



Ricky Carlyle, DDS

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PATIENT INFORMATION

Name _____ Birthdate ___/___/___ Age _____

Social Security Number ___ - ___ - _____

Home Phone Number (____) _____ Cell Phone Number (____) _____

Email Address _____

Which Phone Number would you like for us to use to confirm appointments? (Circle) Home Work Cell

Street Address (required) _____

City _____ State _____ Zip _____

Circle Appropriate: Minor Single Married Divorced Widowed Separated

Patient's Employer _____ Work Phone (____) _____

Spouse's Name _____ Employer _____

Work Phone (____) _____ Cell Phone (____) _____ Email _____

Person to Contact In the Case of an Emergency _____ Phone (____) _____

Whom May We Thank For Referring You _____

IF PATIENT IS A MINOR, PROVIDE INFORMATION

Name of Person Responsible for This Account _____ Relationship _____

Is the Responsible Party Currently a Patient in our Office: YES NO (If no, then continue to next line)

Address _____ City _____ State _____ Zip _____

Social Security Number ___ - ___ - _____ Home Phone Number (____) _____ Work Phone (____) _____

Cell Phone (____) _____ Email _____

Employer _____ Employer Address _____

HEALTH HISTORY

Date of last health care exam: _____ What was this exam for? _____

Have you been hospitalized in the last 5 years? (Please circle) No Yes

If yes, reason: _____

Are you currently receiving care? No Yes If yes, nature of care: _____

Please list all the names and phone numbers of the physicians who are currently providing you care:

1. _____
2. _____
3. _____
4. _____

For the following questions circle Yes or No. Your answers are for our records only and will be confidential. Please note that during your initial visit you will be asked some questions about your responses. Our team may ask additional questions concerning your health.

Anemia or Blood Disorder?	No	Yes	Hepatitis, Any Form	No	Yes
Arthritis, Rheumatism or other inflammatory disease?	No	Yes	Joint Replacement? When placed?	No	Yes
Asthma	No	Yes	Kidney Disease	No	Yes
Abnormal Bleeding from a cut?	No	Yes	Liver Disease (including Jaundice)	No	Yes
Cancer or Tumor?	No	Yes	Sore/Enlarged Lymph Nodes	No	Yes
Diabetes	No	Yes	Psychosis	No	Yes
Emphysema or other Respiratory/Lung Illnesses	No	Yes	Previous Biopsies	No	Yes
Epilepsy	No	Yes	Radiation or Chemotherapy Treatment	No	Yes
Fainting or Dizzy Spells	No	Yes	Rheumatic Fever	No	Yes
Glaucoma	No	Yes	Slow-Healing Mouth Sores	No	Yes
Abnormal Heart or Previous Bacterial Endocarditis	No	Yes	Unintentional Weight Loss/Gain	No	Yes
Heart Valve (artificial) or Heart Transplant	No	Yes	H.I.V. Infection/AIDS or ARC	No	Yes
Congenital Heart Disease	No	Yes	Venereal Disease	No	Yes
Heart Disease, Heart Attack, Heart Surgery	No	Yes	Other Conditions	No	Yes
Heart Stent? When placed?	No	Yes	Recurrent Illnesses	No	Yes

Are you taking any of these medications?

Pre-medication before dental treatment?	No	Yes	Tagamet® (cimetidine) or Prilosec® (omeprazole)?	No	Yes
Antacids?	No	Yes	Cardizem® (diltiazem) or Calan, Isoptin® (Verapamil)?	No	Yes
Dilantin® or Tegretol®	No	Yes	Serzone® (nefazodone)	No	Yes
Barbiturates (any)	No	Yes	Diflucan® (fluconazole) or Sporonox® (itraconazole)	No	Yes
St. John's Wort or Kava-Kava?	No	Yes	Biaxin® (clarithromycin)	No	Yes
Have you been treated with Bisphosphonate drugs (Fosamax®, Aredia®, Zometa®, Actonel®, and Boniva®)? If so, when did the treatment begin? When did the treatment end?				No	Yes
Have you ever taken any prescription drugs such as fen-phen for weight loss?				No	Yes
Do you consume grapefruit juice, grapefruits or grapefruit extract?				No	Yes

Please list any medications you are currently taking and dosages:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Please list any dietary or herbal supplements you are taking, and for what purpose:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Women: Are you pregnant? No Yes
 If no, are you planning a pregnancy in the near future? No Yes
 Are you a nursing mother? No Yes
 Are you taking birth control pills? No Yes

Abnormal Blood Pressure? (Please circle) No Yes
 Have you ever received a diagnosis of "high blood pressure"?
 What is your normal blood pressure? ____ / ____ Today: ____ / ____

Are you allergic or have you had a reaction to:
 a. Local anesthetics No Yes
 b. Penicillin or other antibiotics No Yes
 c. Aspirin, Ibuprofen or Tylenol No Yes
 d. Codeine, Valium® or other sedatives..... No Yes
 e. Latex or Metal No Yes
 f. Other (please specify) _____

Do you use tobacco? If yes, circle type: smoke chew How much per day? For	No	Yes
how long?		
Do you want to quit using tobacco?	No	Yes
Do you consume alcohol? If yes, approximately how many alcoholic beverages per week?	No	Yes
Do you use any mood altering drugs other than those previously listed?	No	Yes

Weight	Meals per Day	Dietary Restrictions	Food Allergies

Sugar in your diet (circle one): none slight moderate high

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health and medication.

 Patient (Print Name) Patient Signature Date

DOCTOR'S USE ONLY

Comments on patient interview concerning medical history:

Significant findings from questionnaire or oral interview:

 Doctor (Print Name) Doctor Signature Date

INSURANCE AUTHORIZATION

I authorize my insurance company to pay the dentist all insurance benefits rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.

By checking the box, I consent the the listed above.

SERVICES AND FINANCIAL POLICY

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the Administration Form.

CANCELLATION POLICY

We understand that unplanned issues can come up and you may need to cancel an appointment. If that happens, we respectfully ask for scheduled appointments to be cancelled at least 24 hours in advance.

Our doctors & hygienists want to be available for your needs and the needs of all our patients. When a patient does not show up for a scheduled appointment, another patient loses an opportunity to be seen. Although we have always had a cancellation policy, circumstances have caused us to enforce a policy of charging for no-show appointments, and those appointments not cancelled within 24 hours.

BROKEN APPOINTMENT POLICY - after two broken appointments with less than 24 hrs notice, you will receive a warning letter; after three broken appointments with less than 24 hrs, you will be dismissed from the practice. This will be determined at our discretion.

Thank you for being a valued patient and for your understanding and cooperation. This policy will enable us to open otherwise unused appointments to better serve the needs of all patients.

By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the Cancellation Policy.

Signature _____ Date _____

ACKNOWLEDGEMENT OF PRIVACY POLICY

Patient Name & Address: _____

I have received a copy of the Notice of Privacy Practices for the above named practice or have the option to request one at any time.

Signature: _____ Date: _____

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- An emergency existed & a signature was not possible at the time.
- The individual refused to sign.
- A copy was mailed with a request for a signature by return mail.
- Unable to communicate with the patient for the following reason:

- Other: _____

Prepared By _____

Signature: _____ Date: _____