

ABOUT YOU

Today's Date: ____/____/____

Patient's Name: _____

☐ Male ☐ Female Driver's License# _____

Birthdate: ____/____/____ Age: ____ SS# _____

E-mail Address: _____

Mailing address: _____

Cell Phone: (____) _____

Referred By: _____

Pharmacy Preferred: _____

Pharmacy location: _____

Emergency Contact: _____

Emergency Contact Phone #: _____

More About You

When was your last dental visit? _____

What is the name of your last dentist or practice? _____

Do you know when your last set of x-rays was taken? _____

Are you interested in changing your smile? Y/N
Explain: _____

Do you have any concerns about your oral health? Y/N
Explain: _____

Have you had implants placed? Y/N
If yes, Who placed it/them and When? _____

Are you interested in a sleep apnea device? Y/N

Are you interested in migraine therapy? Y/N

Have you ever experienced TMJ pain? Y/N

Dan K. Dube, D.M.D.
General & Reconstructive Dentistry
5653 Carolina Beach Road, Suite C-1
Wilmington, NC 28412
910.791.0986 ph 910.791.2902 fax

INSURANCE INFO

Please show your insurance cards at time of check-in

Primary Dental Insurance Co.: _____

Member ID: _____

Group # (Plan, Local, or Policy #): _____

Insured's Employer: _____

Insured's Name: _____

Relation: _____ Date of Birth: ____/____/____

Insured's SS/ID #: _____

Do you have a Second Insurance plan? Y/ N

_____, I hereby authorize assignment of my insurance
Initials rights & benefits directly to the provider for services
rendered. I fully understand I am solely responsible for any
balance not paid by my insurance company.

Office Policies

- To reduce our administrative costs and keep our fees as low as possible, we ask that you pay your estimated cost at the time of service.
- If the account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account. We require 48 hours notice for all rescheduled or cancelled appointments. Failure to do so may result in a \$50 fee.
- I have read & understand the privacy policy. I authorize the staff to perform any necessary services needed during diagnosis & treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Print Name: _____

Signature: _____

PLEASE CONTINUE TO THE NEXT PAGE

DENTAL INFORMATION

Reason for today's visit: Describe: _____

Do you require pre-medication for dental work? ☐ Yes ☐ No ☐ Don't know; Reason: _____

Have you ever taken Bisphosphonates? Y/N

Cardiologist: _____ Phone #: _____

Orthopedist: _____ Phone #: _____

Medical Dr: _____ Phone #: _____

CURRENT MEDICATION LIST

Please list ALL MEDICATIONS you are currently taking:

MEDICINE:	DOSAGE:	REASON:

Do you have or have you had any of the following diseases, medical conditions or procedures?

Y N ADHD/ADD	Y N Chronic Pain	Y N Jaw Pain/TMJ/TMD	Y N Red Dye Allergy
Y N Alzheimer's	Y N Congestive Heart Failure	Y N Kidney Problems	Y N Respiratory Conditions
Y N Anemia	Y N Cosmetic Surgery	Y N Leukemia	Y N Rheumatic Fever
Y N Angina	Y N Diabetic	Y N Liver Disease	Y N Scarlet Fever
Y N Arthritis	Y N Dialysis	Y N Lupis	Y N Severe Frequent Headaches
Y N Artificial Heart Valves	Y N Dizziness	Y N Mental Disorder	Y N Shingles
Y N Artificial Joints	Y N Epilepsy/Seizures	Y N Migraines	Y N Sinus Problems
Y N Ascites	Y N Fainting	Y N Mitro valve Prolapse	Y N Sleep Apnea
Y N Asthma	Y N Fibromyalgia	Y N Multiple Sclerosis	Y N Smoker
Y N A-Fib	Y N Frequent Neck Pain	Y N Nervousness	Y N Stroke
Y N Back Problems	Y N GERD	Y N Osteoporosis	Y N Tuberculosis
Y N Barrett's Esophagus	Y N Gastric Bypass	Y N PTSD	Y N Ulcers/Stomach Problems
Y N Bleeding Problems	Y N HIV+ / AIDS / ARC	Y N Pacemaker	Y N Venereal Disease
Y N Blood Disorder	Y N Hearing loss	Y N Paralysis	Y N Vertigo
Y N COPD	Y N Heart Attack	Y N Parkinson's Disease	Y N **Dementia (or a Version of it)
Y N Cancer/Tumor	Y N Heart Disease	Y N Pre-Diabetic	Y N **Trying to Conceive
Y N Celiac Disease	Y N Heart Murmur	Y N Pregnancy	Y N **IVF
Y N Cerebral Palsy	Y N Heart Surgery	Y N Prostate Conditions	Y N **IV Medications for Osteoporosis
Y N Chemical Dependency	Y N Hepatitis (A,B,C)	Y N Psoriasis	Y N **Bisphosphonates
Y N Chemotherapy	Y N High Cholesterol	Y N Psoriatic Arthritis	Y N **Blood Thinners
Y N Chronic Inflammation	Y N High/Low Blood Pressure	Y N Radiation Treatment	Y N OTHER _____

