PATIENT INFORMATION FORM: DATE________________________________

Please Print

Patient Name____ Birth Date______________________________

Address____

Telephone #'s HOME ______________________ WORK______________________ CELL____________________

E-mail address____

Place of Employment__________________________________ SS#________________________________

Drivers License#_______________________________ Marital Status__________ S M D ______

"Have you ever been a patient at this office before?" Yes No

List all family members below who have been treated at our office before:

____

Husband (print father's information if patient is a minor)	**Wife** (print mother's information if patient is a minor)
Full Name	Full Name
Address	Address
City, Zip	City, Zip
Home & Work Phone	Home & Work Phone
Birthdate SS# Employer	Birthdate SS# Employer

In Case of Emergency Please Notify_________________________ **Phone**____________________

When was the last time:

You went to the dentist? __________________You had a complete exam?________________

You had a full mouth set of x-rays? ________You had an oral cancer screening? ______________

You had your teeth cleaned? ____________ You had a periodontal examination? ______________

Are you having PROBLEMS now? WHAT?	YES	NO
Is your present dental health POOR?	YES	NO
Do you wear DENTURES? (Partials or Full)	YES	NO
Are you UNHAPPY with your denture?	YES	NO
Would you like to know more about PERMANENT REPLACEMENTS?	YES	NO
Are you APPREHENSIVE about dental treatment?	YES	NO
Have you had any PERIODONTAL (GUM) treatments?	YES	NO
Do your gums BLEED, or feel TENDER or IRRITATED?	YES	NO
Have you ever had gum disease or been advised to have gum treatment?	YES	NO
Are your teeth SENSITIVE to hot, cold, sweets, pressure?	YES	NO
Are you UNHAPPY with the APPEARANCE of your teeth?	YES	NO
Are you have aware of GRINDING or CLENCHING your teeth?	YES	NO
Do you have HEADACHES, EARACHES, or NECK PAIN?	YES	NO
Do you have LOOSE, TIPPED, or SHIFTING teeth?	YES	NO
Have you worn BRACES on your teeth? (ORTHODONTICS)	YES	NO
Do you have DISCOLORED teeth that bother you?	YES	NO
Would you like your smile to LOOK BETTER or DIFFERENT?	YES	NO
Do you have problems with teeth/fillings BREAKING?	YES	NO
Do you REGULARLY use DENTAL FLOSS?	YES	NO
Would you like us to help you learn proper methods of Home Care, so you can stop dental problems in your mouth?	YES	NO

Name of Previous Dentist:____

City:____ **State:**______________

How do you feel about your teeth?____

Please RANK the following in order in which they would keep you from having dental work

FEAR of pain	#	LACK of concern	#
COST of treatment	#	MISSING work time	#

CONSENT:

I authorize Tri City Family Dentistry to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. I also authorize to have taken x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the treating dentist to make a thorough diagnosis of my dental needs. I also authorize this office to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents emodies a certain risk. I authorize the treating dentist and staff to release my dental/ medical histories and other information to my insurance company and/or other health professional.

Patient or Guardian sign below:

____

HIPAA Notice

"The Notice of Privacy Practices is posted in this office. A copy of this notice is available upon request. In signing below, I acknowledge that I have been made aware of and agree to the policies outlined in this notice."

____

PATIENT MEDICAL INFORMATION

Tri City Family Dentistry
136 Reservation Dr.
Spindale, NC 28160

NAME____ **DATE OF BIRTH**_____/___/_____

Are you under a physician's care now? Why? Who? __________________________________ YES NO

Have you ever been hospitalized or had a major operation? Discuss______________________ YES NO

____

Have you ever had a serious injury to your head or neck? Discuss_______________________ YES NO

____

Are you taking any medications, pills or drugs? What? ______________________________ YES NO

____PHARMACY______________

Do you take or have you taken Fosamax or Bisphosphonate drugs? _____________________ YES NO

Are you on a special diet? Discuss____ YES NO

Are you allergic to any medications or substances? Please circle below YES NO

Aspirin Penicillin Codeine Acrylic Metal Latex Rubber

Local Anesthesia Other____

Are you taking any Anticoagulant? (blood thinners or aspirin daily)_____________________ YES NO

Do you smoke? ____________How long?______________________________________ YES NO

Do you use snuff of chew tobacco? __________How long?_____________________________ YES NO

Do you have any sores or growths in your mouth? _________________________________ YES NO

Do you drink beer, wine, or liquor? ____ YES NO

Have you ever taken the DIET drugs PHEN-FEN or REDUX (may need antibiotic prophylaxis)____ YES NO

***Drugs such as cocaine, "crack", "speed", narcotics, marijuana, etc. can cause fatal reactions with local anesthetics which may be used in the dental office. Do you use any substances, which may react with local anesthetics? (Information is confidential)** YES NO

WOMEN (Please check): ☐Pregnant/trying to get pregnant ☐Nursing

☐ Taking oral contraceptives (birth control) YES NO

If pregnant when is baby due? ________________Do you have children? How many?______

Check any of the following conditions which you have had or currently have:

