PATIENT INFORMATION (CONFIDENTIAL)

NAME_____DATE _____
FIRST MI LAST

ADDRESS_____CITY_____STATE____ZIP_____

E-MAIL_____CELL PHONE_____HOME PHONE_____

SS#_____BIRTH DATE_____

CHECK APPROPRIATE BOX: ☐ MINOR ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED

IF COLLEGE STUDENT, F.T. P.T., NAME OF SCHOOL _____ CITY _____ STATE_____

PATIENT'S OR PARENT'S/GUARDIAN'S EMPLOYER_____WORK PHONE_____

BUSINESS ADDRESS_____CITY_____STATE____ZIPCODE_____

SPOUSE OR PARENT'S/GUARDIAN'S NAME_____EMPLOYER_____WORK PHONE____

WHOM MAY WE THANK FOR REFERRING YOU?_____

PERSON TO CONTACT IN CASE OF AN EMERGENCY_____PHONE_____

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT_____RELATION TO PT_____
ADDRESS_____HOME PHONE_____
DRIVER'S LICENSE #_____BIRTHDATE_____SS#_____
EMPLOYER_____WORK PHONE_____
IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? ☐ YES ☐ NO

INSURANCE INFORMATION

NAME OF INSURED_____RELATIONSHIP TO PATIENT_____
BIRTHDATE_____SS#_____DATE EMPLOYED_____
NAME OF EMPLOYER_____CITY_____STATE_____ZIPCODE____
EMPLOYER ADDRESS_____CITY_____STATE_____ZIPCODE____
INSURANCE CO._____TEL. #_____ GROUP # _____POLICY/I.D.#_____
HOW MUCH IS YOUR DEDUCTIBLE?_____HOW MUCH HAVE YOU USED?_____MAX ANNUAL BENEFIT?_____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ YES ☐ NO IF YES COMPLETE THE FOLLOWING:

NAME OF INSURED_____RELATIONSHIP TO PATIENT_____
BIRTHDATE_____SS#_____DATE_____
NAME OF EMPLOYER_____TEL# _____
EMPLOYER ADDRESS_____CITY_____STATE_____ZIP_____
INSURANCE CO._____TEL. #_____GROUP # _____POLICY/I.D. #_____
INS. CO. ADDRESS_____CITY_____STATE_____ZIP_____

HOW MUCH IS YOUR DEDUCTIBLE?____HOW MUCH HAVE YOU USED?___MAX ANNUAL BENEFIT?_____

X_____
SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR

HEALTH HISTORY

English

Patient Name:_____ Patient Identification Number:_____

Birth Date:_____

I. CIRCLE APPROPRIATE ANSWER (leave Blank if you do not understand question):

1. Yes No Is your general health good?
2. Yes No Has there been a change in your health within the last year?
3. Yes No Have you been hospitalized or had a serious illness in the last three years?
   If YES, why?_____
4. Yes No Are you being treated by a physician now? For what? _____
   Date of last medical exam?_____ Date of last Dental exam_____
5. Yes No Have you had problems with prior dental treatment?
6. Yes No Are you in pain now?

II. HAVE YOU EXPERIENCED:

7. Yes No Chest pain (angina)?
8. Yes No Swollen ankles?
9. Yes No Shortness of breath?
10. Yes No Recent weight loss, fever, night sweats?
11. Yes No Persistent cough, coughing up blood?
12. Yes No Bleeding problems, bruising easily?
13. Yes No Sinus problems?
14. Yes No Difficulty swallowing?
15. Yes No Diarrhea, constipation, blood in stools?
16. Yes No Frequent vomiting, nausea?
17. Yes No Difficulty urinating, blood in urine?
18. Yes No Dizziness?
19. Yes No Ringing in ears?
20. Yes No Headaches?
21. Yes No Fainting spells?
22. Yes No Blurred vision?
23. Yes No Seizures?
24. Yes No Excessive thirst?
25. Yes No Frequent urination?
26. Yes No Dry mouth?
27. Yes No Jaundice?
28. Yes No Joint pain, stiffness?

