
1149 Kildaire Farm Road
Cary NC 27511

*We warmly welcome you to our office. Please take a few moments to complete the following information so that we can better care for you. It is our goal to help you reach and maintain maximum oral health.*

Name: _____

I prefer to be called: _____ Male Female

Married Single Child Divorced Widowed

Birth date: _____ SSN: _____

Home address: _____

_____

Hm # _____ Cell # _____

Wk # _____

**Email** _____

How do you prefer to confirm your appointments?

___phone ____email ____text

Employer: _____

_____

Occupation: _____

Whom may we thank for referring you? _____

Other family members seen by us?

_____

Previous / Present Dentist: _____

Date of Last Visit: _____ Ph# _____

**In the event of an emergency, is there someone who lives near you that we should contact?**

Name: _____

Relation: _____

Wk # _____ Hm # _____ Cell# _____

## Dental Insurance

### Primary Dental Insurance

Insurance Co. Name: _____

Address: _____

Phone: _____

Employer: _____ Group # _____

Insured's Name: _____

Relation: _____

Insured's Birth date: _____

Insured's SSN/Subscriber# _____

***A note for patients with dental insurance*** – We will assist you to maximize your insurance benefits, and we are happy to file claims to your insurance carrier and agree to accept payment from any carrier that offers an assignment of benefits, if you desire. We will do our best to calculate your available benefit amount, however, regardless of what your insurance plan pays, you are responsible for all fees. Patient portion is due in full at the time of treatment.

I understand it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status.
I authorize the dental team to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Signature _____ Date _____

# DENTAL HISTORY

Name_____ Nickname_____ Age_____
Referred by_____How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Previous Dentist _____How long have you been a patient?_____Months/Years
Date of most recent dental exam _____/_____/_____ Date of most recent x-rays _____/_____/_____
Date of most recent treatment (other than a cleaning) _____/_____/_____
I routinely see my dentist every: ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

**WHAT IS YOUR IMMEDIATE CONCERN?** _____

**PLEASE ANSWER YES OR NO TO THE FOLLOWING:** **YES** **NO**

## PERSONAL HISTORY

1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [____] _____ ☐ ☐
2. Have you had an unfavorable dental experience? _____ ☐ ☐
3. Have you ever had complications from past dental treatment? _____ ☐ ☐
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? _____ ☐ ☐
5. Did you ever have braces, orthodontic treatment or had your bite adjusted? _____ ☐ ☐
6. Have you had any teeth removed? _____ ☐ ☐

## SMILE CHARACTERISTICS

7. Is there anything about the appearance of your teeth that you would like to change? _____ ☐ ☐
8. Have you ever whitened (bleached) your teeth? _____ ☐ ☐
9. Have you felt uncomfortable or self conscious about the appearance of your teeth? _____ ☐ ☐
10 Have you been disappointed with the appearance of previous dental work? _____ ☐ ☐

## BITE AND JAW JOINT

11. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____ ☐ ☐
12. Do you / would you have any problems chewing gum? _____ ☐ ☐
13. Do you / would you have any problems chewing bagels, baguettes , protein bars, or other hard foods? _____ ☐ ☐
14. Have your teeth changed in the last 5 years, become shorter, thinner or worn? _____ ☐ ☐
15. Are your teeth crowding or developing spaces? _____ ☐ ☐
16. Do you have more than one bite and squeeze to make your teeth fit together? _____ ☐ ☐
17. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____ ☐ ☐
18. Do you clench your teeth in the daytime or make them sore? _____ ☐ ☐
19. Do you have any problems with sleep or wake up with an awareness of your teeth? _____ ☐ ☐
20. Do you wear or have you ever worn a bite appliance? _____ ☐ ☐

## TOOTH STRUCTURE

21. Have you had any cavities within the past 3 years? _____ ☐ ☐
22. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? _____ ☐ ☐
23. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? _____ ☐ ☐
24. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? _____ ☐ ☐
25. Do you have grooves or notches on your teeth near the gum line? _____ ☐ ☐
26. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? _____ ☐ ☐
27. Do you frequently get food caught between any teeth? _____ ☐ ☐

## GUM AND BONE

28. Do your gums bleed or are they painful when brushing or flossing? _____ ☐ ☐
29. Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____ ☐ ☐
30. Have you ever noticed an unpleasant taste or odor in your mouth? _____ ☐ ☐
31. Is there anyone with a history of periodontal disease in your family? _____ ☐ ☐
32. Have you ever experienced gum recession? _____ ☐ ☐
33. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? _____ ☐ ☐
34. Have you experienced a burning sensation in your mouth? _____ ☐ ☐

