SeaSide Dentistry
252-764-2784

Thank you for giving us the privilege of serving you! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely. If you have any questions or need assistance, please ask us – we will be more than happy to help!

Patient Information

Name: _____ Nickname: _____ Date of Birth: _____ Sex: _____

SSN #: _____ Address: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

E-mail: _____

Check appropriate box: Minor [ ] Single [ ] Married [ ] Divorced [ ] Widowed [ ] Separated [ ] Other [ ]

Referred to our office by: _____

Responsible Party's Spouse

Name of Responsible Party's Spouse: _____ SSN #: _____ DOB: _____

Address (if different than patient): _____ City, State, and Zip: _____

Occupation: _____ Employer: _____

Employer's Address: _____ Phone: _____

Dental Insurance Information

Insurance Company: _____ Insured Name: _____

Insured DOB: _____ Relationship to Patient: _____

Subscriber #: _____ Group #: _____ Employer: _____

Insurance Co. Address: _____ Phone: _____

Medical Release of Information

I allow **Seaside Dentistry** to access all medical record, including the right to inspect and copy such records. **Initial**____

AUTHORIZATION shall be considered as continuing and you may rely upon it in all respects unless you have previously been advised by men in writing to the contrary. It is expressly understood by the undersigned and you are hereby authorized to accept a copy of photocopy of this medical authorization with the same validity as though an original has been presented to you.

Print Name: _____ Date: _____
Signature: _____ Date: _____

Patient Medical History

General Health: Good [ ] Fair [ ] Poor [ ]

Physician: _____ Office Phone: _____ Date of Last Exam: _____

Are you currently on any prescription or over the counter medication, vitamins, nutritional or herbal supplements? Yes [ ] No [ ]

If "**Yes**" please list medications and purpose:

_____ _____ _____

_____ _____ _____

Are you allergic to any medications? Yes [ ] No [ ] if "**Yes**" please circle or list

Penicillin Codeine Latex Local Anesthetics Sulfa Drugs Barbiturates Sedatives

Iodine Aspirin Any Metals

_____ _____

Please mark the ones that apply to you and your Medical History.

[ ] Need antibiotic coverage prior to dental work?

[ ] Artificial joint replacement or implant?

[ ] Undergone Radiation or IV Chemotherapy?

[ ] Use or have used tobacco products?

[ ] Subject to prolonged bleeding?

[ ] Family history of Diabetes?

[ ] Excessive thirst and/or urination?

[ ] Recent unusual weight loss?

[ ] Subject to fainting?

[ ] Recently hospitalized or past major surgeries?

[ ] (**Women**) currently pregnant?____ How Far? _____

[ ] (**Women**) currently nursing? _____

Please circle* Y *or* N *individually for each question:

Y	N	High Blood Pressure	Y	N	Heart Disease	Y	N	Osteoporosis
Y	N	Heart Attack	Y	N	Cardiac Pace Maker	Y	N	Chest Pains
Y	N	Rheumatic Fever	Y	N	Heart Murmur	Y	N	Long-term Steroid Treatment
Y	N	Swollen Ankles	Y	N	Artificial Heart Valves	Y	N	Scarlet Fever
Y	N	Fainting / Seizures	Y	N	Frequently Tired	Y	N	Tuberculosis
Y	N	Asthma	Y	N	Anemia	Y	N	Glaucoma
Y	N	Epilepsy	Y	N	Emphysema	Y	N	Liver Disease
Y	N	Leukemia	Y	N	Cancer (Type_____)	Y	N	Hemophilia
Y	N	Diabetes (Type:___) (AIC____)	Y	N	Arthritis / Rheumatism	Y	N	Respiratory Problems
Y	N	Kidney Disease	Y	N	Jaundice / Hepatitis (Type___)	Y	N	Mitral Valve Prolapse
Y	N	AIDS / HIV Infection	Y	N	Stomach Troubles / Ulcers	Y	N	Eating Disorders
Y	N	Thyroid Problems	Y	N	Sexually Transmitted Disease	Y	N	Neck or Back Problems