If yes to any of the starred conditions…*Antibiotic pre-medication may be required

☐ Heart Trouble/Disease	☐ Bruise Easily	☐ Asthma	☐	☐ Drug Addiction
☐ Irregular Heart Beat	☐ Anemia	☐ Emphysema	☐ Swelling of limbs	☐ Fever Blisters
☐ Angina/ Chest Pain	☐ Excessive Bleeding	☐ Tuberculosis	☐ Kidney Problems	☐ Herpes
☐ Heart Attack/Failure	☐ Sickle Cell Disease	☐ Cancer	☐ Renal Dialysis	☐ Stroke
☐ Congenital Heart Disorder	☐ Hemophilia (Bleeding Problem)	☐ X-ray Treatment (Radiation)	☐ Thyroid Disease	☐ Convulsions
☐ Mitral Valve Prolapse*	☐ Leukemia	☐ Chemotherapy	☐ Arthritis/Gout	☐ Epilepsy/Seizures
☐ Heart Murmur*	☐ Hepatitis A, B, or C	☐ Reflux/ GERD	☐ Osteoporosis	☐ Glaucoma
☐ Scarlet Fever	☐ Blood Transfusion	☐ Stomach/Intestinal Disease	☐ Rheumatism	☐ Tumors or Growths
☐ Rheumatic Fever*	☐ Yellow Jaundice	☐ Ulcer	☐ Pain in Jaw Joint	☐ Depression
☐ Artificial Heart Valve*	☐ Lung Disease	☐ Recent Weight Loss	☐ Cortisone Medicine	☐ Nervousness
☐ Heart Pace Maker*	☐ Breathing Problem	☐ Frequent Diarrhea	☐ Artificial joint*	☐ Psychiatric Care
☐ Heart Surgery*	☐ Shortness of Breath	☐ Diabetes	☐ Venereal Disease	☐ Alzheimer's
☐ High Blood Pressure	☐ Frequent Cough	☐ Excessive Thirst	☐ AIDS	☐ Allergies (Meds)
☐ Low Blood Pressure	☐ Hay Fever	☐ Hypoglycemia	☐ HIV Positive	☐ Allergies (Pollen)
☐ Blood Disease	☐ Sinus Trouble	☐ Liver Disease	☐ Genital Herpes	☐ Hives or Rash

Have you ever had any other serious illness not checked above? Discuss__________________ YES NO

To the best of my knowledge, all of the preceding answers are correct. If, I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail.

X____ Date_______________

PATIENT SIGNATURE (PARENT OR GUARDIAN)

Cancellation Policy of
Tri City Family Dentistry

Because of excessive missed appointments we are providing each patient with our written cancellation policy. Missed appointments include: 1) not showing for an appointment and 2) canceling an appointment without a full 24 hours notice. If you arrive late for an appointment, that is the same as missing an appointment. Missed appointments have affected our practice in a negative way, causing loss of daily production as well as the inability to offer open appointment times to others. If we know ahead of time you will not be keeping an appointment, we are able to give that appointment to someone with a dental need or emergency. We appreciate having you as a patient. Thank you for honoring our cancellation policy.

We attempt to remind you by telephone prior to your appointment but please do not depend on this courtesy. It is ultimately your responsibility to be at an appointment. If we are unable to contact you by phone, your appointment card will serve as the confirmation of your appointment and implies your obligation to be present. If you made your appointment by phone, it is still your responsibility to remember and keep your appointment. That time has been reserved especially for you.

If you cancel an appointment without 24 hours notice, you will be charged a missed appointment fee. This fee varies depending on what type of appointment you were scheduled for, but will be no less than $45. If your appointment is scheduled on a Monday, we appreciate a call by the Thursday prior to your appointment to change or cancel it. If you cancel or do not show for 2 appointments within a two year period, you may be dismissed from our dental practice…

"I have read, understand, and agree to the above policy concerning cancellations of dental appointments."

______________________________ ______________

Patient Signature Date

NOTICE OF PRIVACY PRACTICES

Tri-City Family Dentistry
136 Reservation Dr.
Spindale, NC 28160
(828) 286-2962

Your Privacy is very important to us here at Tri-City Family Dentistry.
We promise to take every precaution to protect your rights to having your healthcare information secure. Our formal notice of privacy practices is posted in the waiting area. You can read this while waiting for your visit. You are also entitled to a copy of our Notice of Privacy Practices, which will be located at the reception area.
We also need to ask our patients how they wish to be notified about future appointments at least 24 hours in advance. If we are unable to contact you we leave a message on your answering machine, with a family member, or co-worker.

Please answer the following so that we may comply with your wishes concerning appointment information.

Tri-City Family Dentistry may call my home/workplace/cell to confirm future appointments and may leave a message on my home answering machine or voice mail.

_______________ Yes   _______________ No

By my signature, I acknowledge that I have read the posted Notice of Privacy Practices which describes the uses and disclosures of my health information.

Patient Name: ____ (Please Print)

Patient Signature: ____ Date: ______________________

Parent/ Legal Guardian Signature: ________________________________ Date: __________________