Charlotte Dental Partners

Blakeney Dental Center: (704) 541-8600
Steelecroft Dental: (704) 749-6300
Charlotte Dental Esthetics: (704) 926-5162

Personal Information

Name First:________________Last: __________________Preferred name: ______________________ Birth Date: _____________

SS#: ______________________Best Contact Number: ____________________ Email Address:

________________________________ Home Address: ____City

___________________State ________Zip Code ________ Emergency Contact Name: ____________________________________

Relation: _________________ Phone: ____________________ How did you hear about us?

____ Previous Dentist:

______________________Last dental visit: _________Did you have X Rays taken? __ Y, __ N, __ Don't know

Do you have dental insurance? ___Y, ___ N If yes, with which company? ____

Subscriber Name____________________________________ Subscriber DOB________________ Policy Number_______________

Financial and Cancellation Policy

We are happy to file your insurance on your behalf, however, in an effort to keep our fees competitive, balances must be met within 45 days of the procedure date; otherwise, you will be responsible to contact your insurance company for further explanation. If payment is still not received after 90 days, you will be fully responsible for the balance due. Please keep in mind that our estimates are only as accurate as the information provided to us by your insurance representatives. We are not responsible for any unforeseen balances incurred due to incorrect information or policy changes. There could be procedures performed that are subject to being downgraded by your insurance company. While we are happy to submit a pre-treatment estimate on your behalf, we strongly encourage you to contact your insurance company with any questions regarding coverage. Our office understands that sometimes unexpected circumstances may prohibit you from keeping your scheduled appointment. However, we ask that you notify us at least 24 hours prior to your scheduled appointment time. **If we do not receive a 24 hour notice, there will be a $50 Broken Appointment Fee added to your account for hygiene appointments and $100 for treatment appointments.**

Signature of Patient/Legal Guardian: ___________________________________ Date _____________________

HIPAA Policy

I, ____ (print name), acknowledge that I have received a copy of the Notice of Privacy Practices from Charlotte Dental Partners.

Signature of Patient/Legal Guardian: ___________________________________ Date _____________________

Dental History

	Yes	No	
Do your gums bleed when you brush or floss?	□	□	
Are your teeth sensitive?	□	□	If yes, explain: _________________________
Does food or floss catch between your teeth?	□	□	
Is your mouth dry?	□	□	
Have you had any gum treatments?	□	□	
Have you had braces?	□	□	
Have you ever had any issues with dental treatment?	□	□	
Are you currently experiencing any pain?	□	□	
Do you have ear or neck pain?	□	□	
Do you have clicking or popping in your jaw?	□	□	
Have you ever had a serious head or mouth injury?	□	□	If yes, explain: _____________________________
Do you have any loose teeth?	□	□	
Do you have dentures or partial dentures?	□	□	

Medical History

Primary Physician's name: ____________________________________ Phone #: __________________________
Are you currently under the care of a physician? ___ Y, ___ N If yes, for what condition: ____________________________________

Date of your last physical exam: ___________________________

It is recommended by the ADA to have antibiotics prior to any dental treatment, including cleanings, if you have any history of Congenital Heart Disease (CHD), artificial/prosthetic valves or any previous infective endocarditis.
As office policy, if you have had any full joint replacement surgery within the last year of your appointment date, we require a clearance letter from your surgeon, as antibiotics may be recommended before treatment.

Do you use controlled substances (drugs)? ___ Y, ___ N

Do you use any form of tobacco? ___ Y, ___ N If yes, what type? ____________________, frequency? ______________________

Do you drink alcohol? ___ Y, ___ N If yes, how often? _____________________________

Has a doctor or dentist ever recommended you to take antibiotics before dental appointments? _____ Y, _____ N If yes, for what condition? ____ for how long? __________________

Women Only: Pregnant? ____ Y, ____ N Number of weeks: _______Taking birth control pills or hormone replacement ____Y, ____N

Allergies: Are you allergic to or have you had any type of reaction to:

	Yes	No	Specify Type of reaction
Local Anesthetics	☐	☐	______________________________
Aspirin	☐	☐	______________________________
Penicillin or other antibiotics	☐	☐	______________________________
Barbiturates, sedatives or sleeping pills	☐	☐	______________________________
Sulfa drugs	☐	☐	______________________________
Codeine or other narcotics	☐	☐	______________________________
Latex	☐	☐	______________________________

Do you have any of the following medical conditions?

	Yes	No		Yes	No
Cardiovascular Disease	☐	☐	Tuberculosis (TB)	☐	☐
Angina	☐	☐	Cancer	☐	☐
Congestive Heart Failure	☐	☐	Chemo/Radiation therapy	☐	☐
Damaged heart valves	☐	☐	Diabetes	☐	☐
Heart attack	☐	☐	Eating Disorder	☐	☐
Low blood pressure	☐	☐	GERD/Heartburn	☐	☐
High blood pressure	☐	☐	Thyroid problems	☐	☐
Pacemaker	☐	☐	Stroke	☐	☐
Abnormal bleeding	☐	☐	Glaucoma	☐	☐
AIDS or HIV infection	☐	☐	Hepatitis	☐	☐
Autoimmune disease	☐	☐	Liver or Kidney disease	☐	☐
Epilepsy	☐	☐	Fainting spells or seizures	☐	☐
Recurrent infections	☐	☐	Osteoporosis	☐	☐
Artificial joints	☐	☐	Herpes/Cold sores	☐	☐
Sickle cell disease/traits	☐	☐	Joint Replacements	☐	☐

Do you have any disease, condition or problem that was not listed above? ___ Y, ___ N

If yes, what is it? ____

What medications are you currently taking? ____