Type: _____

Do you have other medical conditions which is not listed? Yes [ ] No [ ] if "**Yes**" please list

_____

Signature: _____ **Date:** _____ **Staff:** _____

Preferred Pharmacy: _____ **Address:** _____

City: _____ **State:** _____ **Zip Code:** _____

Emergency Contact

Name of Relative or Person NOT LIVING with you:_____Relationship to you:_____

Phone: _____ Address: _____

Dental History

Name of Previous Dentist:_____ Last Visit?_____ Reason for today's visit?_____

Have you ever had serious problems associated with a previous dental treatment? Yes [ ] No [ ]

If "**Yes**" explain _____

How often do you brush?_____ How often do you floss?_____ How often do you do cleanings? _____

What dental aids do you use? Floss [ ] Toothpick [ ] Water Pick [ ] Electric/Sonicare Toothbrush [ ] Other [ ]

Please answer **Yes [ ]** *or* **No [ ]**.

Are you hesitant to come to the Dentist?	Yes [ ] No [ ]	Do you snore or have trouble sleeping?	Yes [ ] No [ ]
Do your gums bleed during brushing/flossing?	Yes [ ] No [ ]	Would you like to have a whiter/brighter smile?	Yes [ ] No [ ]
Do you have a bad taste or odor in your mouth?	Yes [ ] No [ ]	Would you like to have straighter teeth?	Yes [ ] No [ ]
Does food get stuck between your teeth?	Yes [ ] No [ ]	Do you have missing teeth you want replaced?	Yes [ ] No [ ]
Do you have dental fillings that you don't like?	Yes [ ] No [ ]	Do you have loose dentures or partials?	Yes [ ] No [ ]
Do you believe in the benefits of fluoride?	Yes [ ] No [ ]	Are you wearing away your teeth?	Yes [ ] No [ ]

What do you **NOT** like about your smile? _____

What can we do to make your smile look better? _____

Consent for Treatment

I certify that I have read and understand the above information of the best of my knowledge. The above questions have been accurately answered. I understand that providing the incorrect information can be dangerous to my health. I hereby authorize SeaSide Dentistry to administer and perform the necessary procedures, such as x-rays, anesthetics and dental treatment deemed necessary or advisable with the diagnosis of my dental condition. I understand there are certain risks inherent in dental treatment, such as but no limited to: pulpal sensitivity or damage, tissue swelling or bruising, soreness of jaw, paresthesia and other procedure specific risks.

Insurance Release: I authorize release of information regarding my dental treatment to my insurance carrier. I agree to be responsible for payment on services rendered during my ineligible insurance period and any balance not paid by the insurance carrier. I understand that insurance are billed as a courtesy and that I am ultimately responsible for all costs of treatment.

Responsibility for Payment: In the event that his matter is turned over to a collection agency or attorney for collection of any of the fees due herein; I hereby agree to pay all collection agency fees and all attorney fees, whether or not a lawsuit is instituted. I also acknowledge that I would be responsible for all court costs incurred in making collection sums due and unpaid for the work herein set forth/

Signature: _____ Date: _____

Children or Minors

Because (name of child)_____ is a minor, it is necessary that signed permission be obtained from a parent or guardian before any dental services are rendered. Such authorization is hereby granted. Furthermore, I agree to be responsible for any bills incurred on behalf of this child during their treatment.

Signature: _____ Date: _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____ _____Telephone _____

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

CONTACT OFFICER: Carlo Cruz, BUSINESS ADMINISTRATOR TELEPHONE: 252-764-2784 FAX: 252-764-2790

ADDRESS: 1165 Cedar Point Blvd. Suite P, Cedar Point, N.C. 28584

PATIENT INITIALS/SIGNATURE

Patient's Initials_____ I have received a copy of this office's privacy practices and have had full opportunity to read and consider the contents of this Consent form and Notice of Privacy Practices.

