Welcome

1149 Kildaire Farm Road
Cary, NC 27511 • 919-460-6884
Visit our website at www.CaryDental.com

Health History Form

Today's Date: ______________

NOTE: The parent or Guardian who accompanies the child is responsible for payment at the time of service.

1. Tell Us About Your Child

Child's Name ____
Last First MI

Goes by: ______________________ ☐ Male ☐ Female

Siblings that we treat ________________________________

Child's Birthdate _____/_____/_____ Child's Age __________

School______________________________Grade__________

Child's Home # (__________)__________________________

SS#____

Child's Home Address:_______________________________

____
City State Zip

2. Mother's Information

Name ____

Mother Stepmother Guardian Birthdate _____/_____/_____

Employer ____

Work # (_________)___________________ Ext. __________

Home # (_________)_________________________________

Cellular Phone # (_________)__________________________

SS # _____________________ DL# ____________________

Email address:_______________________________________

3. Father's Information

Name ____

Father Stepfather Guardian Birthdate _____/_____/_____

Employer ____

Work # (_________)___________________ Ext. __________

Home # (_________)_________________________________

Cellular Phone # (_________)__________________________

SS # _____________________ DL# ____________________

Email address:_______________________________________

4. Who is Accompanying the Child Today?

Name ____

Relationship____

Do you have legal custody of this child? ☐ Yes ☐ No

5. Person Responsible for Account

Name____

Relationship____

Billing Address ______________________________________

____
City State Zip

Home # (___________)_________________________________

Work # (___________)_________________________________

Cellular # (___________)______________________________

E-mail ____

6. Primary Dental Insurance

Insurance Co. Name ___________________________________

Insurance Co. Address _________________________________

____

Insurance Co. Phone # (___________)___________________

Group # (Plan, Local, or Policy #) _____________________

Policy Owner's Name __________________________________

Relationship to Patient_________________________________

Policy Owner's Birthdate ______/ ______/ ______

Social Security # _____________________________________

Policy Owner's Employer _______________________________

7. Who may we thank for referring you to our office?

____

8. *Dental History*

Is this your child's first visit to the dentist? ________________

If not, how long since the last visit to the dentist? ____________

Previous Dentist's Name_____________________________

Were any x-rays taken at previous dental visits? ___________

Have there been any injuries to the teeth, face or mouth? _____

If yes, please explain ________________________________

____

____

Why did you bring the child to the dentist today? ___________

____

____

Does the child have any of the following habits?

Y N Lip Sucking / Biting   Y N Nail Biting

Y N Nursing / Bottle Habits   Y N Thumb / Finger Sucking

Has the child ever had a serious or difficult problem associated with previous dental work? Yes No

If yes, please explain ________________________________

____

Is the child's water fluoridated? Yes No

Is the child taking fluoride supplements? Yes No

Has the child ever had any pain or tenderness in his/her jaw/ joint? (TMJ/TMD)? Yes No

Does the child brush his/her teeth daily? Yes No

Floss his / her teeth daily? Yes No

9. *Health History*

Has the child ever had any of the following conditions?

Y N Abnormal Bleeding

Y N Allergies to any Drugs

Y N Any Hospital Stays

Y N Any Operations

Y N Asthma

Y N Cancer

Y N Congenital Birth Defects

Y N Convulsions/Epilepsy

Y N Pregnancy

Y N Tuberculosis

Y N ADD / ADHD

Y N Disabilities/Special Needs

Y N Hearing Impairment

Y N Heart Disease/Murmur

Y N Hemophilia/Blood Disorders

Y N Hepatitis

Y N HIV + / AIDS

Y N Kidney/Liver Conditions

Y N Rheumatic/Scarlet Fever

Y N Allergies to Latex Product

Y N Diabetes

Y N Autism

Please discuss any serious medical conditions the child has had

____

____

Please list all drugs the child is currently taking ____________

____

Please list all drugs the child is allergic to _______________

____

Child's Physician ______________________________

Phone (____________)__________________________

Is the child currently under the care of a physician? Yes No

Please describe the child's current physical health...

Good **Fair** **Poor**

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA the CDC, and the ADA.

10.

I understand that the information I hav e given is correct to the best of my kn owledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

____ ________________________

Signature of Parent or Guardian D ate R elationship to Patient

For Office Use Only

I verbally reviewed the medical / dental information above with the parent / guardian and patient named herein.

Initials ____________ Date ______________

Doctor's Comments ___________________________

____

____

____

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 paid prior to treatment
- 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 CitiHealth 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

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

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