Carolina Center for Dental Implants and Periodontics

Patient Information

Patient Name: ____ Date:_____________
Last, First MI (Preferred Name)
Gender: __________ Family Status: ________________Birth Date ___________ Height ____ Weight _______
Phone (Cell): ________________ (Home): ______________
Emergency Contact____
Preferred appointment times: ☐ Morning ☐ Afternoon ☐ Any Time ☐M ☐T ☐W ☐T
Address: ____
Street Apartment #
____
City State Zip Code

Health Information

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS
- ☐ Allergies ___________ ___________
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Pregnancy Due date:_________
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy

OTHER:
- ☐ ________________
- ☐ ________________

Have you ever been told you have a heart condition, heart murmur, or blood vessel diseases? ☐ Yes ☐ No
Are you allergic to medicine, drugs, dental anesthetics, or adhesive tape? ☐ Yes ☐ No
Have you ever had any bleeding problems, blood disorders, or a blood transfusion? ☐ Yes ☐ No
Have you had breathing problems, asthma, emphysema, or chronic cough? ☐ Yes ☐ No
Do you or have you ever smoked or used smokeless tobacco products? ☐ Yes ☐ No
Have you been placed on a steroid drug in the past two years for any reason? ☐ Yes ☐ No
Have you been told to take antibiotics before dental visits? ☐ Yes ☐ No
Are you now under the care of a physician? ☐ Yes ☐ No
If yes, please explain: ____
Name of Physician: ______________________________________ Phone: ________________
Do you have any health problems that need further clarification? ☐ Yes ☐ No
If yes, please explain: ____
List all prescriptions, medicines, supplements, vitamins or pills you take:_____________________________________
____
____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

____ Date: ________________
Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient ☐ Dental Office ☐ Google ☐ Other __
Name of person or office referring you to our practice: _______________________________________
Name of your General Dentist: ____

Employment Information

Employer Name: ______________________ Occupation: ______________________

Address: ____
Street City, State Zip Code Phone

Insurance Information

Primary

Name of Insured: ______________________ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: ____________ ID #: ____________ Group #: ____________

Insured's Address: ____
Street City State Zip Code

Insured's Employer Name: ____

Address: ____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other ____________

Insurance Plan Name and Address: ____

____

Secondary

Name of Insured: ______________________ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: ____________ ID #: ____________ Group #: ____________

Insured's Address: ____
Street City State Zip Code

Insured's Employer Name: ____

Address: ____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other ____________

Insurance Plan Name and Address: ____

____

Consent for Services

Dr. Patrick McDonough and staff are proud to be a team whose primary mission is to deliver the finest and most comprehensive periodontal services available today. We are concerned about your dental care and want to ensure you that it is performed in the most responsible manner. In order to assist you with the investment in your dental health, we have outlined our payment policy.

Forms of Payment

Payment is due in **FULL** at the time of service**.** For your convenience we accept cash, checks, money orders, and credit card payments (MasterCard, VISA, CareCredit).

CareCredit is outside financing with 0% interest. You can apply for CareCredit by calling 1-800-365-8295 or online at https://www.carecredit.com.

Additionally, we grant a 5 percent discount to all patients who pay with cash or check for their procedures except maintenance appointment.

Returned Check Policy

There will be a $30.00 handling fee for any returned checks.

Insurance Policy

We are not in network with any dental insurance companies. As a courtesy, our Insurance Coordinator will file your claims and provide reasonable information requested by your carrier in a timely manner. The insurance company will then **reimburse you** for the procedures that were covered.

It is your responsibility to be aware of the effective dates, waiting periods, yearly maximums, and any missing tooth clauses which may affect your coverage. We do our best to provide you with accurate coverage estimates based on information available to us. Many insurance companies will not give out fees until after the treatment is completed. However, we can file a pre-treatment estimate with your insurance prior to treatment. As a courtesy, we ask that you keep us informed of any change to your insurance. It is important that all information about you and your insurance is current.

Missed Appointment Policy

The nature of our service is such that we reserve time especially for you. If you are unable to keep your appointment, cancellations should be made **two business days** prior to your non-surgical appointment. Changes to any surgical appointments require a notice of **one week**. This allows us to be of service to other patients.
Broken surgical appointment: $250.00, Broken maintenance appointment: $60.00, All other appointments: $80.00

Medicare Opt-out

Is a contract between a provider, beneficiary and Medicare where the provider or beneficiary **does not** file a claim to Medicare. The physician or practitioner bills the beneficiary directly and neither party is reimbursed by Medicare.

I have read the Carolina Center for Dental Implants and Periodontics Patient Financial Policy and I understand and agree to it.

______________________________ Date: ____________ Relationship to Patient: ____________
Signature of patient, parent or guardian