Patient's Initials_____I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations.

Patient's Signature_____Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name:

Relationship to Patient:

_____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

RESTRICTIONS FOR RELEASE OF PROTECTED HEALTH INFORMATION

I am exercising my right to restrict the disclosures made on my protected health information. I have listed below specific instructions for this office to follow regarding the disclosure of my protected health information. I understand these restrictions will remain in effect until I inform this office in writing otherwise.

Restriction Instructions: _____

_____

Patient's Name: _____ Date_____

Authorized Signature_____

Relationship of Authorized Person, if other than Patient: _____

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HIPAA Right of Access Form for Family Member/Friend

I, _____, direct my health care and medical services providers and payers to disclose and release my protected health information described below to:

Name: _____ Relationship: _____

Contact information:
Address: _____
Phone Number: _____

Health Information to be disclosed upon the request of the person named above –
(Circle either **A** or **B**):

A. Disclose my complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions)

OR

B. Disclose my health record, as above, BUT do not disclose the following (circle as appropriate):

Mental health records Communicable **diseases (including HIV and AIDS)**
Alcohol/drug abuse treatment

Other (please specify): _____ _____

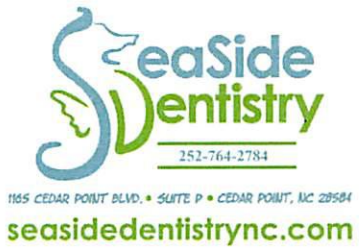
Form of Disclosure (unless another format is mutually agreed upon between my provider and designee):
An **Electronic record** or **Hard copy**

This authorization shall be effective until (Check one): All past, present, and future periods, OR Date or event: _____ unless I revoke it.
(NOTE: You may revoke this authorization in writing at any time by notifying your health care providers, preferably in writing.)

_____ _____
Name of the Individual Giving this Authorization Date of birth (MMDDYYYY)

_____ _____
Signature of the Individual Giving this Authorization Date (MMDDYYYY)

Note: HIPAA Authority for Right of Access: 45 C.F.R. § 164.524



RECORDS RELEASE

I, _____ am requesting that your office release the following information to Donna Gentry, D.D.S.

____ Bitewing or PA x-rays taken in the last 18 months.

____ Panoramic films taken within the last 5 years.

____ Treatment notes

Please release this Information on the following family members:

_____

_____

_____

_____

_____

Previous Dentist's Information:

_____

_____

_____

_____

_____

Please mail, email or Fax to:

Donna M. Gentry D.D.S.

1165 Cedar Point Blvd. Suite P

Cedar Point, NC 28584

dentistry@seasidedentistrync.com

Fax: 252-764-2790

Signature: _____ Date: _____

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Authorization – Non-Parent/Guardian to Accompany Patient

Periodically there may be times when you are unable to bring your child to the office for an appointment and need to rely on a family member or friend. We understand these circumstances; however, we must have a written authorization letter allowing this person to accompany your child(ren). The person brining your child will need to present a photo identification at time of service.

This authorization gives the person permission to bring your child(ren) in, speak to the dentist, given authorization for treatment for certain procedures, receive prescriptions, and make general health decisions.

I, _____, give the person(s) listed below permission to bring my child to SeaSide Dentistry and to discuss and share medical/dental information about my child. I further authorize them to see all necessary records and make health care decisions of a routine nature as determined at the sole discretion of the SeaSide Dentistry provider.

I also give them authority to make more serious or urgent treatment decisions in the event I cannot be reached or where it is of an emergency nature where there is not sufficient time to seek out my specific consent.

