PERSONAL INFORMATION

Mr./Mrs./Ms/Miss/Dr. ____

Last *First* *Middle Initial*

Date of Birth _____/_____/_____ Social Security # ______________________

Address ____________________________________ City _____________ State _____ Zip _______

Home Ph _________________ Work Ph ______________ **Email**__________________________

Have we seen anyone else in your family? _______ Your Preferred Name: ___________________

WHO MAY WE THANK FOR REFERRING YOU? ____

MEDICAL HISTORY

Do you have or ever had any of the following? Please check either Yes or No as applicable.

Bleeding Problems	☐ No	☐ Yes	Diabetes	☐ No	☐ Yes	Anxiety / Nervous	☐ No	☐ Yes
Hepatitis	☐ No	☐ Yes	Rheumatic Fever	☐ No	☐ Yes	Depression	☐ No	☐ Yes
High Blood Pressure	☐ No	☐ Yes	Heart Murmur	☐ No	☐ Yes	HIV/AIDS	☐ No	☐ Yes
Artificial Joints	☐ No	☐ Yes	Pre-Medication	☐ No	☐ Yes	Kidney Problems	☐ No	☐ Yes
Are You Pregnant	☐ No	☐ Yes	Asthma	☐ No	☐ Yes	Radiation Therapy	☐ No	☐ Yes
Cancer	☐ No	☐ Yes	Epilepsy, Seizures	☐ No	☐ Yes	Migraines	☐ No	☐ Yes

ALLERGIES – HYPERSENSITIVITIES

Penicillin	☐ No	☐ Yes	Aspirin	☐ No	☐ Yes	Codeine	☐ No	☐ Yes
Anesthetic	☐ No	☐ Yes	Latex	☐ No	☐ Yes	Other	☐ No	☐ Yes

Are there any other health related issues you would like to make us aware of? _________________________

Have you been hospitalized in the last two years? ☐ No ☐ Yes If yes, please explain. __________________

Please list any drugs (Rx or OTC) currently being taken. ____

I hereby authorize Raleigh Dental Arts to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by Raleigh Dental Arts to make a thorough diagnosis of my dental needs. I also authorize Raleigh Dental Arts to prescribe any and all forms of medication, and perform any therapy that may be indicated and agreed upon.

I further authorize the release of any information, including the diagnosis and the records of any treatments or examinations rendered, to my insurance company or consulting professionals. The release to the insurance company is solely for the purpose of facilitating the billing and reimbursement directly to the dentist of insurance benefits under which I am entitled.

I further authorize the use of my name or a photograph(s), video, slides, or any other image as may be necessary of me, with or without my given name, or with a fictitious name for advertising, education, or any other lawful purpose and I release and forever discharge him from any claim, demands, or liability on account of such use or for the quality of the reproduction of the photograph or photocopy provided.

I have received a copy of this office's Notice of Privacy Practices.

Signature of patient ____ **Date** ______________

INSURANCE AUTHORIZATION

At Raleigh Dental Arts we want to help you maximize your insurance benefits to allow you to have the best dental care possible.

Dental Insurance

Insurance Carrier ________________________________ Employer ___________________________

Subscriber Name ________________________________ Subscriber ID ________________________

Subscriber Date of Birth ___________________________ Group # ____________________________

Medical Insurance

Insurance Carrier ________________________________ Employer ___________________________

Subscriber Name ________________________________ Subscriber ID ________________________

Subscriber Date of Birth ___________________________ Group # ____________________________

Dental Insurance Benefits

Raleigh Dental Arts will file your dental/medical claim as a courtesy and accept assignment of benefits. Please be aware that some services provided may be non-covered services or considered above the usual and customary. You are responsible for anything not covered by dental insurance.

Medical Insurance Benefits

Raleigh Dental Arts may file medical insurance for many of the diagnostic and surgical procedures as a courtesy and accept assignment of benefits. Please be aware that some of the services provided may be processed towards your deductible. You are not responsible for medical benefits that are not covered or deemed medically unnecessary.

I understand that I am ultimately responsible for payment regardless of my insurance company's willingness to pay a benefit.

Signature of patient ____ Date _______________