III. DO YOU HAVE OR HAVE YOU HAD:

29. Yes No Heart disease?
30. Yes No Heart attack, heart defects?
31. Yes No Heart murmurs?
32. Yes No Rheumatic fever?
33. Yes No Stroke, hardening of arteries?
34. Yes No High blood pressure?
35. Yes No Asthma, TB, emphysema, other lung diseases?
36. Yes No Hepatitis, other liver disease?
37. Yes No Stomach problems, ulcers?
38. Yes No Allergies to: drugs, foods, medications, latex?
39. Yes No Family history of diabetes, heart problems, tumors?
40. Yes No AIDS
41. Yes No Tumors, cancer?
42. Yes No Arthritis, rheumatism?
43. Yes No Eye diseases?
44. Yes No Skin diseases?
45. Yes No Anemia?
46. Yes No VD (syphilis or gonorrhea)?
47. Yes No Herpes?
48. Yes No Kidney, bladder disease?
49. Yes No Thyroid, adrenal disease?
50. Yes No Diabetes?

IV. DO YOU HAVE OR HAVE YOU HAD:

51. Yes No Psychiatric care?
52. Yes No Radiation treatments?
53. Yes No Chemotherapy?
54. Yes No Prosthetic heart valve?
55. Yes No Artificial joint?
56. Yes No Hospitalization?
57. Yes No Blood transfusions?
58. Yes No Surgeries?
59. Yes No Pacemaker?
60. Yes No Contact lenses?

V. ARE YOU TAKING:

61. Yes No Recreational drugs?
62. Yes No Drugs, medications, over-the-counter medicines (including Aspirin), natural remedies?
63. Yes No Tobacco in any form?
64. Yes No Alcohol?

Please list:_____

_____

VI. WOMEN ONLY:

65. Yes No Are you or could you be pregnant or nursing?
66. Yes No Taking birth control pills?

VII. ALL PATIENTS:

67. Yes No Do you have or have you had any other diseases or medical problems NOT listed on this form?

If so, please explain:_____

_____

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication.

Patient's signature:_____ Date:_____

RECALL REVIEW:

1. Patient's signature_____ Date:_____
2. Patient's signature_____ Date:_____
3. Patient's signature_____ Date:_____

The Health History is created and maintained by the University of the Pacific School of Dentistry, San Francisco, California.
Support for the translation and dissemination of the Health Histories comes from MetLife Dental Care.

DENTAL HISTORY

Reason for today's visit_____ Date of last dental visit_____

Former Dentist_____ Date of last dental X-rays_____

Address_____

Check(/) if you have had any of the following:

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Clicking or popping jaw
- ☐ Food collection between the teeth
- ☐ Grinding teeth
- ☐ Loose teeth or broken fillings
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to heat
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores or growths in your mouth

How often do you floss?_____ How often do you brush? _____

After reading this dental history, I have answered the questions to the best of my knowledge and correctly.

Signature: _____

ASSIGNMENT OF BENEFITS

AUTHORIZATION AND RELEASE

I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I authorize the doctor to release all information necessary to secure the payment of benefits. I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all insurance submissions, and credit card payments.

_____ _____

Signature of patient or parent if minor Date

FINANCIAL POLICY

We welcome and encourage frank discussion of services and fees prior to treatment to avoid misunderstanding. We want our patients to understand our fees and be satisfied they are reasonable and equitable. If you have insurance, you are still responsible for payments on this account. **REMEMBER – YOUR INSURANCE POLICY IS AN AGREEMENT BETWEEN YOU AND THE INSURANCE COMPANY.** We are only a third party to this agreement. No insurance company attempts to cover all dental/medical costs. Some pay fixed allowances for certain procedures; others pay a percentage of the charge. It is **YOUR** responsibility to pay any deductible and any balance not paid by your insurance. Any questions about insurance can be discussed with the business staff. We will be happy to help you receive the maximum benefits available under your policy.

In an effort to control operating expenses, we require that you pay 50% of your total bill for all non-preventative procedures (not including your deductible). The balance is due in full within thirty days. We also collect $30.00 at the time of your initial visit if our office does not participate with your insurance company. This amount will remain on your account as a credit until we receive all payments from your insurance company. Please call the business office to request any refunds. If a refund is requested from a credit card processed, we must credit your refund back to a credit card.

Since we are not a party to the agreement with your insurance carrier, it is not our policy to contact carriers to establish why they have not paid or why they are paying less than originally indicated.

There is a $25.00 charge on all returned checks.

There is a $25.00 charge for broken appointments. Please give at least 24 hour notice for cancellations.

A finance charge of 1.5% per month (18% APR) is added to all balances over 30 days old.

I have read and understand the above policies and my financial obligation to this office and agree to all the terms.

Signature _____

Date _____

Notice of Privacy Practices Acknowledgement

Keisha B. Davis, DDS, PA.
500 Holly Springs Road, Suite 104
Holly Springs, NC 27540

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private 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: _____

Relationship to Patient: _____

Signature: _____

Date: _____

Office Use Only

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date	Initials	Reason