Child's Name: _____ DOB: _____
Child's Name: _____ DOB: _____
Child's Name: _____ DOB: _____

(IF ONLY PARENTS ARE ALLOWED TO BRING CHILD IN, PLEASE INDICATE 'NONE')

_____ _____
Name of Person (allowed to bring child) Relationship

_____ _____
Name of Person (allowed to bring child) Relationship

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CREDIT / DEBIT CARD AUTHORIZATION FORM

I hereby authorize SeaSide Dentistry to submit electronic claims on my behalf and agree to assign the payment directly to SeaSide Dentistry. I understand that my dental benefit reimbursement plan is an agreement between my insurance company and myself. I further understand that I am responsible for any service fees or balances that may not be covered by my dental benefit plan and any differences resulting from the amount billed, including estimated copayments already collected, and the amount covered by my plan. I authorize SeaSide Dentistry to debit my credit card account for payment of any account balance remaining with my permission; once the insurance check is posted to my account. (Charges are not to exceed $75.00). In the case that the balance exceeds $75.00, I will be notified before any charges are made. I also understand that a receipt will be sent in the mail to me for each transaction along with an explanation.

PATIENT NAME _____ DATE _____

SIGNATURE _____ PHONE # _____

RESPONSIBLE PARTY NAME _____ ZIP CODE _____

Please circle credit card: MasterCard Visa Discover American Express

CARD ACCOUNT # _____ EXP. DATE _____ CC SEC. CODE _____

CARDHOLDER SIGNATURE _____ DATE _____

OFFICE INITIAL _____

WAIVER TO SIGN

If you are unwilling to give us credit card authorization, you agree to pay in full for all services and the insurance company will reimburse you directly.

PATIENT SIGNATURE _____ DATE _____

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SMILE EVALUATION

1. Do you like the way your teeth look? Yes ( ) No ( )

Explain: _____

2. Are you happy with the color of your teeth? Yes ( ) No ( )

Explain: _____

3. Would you like for your teeth to be whiter? Yes ( ) No ( )

Explain:_____

4. Would you like your teeth to be straighter? Yes ( ) No ( )

Explain: _____

5. Do you have spaces between your teeth that you would like closed?

Yes ( ) No ( )

If so, Upper_____Lower_____Both_____?

6. Would you like your teeth to be longer? Yes ( ) No ( )

Explain: _____

7. Do you like the shape of your teeth? Yes ( ) No ( )

Explain: _____

8. Do you have missing teeth that you would like replaced?

Yes ( ) No ( )

Explain:_____

9. Do you have old silver fillings that you would like to be replaced with tooth-colored fillings? Yes ( ) No ( )

10. If you could change anything about your smile, what would you change?

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PAIN QUESTIONNAIRE

When did the pain start? _____

Can the pain be described as Sharp [ ] Dull [ ] Throbbing [ ] Constant [ ] Comes and Goes [ ]

On scale from 1 to 10, describe the intensity of the pain: 1 2 3 4 5 6 7 8 9 10

Where is the location of the pain? _____

Does the pain spread to other areas? _____

What remedies have you tried to alleviate the pain? _____

Is it troublesome to chew food? Yes [ ] No [ ]

Is the area sensitive to (select all that apply): Touch [ ] Hot [ ] Cold [ ] Sweet Foods [ ]

Does the pain wake you up from sleep? Yes [ ] No [ ]

Do you have any of the following conditions?

Prosthetic cardiac valve or prosthetic material used for cardiac valve repair Yes [ ] No [ ]

History of infective endocarditis Yes [ ] No [ ]

Cardiac transplant that develops cardiac valvulopathy Yes [ ] No [ ]

The following congenital (present from birth) heart disease:

Unrepaired cyanotic congenital heart disease, including palliative shunts and conduits Yes [ ] No [ ]

A completely repaired congenital heart defect with prosthetic material or device, whether placed by surgery or by catheter intervention, during the first six months after the procedure Yes [ ] No [ ]

Any repaired congenital heart defect with residual defect at the site or adjacent to the site of a prosthetic patch or a prosthetic device Yes [ ] No [ ]

Have you ever been instructed to take medication prior to a dental appointment? Yes [ ] No [ ]

If "**YES**" please list all medications taken: _____

Have you had any joint replacement surgery within the last 6 months? Yes [ ] No [ ]

Signature: _____ Date: _____