351 Wellesley Trade Lane, Suite 211, Cary, NC 27519

Welcome to West Cary Dental – Tell us About Yourself

Patient Information Today's Date: ____-____-_________

First Name: _________________ Middle Initial:_____ Last Name:______________________________

Preferred Name:________________

Marital Status: Single ( ) Married ( ) Separated/Divorced ( ) Other ( ) Gender: Male ( ) Female ( )

Social Security Number:_________________Date of Birth:______________________Age:______

Street Address: _____________________________

City: ________________________ State: ________ Zip: _____________

Phone- Home Number: ______-______-______ Phone- Cell Number:______-______-______

Phone- Work Number: _____-_____-_______

Email: ____

Additional Information

Occupation: ___________________________________ Student: Full-Time ( ) or Part-Time ( )

Employer:_____________________________________ School:____

Spouse's Name: ________________________________ Parent Guardian: ______________________________________

Emergency Contact Name: _______________________________________

Emergency Contact Phone Number: ____________________

How did you hear about our office? Internet/Blog: __________ Current Patient Name: _____________________________
Delta Dental: _______ Employer Intranet Site: _________ Website: _______ Other__________________________

Dental Insurance Information

Primary Insurance

Insured Name: ________________________________

Insured SS#:__________________________________

Insured Date of Birth: _________________________

Insured ID#: _________________________________

Employer Name: _____________________________

Relationship to Insured: Self ( ) Spouse ( ) Child ( ) Other ( )

Insurance Company:____________________________

Insurance Phone #:_____________________________

Group #:____________________

Secondary Insurance

Insured Name: ________________________________

Insured SS #:__________________________________

Insured Date of Birth: _________________________

Insured ID#:__________________________________

Employer Name: _____________________________

Relationship to Insured: Self ( ) Spouse ( ) Child ( ) Other ( )

Insurance Company:____________________________

Insurance Phone #:_____________________________

Group #:___________________

West Cary DENTAL
DR AMIT PATEL

Medical History

Patient Name: ____ Date: ____________

Physician's Name: ______________________ Phone: ______________ Date of Last Visit: ________

Have you had any serious illness or operations? ☐ Yes ☐ No
If yes,____

Have you had any metal rods, pins, implants or joints placed? ☐ Yes ☐ No

Have you ever had any surgical procedures/hospitalization? ☐ Yes ☐ No
If yes, ____

Have you had any abnormal bleeding associated with previous surgery, tooth extraction or trauma? ☐ Yes ☐ No

Are you taking any blood thinning medications? (Aspirin, Plavix, Coumadin, Heparin, etc.) ☐ Yes ☐ No

Do you take any antibiotic prophylaxis before your dental visit? ☐ Yes ☐ No

Have you ever been diagnosed with osteoporosis, or taken any bone altering/preserving medications? ☐ Yes ☐ No

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐No Taking birth control pills? ☐ Yes ☐ No

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

☐ Anemia	☐ Congenital Heart Defect	☐ Hepatitis	☐ Respiratory Disease
☐ Arthritis	☐ Cortisone Treatments	☐ High Blood Pressure	☐ Shortness of breath
☐ Artificial Heart Valve	☐ Diabetes	☐ HIV/AIDS	☐ Skin Rash
☐ Artificial Joints	☐ Epilepsy	☐ Jaw Pain	☐ Stroke
☐ Asthma	☐ Fainting	☐ Kidney Disease	☐ Swelling Feet/Ankles
☐ Blood Disease	☐ Glaucoma	☐ Liver Disease	☐ Thyroid Problems
☐ Cancer	☐ Headaches	☐ Osteoporosis	☐ Tobacco Habit
☐ Chemical Dependency	☐ Heart Problems	☐ Pacemaker	☐ Tuberculosis
☐ Chemotherapy	☐ Heart Surgery	☐ Radiation Treatment	☐ Ulcers
☐ Circulatory Problems	☐ Hemophilia	☐ Seizures	OTHER: ____________

