



# 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

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

## 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:

	<b>Yes</b>	<b>No</b>	<b>Specify Type of reaction</b>
Local Anesthetics	<input type="checkbox"/>	<input type="checkbox"/>	_____
Aspirin	<input type="checkbox"/>	<input type="checkbox"/>	_____
Penicillin or other antibiotics	<input type="checkbox"/>	<input type="checkbox"/>	_____
Barbiturates, sedatives or sleeping pills	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sulfa drugs	<input type="checkbox"/>	<input type="checkbox"/>	_____
Codeine or other narcotics	<input type="checkbox"/>	<input type="checkbox"/>	_____
Latex	<input type="checkbox"/>	<input type="checkbox"/>	_____

Do you have any of the following medical conditions?

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

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? \_\_\_\_\_