CAROLINA DENTISTRY & DENTURES

Welcome! Tell Us About Yourself!

Name: ____ Date: _________________
Preferred Name: _________________________________ Gender: M / F (circle one)
Address: _____________________________ City: ______________ State: _____ Zip: _____
SSN: _____-___-______ DOB: _______________________
Home Phone: ______________________ Work Phone: ____________________________
Cell Phone: ________________________ Email Address: ____________________________
Employer: _________________________ Occupation: _______________________________
Marital Status (circle): Single / Married / Divorced / Widowed / Separated / Domestic Partner
How did you hear about our office? (circle): Google, Facebook, Drive-by, Friend, Dentist Referral, Other_____________
Do you prefer to be contacted for appointment confirmation via email or phone? (please circle)
Do you consent to receiving text messages from us? **Yes** or **no**?
Emergency contact- Name: ______________________Phone number: ___________________
Preferred Pharmacy: Name: ____________________ Phone number: __________________
Address: ____

Please **initial** each section to note you have read and understand:
_____ I may request a copy of the Notice of Privacy Practices that has been made available to me. I consent to the use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operations.

_____ I give permission for the release of appointment and treatment information to the people **listed**:
____

PHOTOGRAPHY AND VIDEO MODEL RELEASE

I, the undersigned, do hereby assign to Catherine B. Laws, DDS, PLLC absolutely the copyright and/or right to copyright such photographs or videos taken throughout my treatment, including before and after photos. I hereby allow the right of reproduction thereof for use by Catherine B. Laws, DDS, PLLC in the use of patient education, case publishing in profession journals, lectures, and website including practice marketing, print media, and website in any manner. I understand that I have voluntarily allowed my photograph or video to be made, and that I will receive no payment for posing or for allowing my photographs or videos to be reproduced. I hereby waive any right to approve the finished photograph or video, or any copy, which might be used in conjunction with the finished photograph or video.

Signature: _____________________________________ DATE: _______________

ASSIGNMENT AND RELEASE
I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Carolina Dentistry all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.
Responsible Party Signature: ____
Relationship: ___________________________________ Date: ________________

CONSENT
I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.
Signature: ____

Carolina Dentistry Medical History Form

Date: _________________ Patient Name:________________________________ Date of Birth:_________________

Are you under a physician's care now? **Yes** or **no**?____
Have you ever been hospitalized or had a major operation? **Yes** or **no**?___________________________________
Have you ever had a serious head or neck injury? **Yes** or **no**?____
What medications are you taking?____

____
Have you ever taken any medicines for bone problems? **Yes** or **no**?_______________________________________
Do you take Aspirin 81mg? _________ **If yes, why? Please circle one:** Preventative OR Heart Attack OR Stroke
Do you take pain medicine/use controlled substances? __________If **yes**, please list: _____________________________

____
Are you a Vegetarian or Vegan? ________________ Are you able to lie all the way back in the dental chair? **Yes** or **No**
On a scale of 1-10, how nervous are you to have teeth extracted? __________________
Women: Are you pregnant or nursing?____
Are you allergic to any of the following? Aspirin Penicillin Codeine Sulfa Acrylic Metal Latex
Local Anesthetics Other:_______________________________________

Do you have, or have you had, any of the following:

	Yes	No		Yes	No		Yes	No
Aids/HIV			Congestive Heart Failure			High Cholesterol		
Alzheimer's Disease			Cortisone Medication			Hives		
Anaphylaxis			Diabetes			Irregular Heartbeat		
Anemia			Dialysis			Kidney Problems		
Angina			Drug Addiction			Leukemia		
Arthritis/Gout			Emphysema			Liver Disease		
Artificial Heart Valve			Epilepsy/Seizures			Lung Disease		
Artificial Joint			Excessive Bleeding			Mitral Valve Prolapse		
Asthma			Excessive Thirst			Osteoporosis		
Blood Disease			Fainting Spells			Psychiatric Care		
Blood Thinner			Frequent Headaches			Radiation Treatment		
Blood Transfusion			Glaucoma			Rheumatism		
Breathing Problems			Heart Attack			Shingles		
Bruise Easily			Heart Murmur			Smoker/ Tobacco Use		
Cancer			Heart Pacemaker			Stomach/Intestinal Disease		
Chemotherapy			Learning Disability			Stroke		
Chest Pains			Hemophilia			Thyroid Disease		
Cold Sores			Hepatitis A, B, or C			Tuberculosis		
Convulsions			High Blood Pressure			Tumors		

Do you currently have, or ever had, any condition or serious illness not listed above?

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 (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature or Patient: Date:

____ ____________________