Patient's Signature _____ Date_____

Doctor's Signature _____ Date _____

# MEDICAL HISTORY

Patient Name _____ Nickname _____ Age _____

Name of Physician/and their specialty _____

Most recent physical examination _____ Purpose _____

What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

| DO YOU HAVE or HAVE YOU EVER HAD: | YES | NO |
|---|---|---|
| 1. hospitalization for illness or injury_____ | ☐ | ☐ |
| 2. an allergic reaction to | | |
| ☐ aspirin, ibuprofen, acetaminophen, codeine | | |
| ☐ penicillin | | |
| ☐ erythromycin | | |
| ☐ tetracycline | | |
| ☐ sulfa | | |
| ☐ local anesthetic | | |
| ☐ fluoride | | |
| ☐ metals (nickel, gold, silver, _____) | | |
| ☐ latex | | |
| ☐ other _____ | | |
| 3. heart problems, or cardiac stent within the last six months __ | ☐ | ☐ |
| 4. history of infective endocarditis _____ | ☐ | ☐ |
| 5. artificial heart valve, repaired heart defect (PFO) _____ | ☐ | ☐ |
| 6. pacemaker or implantable defibrillator _____ | ☐ | ☐ |
| 7. artificial prosthesis (heart valve or joints) _____ | ☐ | ☐ |
| 8. rheumatic or scarlet fever_____ | ☐ | ☐ |
| 9. high or low blood pressure_____ | ☐ | ☐ |
| 10. a stroke (taking blood thinners) _____ | ☐ | ☐ |
| 11. anemia or other blood disorder _____ | ☐ | ☐ |
| 12. prolonged bleeding due to a slight cut (INR > 3.5) _____ | ☐ | ☐ |
| 13. emphysema, sarcoidosis _____ | ☐ | ☐ |
| 14. tuberculosis _____ | ☐ | ☐ |
| 15. asthma _____ | ☐ | ☐ |
| 16. breathing or sleep problems (i.e. snoring, sinus)_____ | ☐ | ☐ |
| 17. kidney disease _____ | ☐ | ☐ |
| 18. liver disease _____ | ☐ | ☐ |
| 19. jaundice _____ | ☐ | ☐ |
| 20. thyroid, parathyroid disease, or calcium deficiency _____ | ☐ | ☐ |
| 21. hormone deficiency _____ | ☐ | ☐ |
| 22. high cholesterol or taking statin drugs _____ | ☐ | ☐ |
| 23. diabetes (HbA1c =_____) _____ | ☐ | ☐ |
| 24. stomach or duodenal ulcer _____ | ☐ | ☐ |
| 25. digestive disorders (i.e. gastric reflux)_____ | ☐ | ☐ |

| | YES | NO |
|---|---|---|
| 26. osteoporosis/osteopenia (i.e. taking bisphosphonates) __ | ☐ | ☐ |
| 27. arthritis _____ | ☐ | ☐ |
| 28. glaucoma_____ | ☐ | ☐ |
| 29. contact lenses _____ | ☐ | ☐ |
| 30. head or neck injuries _____ | ☐ | ☐ |
| 31. epilepsy, convulsions (seizures) _____ | ☐ | ☐ |
| 32. neurologic problems (attention deficit disorder) _____ | ☐ | ☐ |
| 33. viral infections and cold sores _____ | ☐ | ☐ |
| 34. any lumps or swelling in the mouth_____ | ☐ | ☐ |
| 35. hives, skin rash, hay fever_____ | ☐ | ☐ |
| 36. venereal disease _____ | ☐ | ☐ |
| 37. hepatitis (type ___) _____ | ☐ | ☐ |
| 38. HIV / AIDS _____ | ☐ | ☐ |
| 39. tumor, abnormal growth_____ | ☐ | ☐ |
| 40. radiation therapy_____ | ☐ | ☐ |
| 41. chemotherapy_____ | ☐ | ☐ |
| 42. emotional problems _____ | ☐ | ☐ |
| 43. psychiatric treatment_____ | ☐ | ☐ |
| 44. antidepressant medication _____ | ☐ | ☐ |
| 45. alcohol / street drug use _____ | ☐ | ☐ |
| **ARE YOU:** | | |
| 46. presently being treated for any other illness _____ | ☐ | ☐ |
| 47. aware of a change in your health (i.e. fever, new cough) __ | ☐ | ☐ |
| 48. taking medication for weight management (i.e. fen-phen) | ☐ | ☐ |
| 49. taking dietary supplements_____ | ☐ | ☐ |
| 50. often exhausted or fatigued _____ | ☐ | ☐ |
| 51. experiencing frequent headaches_____ | ☐ | ☐ |
| 52. a smoker, smoked previously or use smokeless tobacco _ | ☐ | ☐ |
| 53. considered a touchy person _____ | ☐ | ☐ |
| 54. often unhappy or depressed_____ | ☐ | ☐ |
| 55. FEMALE - taking birth control pills _____ | ☐ | ☐ |
| 56. FEMALE - pregnant _____ | ☐ | ☐ |
| 57. MALE - prostate disorders _____ | ☐ | ☐ |