Medications	Allergies	
List medications you are currently taking:	☐ Aspirin	☐ Penicillin
______________________________	☐ Barbiturates (sleeping pills)	☐ Sulfa
______________________________	☐ Codeine	☐ Latex
______________________________	☐ Local Anesthetic	☐ Erythromycin
______________________________	☐ Valium	☐ Other
______________________________	______________________________	

Authorization and Release

I certify that I have read and understand all health questions given to me to the best of my knowledge. All health questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits, otherwise payable to me. I understand that I am financially responsible for all charges whether or not paid by insurance. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

______________________________________ ____________ ______________

Signature of Patient or Legal Guardian Date Relationship to Patient

West Cary DENTAL
DR AMIT PATEL

Dental History

Reason for Today's Visit ______________________________ Date of last dental care: ____________

Former Dentist ______________________________ Date of last dental x-rays: ____________

Are you currently in pain?	☐ Yes	☐ No
Are you satisfied with your smile?	☐ Yes	☐ No
Are you happy with the color of your teeth?	☐ Yes	☐ No
Do your gums bleed when brushing?	☐ Yes	☐ No
Have you ever had any difficulty with dental work in the past?	☐ Yes	☐ No

If yes, explain ______________________________

Do you smoke or chew tobacco? ☐ Yes ☐ No
If yes, How much? ____________________ How long? ____________________

How would you describe your current dental health: ☐ Good ☐ Fair ☐ Poor
How often do you brush? ____________________ How often do you floss? ____________________

What is important to you about your dental visit today? ______________________________

Check (☐) if you have had problems with the following:

☐ Bad Breath	☐ Grinding Teeth	☐ Sensitivity to hot	☐ Sensitivity to cold
☐ Bleeding Gums	☐ Loose teeth or broken fillings	☐ Sensitivity to sweets	☐ Sensitivity to biting
☐ Clicking or popping jaw	☐ TMJ (jaw joint) pain	☐ Periodontal/Gum Treatment	☐ Food collection between teeth
☐ Reaction to local anesthetic	☐ Sores or growths in mouth		

Acknowledgement of Receipt of Notice of Privacy Practices

State and Federal laws requires us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with a Notice of Privacy Practices. Our Notice is available online. A copy can also be provided to you please ask one of our staff for a copy of the Notice.
I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding Privacy Practices.

List names of persons we can share your information we have on record.

Name: ______________________________ Relationship: ____________

Name: ______________________________ Relationship: ____________

______________________________ ____________
Signature of Patient or Legal Guardian Date

West Cary DENTAL
DR AMIT PATEL

Office Financial Policy

Thank you for choosing our practice for your dental healthcare needs. We are committed to providing you with the best possible care. We expect each patient, parent, or legal guardian to accept financial responsibility of the fees involved in the dental treatment of you and your family. Please read the financial information and sign. If you have any questions, please feel free to ask our staff.

1. We recommend optimal and ideal care for you regardless of dental insurance limitations.
2. Your insurance is a contract between you, your employer and the insurance company.
3. Co-payments and deductibles (for those with insurance) or full payment (for those without insurance) is due at the time of service.
4. You are responsible for all charges regardless of estimated insurance coverage. Claims not paid after 45 days will be billed to you for payment.
5. A finance charge of 1.5% (18% annually) is added to all balances great than 90 days old along with a $15.00 billing charge. If we must pursue payment through our attorney for collections, you will be responsible for all added fees.
6. There is a **$30** charge for all returned checks
7. There is a **$50** charge for short notice or less than 24 hour cancellations or no show appointments. **It is your responsibility to remember your appointment time**. However, if time permits we will remind you with a courtesy call.
8. Any appointments **15 minutes late** or more will be rescheduled and charged a $50 fee.

I certify that I have read and understand the above information.

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Signature of Patient or Legal Guardian Date