumatic Fever
O Epilepsy or Seizures
O Hives or Rash
O Sickle Cell Disease
O Sinus Trouble
O Spina Bifida
O Breathing Problems
O Bruise Easily
O Glaucoma
O Hay Fever
O Heart Attack/Failure
O Heart Murmur
O Ulcers
O Eye Disorder
O Excessive Nervousness

List any other serious illnesses you have had if not listed above ____

List any handicaps or congenital birth defects you have ____

Please list any medications (including dosages and frequency) you take____

____

Please list any drugs that have adverse reactions in you____

Please list any allergies you have ____

Do you use any controlled substances? **O** Yes **O** No If yes, explain ____

Women, are you: **O** Pregnant (Trying to get Pregnant) **O** Nursing **O** Taking Contraceptives

Physician's Name______________________________ Date of Last Physical Exam_____/_____/________

DENTAL HISTORY

O Tooth Pain
O Teeth Sensitivity
O Clenching or Grinding
O Complications from Extractions
O Orthodontic Treatment
O Bleeding Gums
O Swelling/Lumps in Mouth
O Well Balanced Diet
O Trauma to Mouth/Teeth
O Fever Blisters/Cold Sores
O Mouth Breathing
O Food Impaction
O Bad Breath

Chief Complaint______________________________ Previous Dentist__________________________ Phone# (_____)______-_______

Date of Last Dental Exam_____/_____/________ Any Previous Unfavorable Dental Experience **O** Yes **O** No

If Yes, Explain____

List any other information that will be of value to us in treating you____

____

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

Patient (sign)____ Date _____/_____/________

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SLEEP APNEA EVALUATION

Have you ever been diagnosed with the following (check all that apply):

O Obstructive Sleep Apnea **O Morning Headache** **O Insomnia**

O High Blood Pressure **O Nighttime Urination** **O COPD**

O Stroke **O Loud Snoring** **O Restless Leg Syndrome**

O Thyroid Disorders **O Heart Disease**

O Depression **O Diabetes**

Use the following scale to choose the most appropriate number for each situation and write the number on the line next to it. This evaluates how often dozing/sleeping can occur during these activities.

0= Never Doze 1= Slight Chance 2= Moderate Chance 3= High Chance

1. _____Sitting and reading
2. _____Sitting quietly in a public place
3. _____Watching TV
4. _____Sitting quietly after lunch w/o alcohol
5. _____As a passenger in a car
6. _____In a car while stopped in traffic for a few minutes
7. _____Lying down in the afternoon

Patient (sign)____ Date _____/_____/________

Welcome to Premier Dental Associates of the Carolinas

(PREMIER DENTAL ASSOCIATES OF THE CAROLINAS)

Acknowledgement of Receipt
Of Notice of Privacy Practices

Patient Name & Address: ____

____

____

I have received a copy of the Notice of Privacy Practices for the above named practice.

________________________________ ______________________

Signature Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- ❑ An emergency existed & a signature was not possible at the time.
- ❑ The individual refused to sign.
- ❑ A copy was mailed with a request for a signature by return mail.
- ❑ Unable to communicate with the patient for the following reason: ____
- ❑ Other:____

Prepared By ______________________________________

Signature ______________________________________

Date ______________________________________

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Authorization for Release of Information – Compound Release

Name of Patient: ________________________________ Date of Birth: _____________

____ is authorized to release PHI about the above named patient in the following manner and/or to selected persons.

CHECK EACH PERSON/ENTITY APPROVED TO RECEIVE INFORMATION.	CHECK TYPE OF INFORMATION THAT CAN BE GIVEN TO PERSON/ENTITY ON THE LEFT IN THE SAME SECTION.
☐ Voice Mail	☐ Results of lab tests/x-rays ☐ Other______________________________
☐ Other person (s) (provide name and phone number)	☐ Financial ☐ Medical
☐ Email communication-Provide email address* ___________________________________ *For email communication to occur, please accept the disclosure below:	☐ Financial ☐ Medical ☐ Appointment reminders ☐ Breach notification
☐ Text communication – Provide number * ___________________________________ *For text communication to occur, accept the disclosure below:	☐ Appointment reminder ☐ Other: ___________________________________
☐ For **email and/or text communication** I understand that if information is *not* sent in an encrypted (secure) manner, there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected.	
☐ Photo of patient received by patient or legal guardian ☐ Photo taken by staff (Example: pre/post procedure) ☐ Other: _____________________________________	☐ May be posted in office ☐ May be posted on website ☐ Other:_________________________________

Patient's Rights:

- I have the right to revoke this authorization at any time by contacting this office.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization will remain in effect until revoked by the patient.

Signature of Patient or Personal Representative: ____ Date: __________

*Description of Personal Representative's Authority (attach necessary documentation)

☐ Revoked by patient or personal representative on ___________________________.
DATE

How revoked: ☐ orally (in person or via phone) ☐ in writing (place copy in patient's file)

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PLEASE FILL OUT THE FORM <u>COMPLETELY AND IN INK.</u> Patient's Name______________________

Please tell us how you heard about our office. Check (✓) the options that apply and write the name of the person who referred you if applicable.

REFERRAL FORM

O Office Sign

O Website

O Instagram

O Facebook

O Daycare/School

O Online Yellow Pages

O Employee________________________________

O Pediatrician Referral: Dr.__________________ City___________________

O Dentist Referral: Dr.__________________ City___________________

O Insurance Company: Name of Insurance______________________________

O Friend Referral (Please share their name, address, and phone # so we may send a thank you card)

____

O Family Referral (Please share their name, your relationship, address, and phone # so we may send a thank you card)

____

Patient (sign)____ Date _____/_____/________