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections)

_____

List all medications, supplements, and or vitamins taken within the last two years

| Drug | Purpose | Drug | Purpose |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Ask for an additional sheet if you are taking more than 6 medications

**PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.**

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

CARY
Family Dental

# *Financial Policy*

In our continued commitment to provide the highest quality of dental care available to all our patients and to have those services comfortably affordable, we are pleased to offer you these options for payment.

- 5% discount with cash or check, 3% with credit card,
- VISA, MasterCard, American Express, Discover, Check or Cash-Time of Services
- Co-pays 50% at appointment and 50% 30 days later with Credit Card Consent
- Care Credit or Chase Health Card (up to 12 months interest free)

We will, as a courtesy, process your insurance benefits in our office. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer and your insurance company. If your insurance company has not made payment with 60 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount.

I agree that I am fully responsible for the total payment of all procedures performed in this office, and this includes any treatment that is not a benefit of any dental insurance that I may have. In the event that your insurance carrier pays less than the estimated amount or your treatment is not covered due to limitations, exclusions or waiting periods you are responsible for the unpaid balance. I understand that all services are due to be paid in full within **sixty (60) days of date of service**, regardless of whether or not my insurance benefits have been received. One and a half percent (1.5 %) per month interest (18% per year) will be charged on accounts after 60 days from treatment date.

We reserve the right to charge a $50.00 per hour missed appointment fee for broken/missed appointments. Broken appointments affect many people. If two (2) broken/missed appointments occur or two cancellations **without 48 hrs notice**, our office reserves the right to not schedule any subsequent appointments.

We are here to assist you in any way possible. Please make your questions and concerns known to our team. Our goal is to ensure that you have an outstanding experience.

_____ _____

Signature (responsible party) Date

1149 Kildaire Farm Rd • Cary, NC 27511 Tel (919) 460-6884 • Fax (919) 460-8787


# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**** You may refuse to sign this acknowledgement ****

I, _____, have reviewed and/or received a copy of this office's Notice of Privacy Practices.

_____
(Please print name)

_____
(Signature)

_____
(Date)

I give my permission for Cary Family Dental to speak to the following individuals in regards to my treatment:

1._____ 2. _____ 3. _____

## 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

__ Communication barriers prohibited obtaining the acknowledgement

__ An emergency situation prevented us from obtaining acknowledgement

CARY
Family Dental
1149 Kildaire Farm Road
Cary NC 27511

# Easy Pay Consent

**To accept assignment of benefits, we now ask for a credit/debit card to be left on file with our office.**

To provide you with the best service possible, we require patients to pay any outstanding balance and/or issue any credit back after your insurance has paid.
Please complete the form below:
I authorize **CARY FAMILY DENTAL** to keep my signature on file and to charge and/or credit my credit card account for:

- Balance of charges not paid by insurance within 60 days and not to exceed $100.00. We will call on all balances over $100.00 for authorization before charging your credit card.

- Any overpayment on the account will be refunded to the same credit card I use for payment.

I assign my insurance benefits to the provider listed above. I understand this agreement is my commitment for payment unless I cancel the authorization through written notice to Cary Family Dental and provide alternative payment arrangements. **Please present us with your credit card when you arrive for your appointment and your card number will be placed under password protection** attached to your account. I understand that this credit card information will be kept highly confidential.

Patient Name: _____

Cardholder Name: _____

Cardholder Signature: _____

Date