C2 DENTISTRY | COLLEEN CARTER, D.D.S. PA

Welcome! We'd like to get to know you better

This personal information will help us give you our best professional help. All information on this form is for our records only and will be considered confidential.

Are you aware of any particular dental problems? ______________________________

How long has it been since you last visited a dental office? __________ What was done? ______________

Patient ______________________________

Social Security # ________________ Birthdate __________

Address ______________________________

____

Home Phone ______________________________

Occupation ______________________________

Employer ______________________________

Work Phone ____________________

Cell Phone ______________________

Email ______________________________

Spouse/Parent (if minor) ______________________________

Social Security # ________________ Birthdate __________

Occupation ______________________________

Employer ______________________________

Work Phone ____________________

Dental Insurance Coverage

Name & relation to person carrying insurance	____________	____________
Employer Who Carries Insurance	____________	____________
Insurance Company	____________	____________
Address	____________	____________
Phone # / Policy #	____________	____________

Who may we thank for referring you to our office? ______________________________

Medical Health History

Primary Physician's Name ______________________________ Date of last exam ______________

Address ______________________________ Exam reason: ______________

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Has there been any problem or change in your general health within the last 5 years? ____________

If so, what was the problem? ______________________________

Are you under a physician's care now? __________ If so, for what? ______________________________

Please list any medications you are presently or have recently taken (including aspirin, vitamins, etc.) ______________

____

Please indicate with a (✔) any of the following conditions you have had or have:

- ☐ Have you been hospitalized or received medical treatment in the past 5 years?
- ☐ Rheumatic Fever? ☐ Heart Murmur?
- ☐ Heart Attack? ☐ Pains in your chest?
- ☐ Mitral Valve Prolapse?
- ☐ Do you require pre-medication for dental treatment?
- ☐ High Blood Pressure? ☐ Stroke?
- ☐ Circulatory Problems? ☐ Fainting Spells?
- ☐ Diabetes? ☐ Anyone in the family with Diabetes?
- ☐ Liver Disease? ☐ Jaundice? ☐ Hepatitis?
- ☐ Tuberculosis? ☐ Lung Problems?
- ☐ Thyroid Disease?
- ☐ Cancer?
- ☐ Chemotherapy? ☐ Radiation Treatments?
- ☐ Do you have a tendency to bleed longer than normal from tooth extractions, small cuts or surgery?
- ☐ Are you taking blood thinning medicine?
- ☐ Epilepsy? ☐ Seizures? ☐ Arthritis?
- ☐ Ear, Tonsil, Adenoid problem?
- ☐ Nose, Throat, Sinus Problem? ☐ Asthma?
- ☐ Heart Valve Replacement?
- ☐ Hip Replacement?
- ☐ Joint Replacement?
- ☐ Pacemaker Implant?
- ☐ Do you have allergies?
- ☐ Does your skin break out when it comes into contact with any metals?
- ☐ Have you ever had a reaction to a local anesthetic?
- ☐ Do you use tobacco of any form?
- ☐ Psychiatric care/Emotional problems?
- ☐ Sexually transmitted diseases?
- ☐ Have you ever been rejected as a blood donor?
- ☐ Have you ever tested positive for HIV (AIDS) virus?
- ☐ Woman: Are you pregnant?

Are you sensitive or allergic to any of the following medications?

☐ Penicillin ☐ Codeine ☐ Aspirin/Tylenol ☐ Novocaine ☐ Anesthetics

☐ Any other drugs - specify ______________________________

Do you exercise regularly? ____________________ If so, what? ____

Are you on a special diet now? _________________ If so, what? ____

Do you have any disease, conditions or problem not listed that you think we should know about? ______________________

____

Dental Health History

Please indicate with a (✔) any of the following conditions you have had or have:

☐ Do you have frequent headaches?
☐ Do you clench your teeth during the day ( ) or night ( )?
☐ Are you aware of any tenderness or pain around your ears, face, neck or shoulders?
☐ Do any of your teeth seem to strike together before others when closing?
☐ Have you ever had your bite adjusted?
☐ Do you have clicking, popping or unusual sounds in your ears while eating?
☐ Do you favor chewing on one side? If so, which side? ___________________
☐ Do any of your teeth feel loose?
☐ Have you ever had any injuries to your face or jaws?
☐ Have you ever had orthodontic treatment? If yes, when? ______________________
Orthodontist name ____

Are your teeth sensitive to:
☐ Heat
☐ Cold
☐ Sweets
☐ Biting pressure

☐ Do you have any food traps between your teeth?
☐ Do you often have fillings replaced?
☐ Do your gums feel tender?
☐ Do your gums bleed when brushing?
☐ Have your gums ever been treated?
☐ Have you ever had any sores or swellings in your mouth that did not heal in one week?
☐ Have you ever had bad breath or an unpleasant taste in your mouth?
☐ Have you ever had an unpleasant dental experience?

How often do you brush your teeth? ________________ Floss? _________________

Do you have any questions concerning their appearance? ____

____

Do you have any other questions concerning your teeth or treatment? ____

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C2 DENTISTRY
COLLEEN CARTER, D.D.S. PA
8035 Providence Road, Suite 310
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PATIENT AUTHORIZATION FORM AND GENERAL OFFICE POLICIES

Your time is valuable and we pride ourselves on staying on schedule. In order for us to maintain our high standard of quality, we ask that you arrive promptly for all scheduled appointments. If you must change a scheduled appointment kindly give our receptionist a 48-hour notice so that others will have the opportunity to use this time. *We also reserve the right to charge for broken appointments.*

As a courtesy to you, we will gladly submit your insurance. However, we expect payment of your portion at the time the services are rendered. After 30 days, you will be responsible for any remaining balance that your insurance company has not paid.

We gladly accept Cash, Check, Master Card and Visa for your convenience. We also offer no interest payment plans through Care Credit and Chase Health Advance. We are not under contract with most dental insurance companies. Therefore, we encourage you to take an active role in your relationship with your insurance company. If you have any questions about whether a procedure will be covered, we ask that you check with your insurance carrier beforehand. Every insurance company has their own policies, which change from time to time and we cannot be responsible for assuring that a procedure will be covered. We will be happy to discuss our fees with you at anytime.

If you do not carry dental insurance, we expect payment in full the date of service. If you are interested in financing we will be more than happy to discuss your options prior to your appointment.

I accept the terms of the above policy:

Patient Signature: ____ Date: _____________

If patient is under 18: Responsible Party: ____

Relationship: ________________________________

CONSENT TO TREATMENT

This is to certify that I, the undersigned, consent to the performance of any and all procedures and the use of any and all drugs that are agreed to be necessary or advisable.

Patient Signature: ____ Date: _____________

If patient is under 18: Responsible Party: ____________________________

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PATIENT ACKNOWLEDGMENT OF RECEIPT
CONSENT FORM
NOTICE OF PRIVACY PRACTICES

Our Notice of Privacy Practices provides information on how we may use and disclose protected health information about you. The notice contains a patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent Form. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how your protected health information is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do agree, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has been given the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon the execution of this Consent.

This consent was signed by__________________________________ Date_____________

Patient or Patient Representative

Relationship to Patient (if other than patient)____________________________________