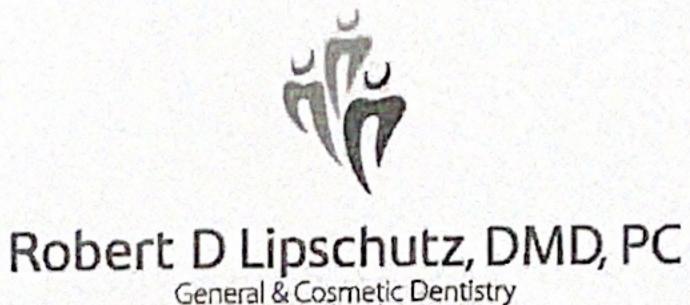


<PERSONAL INFORMATION>

Name				
Address street		apt#	Phone Number	
City	State	Zip	E-mail	
Employer (School)				
Address street		apt#	Phone Number	
City	State	Zip code		
Date of Birth				
Social Security #				
Please circle: single	married			
How did you hear about	t us?			
<insurance infor<="" td=""><td>MATION></td><td></td><td></td><td></td></insurance>	MATION>			
Insurance Company				
Address street	Carolina Disease of the	apt#	Phone Number	
City	State	Zip code		
Group/Policy Number_				
If you are a dependant:				
Beneficiary's name				
Employer: Phone number:				
Social Security Number				
Relationship to beneficia				
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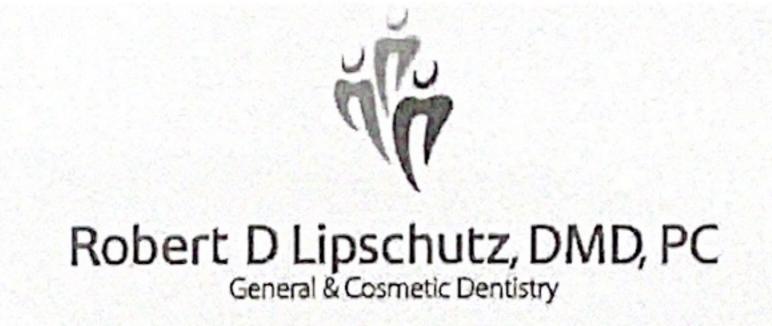
<DENTAL HISTORY> Are you in pain now? _____ What would you like attended to today? Purpose of your last dental visit and date When did you have your last full set of x-rays taken? Did you ever experience any difficulty or complication following dental treatment? Explain. Which of the following best describes your feeling about going to the dentist? <MEDICAL HISTORY> Please be assured that the information requested for your health record and treatment will be kept strictly confidential. Height_____Weight_____
Physician's name _____ Physician's address_ Date and nature of last visit _____ Other healthcare providers you have consulted in the last 2 years other than dentists. Explain. Are you currently taking any medication? Have you ever had a bad reaction to any medication? Do you have any allergies? Have you ever been seriously injured or hospitalized? Have you ever had surgery?_____ Have you ever been treated orthopedically for any reason?_____ Have you ever received radiation therapy? If you are a woman, are you pregnant? Do you smoke? How much?_____ Do you have or have you ever had any of the following (please circle): AIDS/ARC (AIDS Related Complex) Arthritis Blood or bleeding abnormality Asthma Cancer or tumor Bone or skeletal disease Colds(frequent) Circulatory problems Covid-19 Congenital defect Dizziness or fainting spells Diabetes Eye, ear, nose or throat problems Epilepsy Heart murmur disease or defect Gastro-intestinal or stomach disorder High or low blood pressure Hepatitis, liver disease Hormonal or endocrine imbalance Kidney disease Neurological disorder Migraine or tension headache Psychiatric problems Postnasal drip Rheumatic fever Respiratory disease

Thyroid disease

Venereal disease

Sinusitis

Ulcer



OFFICE POLICY

PAYMENTS

For your visit today, and all future visits, your balance is expected to be paid in full at the time treatment is rendered unless other arrangements have been made in writing. Please feel free to discuss financial matters with the doctor, including the cost of today's services and that of any future treatment if you have not been so advised. We offer flexible methods for extending payments over time and offer a number of different discount options if you are on a limited budget. We accept cash, checks and all major credit cards. In the event that your check is returned for insufficient funds or other reason, there will be an administrative fee.

Any estimate given as to what your insurance will pay is not a guarantee. Although we take assignment of benefits under certain conditions, you will be responsible for the difference between our fee and the insurance payments we receive on your behalf. Our office cannot know all the limitations and exclusions of every dental insurance plan nor shall it take responsibility for payments denied by your carrier based on the provisions of your policy.

APPOINTMENTS

Your dental treatment requires a sincere commitment on your part and substantial advance preparation on ours. Reserved time for your appointment is time denied to another patient. If there is a possibility that work or personal matters may conflict with the fulfillment of your appointment obligation, it is suggested, in fairness to all, that you try to be worked in on a same day as your availability and ours permits, rather than reserve time in advance.

If you cancel an appointment with less than 24 hours prior notice, you will be charged \$75 for each hour of reserved time. Notice must be given during the hours of 9:00am to 6:00pm Tuesday through Saturday. Messages left on our answering machine or sent via e-mail before or after business hours, do not constitute adequate notice. However, there will be no charge if your appointment can be reassigned to another patient or if you are able to fill another open time in our schedule, should it be available that same day. If you are late for an appointment by more than 20 minutes, it may not be possible to treat you that visit and you will be charged the same as if it were a cancellation. In the event that you break your appointment without calling to advise us at all, the fee is \$75 for each hour reserved. These fees will be billed to you and are not covered by dental insurance. Repeated appointment failures may result in dismissal from our practice.

GUARANTEES

Our office prides itself in the quality of care we have provided to our dental patients. In spite of our commitment to excellence, as with any of the health professions or healing arts, no guarantees are given or implied. Occasionally, unforeseen complications arise. Treatment outcomes may not meet the expectations of every patient. However, we will inform you in advance of the benefits, risks, and limitations of treatment, address your concerns, and try to achieve the best result we can.

I understand and accept your office policy as stated above and agree to abide by its terms as a condition to my dental treatment.

Patient's Signature	Date	
Doctor's Signature	Date	

Patient Screening Form

Patient Name:

	PRE-APPOINTMENT	IN-OFFICE
	Date:	Date:
Do you/they have fever or have you/they felt hot or feverish recently (14-21 days)?	☐ Yes ☐ No	☐ Yes ☐ No
Are you/they having shortness of breath or other difficulties breathing?	☐ Yes ☐ No	☐ Yes ☐ No
Do you/they have a cough?	☐ Yes ☐ No	☐ Yes ☐ No
Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	☐ Yes ☐ No	☐ Yes ☐ No
Have you/they experienced recent loss of taste or smell?	☐ Yes ☐ No	☐ Yes ☐ No
Are you/they in contact with any confirmed COVID-19 positive patients? Patients who are well but who have a sick family member at home with COVID-19 should consider postponing elective treatment.	☐ Yes ☐ No	☐ Yes ☐ No
Is your/their age over 60?	☐ Yes ☐ No	☐ Yes ☐ No
Do you/they have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	☐ Yes ☐ No	Yes No
Have you/they traveled in the past 14 days to any regions affected by COVID-19? (as relevant to your location)	☐ Yes ☐ No	Yes No

Positive responses to any of these would likely indicate a deeper discussion with the dentist before proceeding with elective dental treatment.

• For testing, see the list of State and Territorial Health Department Websites for your specific area's Information.