List all other surgeries or medical conditions you have or ever had: _____

Are you allergic to any of the following? ☐ NO ☐ YES Latex ☐ Penicillin/Amox ☐ Tetracycline ☐ Aspirin Sulfur Dental Anesthetics/Epinephrine ☐ Foods: _____ ☐ Others: _____

Do you use tobacco? ☐ No ☐ Yes/how used? _____ How much? _____ How long? _____

I certify that the above information is completed to the best my knowledge and understand it is my responsibility to inform this office of any changes to my health.

Signature: _____

Date: _____

MEDICAL HISTORY

Dan K. Dube, D.M.D.
General & Reconstructive Dentistry
dandubedentistry.com
FINANCIAL AGREEMENT

This agreement is to inform you of your financial obligation to our practice. We are committed to providing you with the most comprehensive dental care using only the highest quality materials and technology available in the market today. We are also committed to providing you with up-to-date information and educational tools so that you may fully participate in maintaining optimum oral health. This financial agreement is intended to facilitate our ability to provide excellent service to you while minimizing our administrative costs.

All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is an agreement between you, your employer, and the insurance company. Our practice is not a party to that agreement. *If payment from your insurance company is not received within 60 days from date of service, you will be expected to pay the balance in full.*

As a courtesy to you we will help you process all your insurance claims. You may direct your insurance company to pay your benefits directly to our practice by signing the authorization on the Assignment of Benefits Agreement. In order for our practice to file your insurance claim, you must bring proof of insurance to each appointment.

Your **estimated** copayment for treatment, which is the amount not covered by your insurance, is due at the time treatment is provided. Your **estimated** copayment may be adjusted after the time of treatment depending upon the final reconciliation of insurance payments. Our practice accepts cash, personal checks, MasterCard, Visa, American Express, and Discover. Third party, extended payment financing is available upon your request and approval through Springleaf Financial and CareCredit.

Returned checks and balances older than 60 days will be subject to collection fees (30% of balance) and finance charges at the rate of 1.5% per month (18% annually).

*A scheduled appointment is a commitment of time between you and our practice. We have reserved that time **just for you**. When appointments are missed or cancelled, that is time permanently lost. Therefore, our practice will charge \$50 for appointments that you do not keep and for appointments that you do not cancel with a **48-hour notice**.*

Printed Name & Signature of Patient or Responsible Party

Date

5653 Carolina Beach Road, Suite C-1 Wilmington, NC 28412
910.791.0986 ph 910.791.2902 fax
info@dandubedentistry.com

HIPAA: ACKNOWLEDGMENT OF PRIVACY POLICY

This form is optional under the new patient privacy regulations recently issued by the United States Department of Health and Human Services. We have elected to use this form.

Prior to commencing your dental treatment, you should review, sign and date this form. Your protected health information (i.e., individually identifiable information such as names, dates, phone/fax numbers, email addresses, home addresses, social security numbers, and demographic data) may be used in connection with your treatment, payment of your account or health care operations (i.e., performance reviews, certification, accreditation and licensure).

You have the right to review our office's privacy notice prior to signing this Consent, a copy of which was given to you with this Consent. You have the right to request restrictions on the use of your protected health information. However, we are not required to, and may not, honor your request. We may amend the attached privacy notice at any time. If we do, we will provide you with a copy of the changes, and the changes may not be implemented prior to the effective date of the revised notice.

You may revoke this Consent at any time in writing. However, such revocation will not be effective to the extent that any action has been taken in reliance on this Consent.

I authorize the following people to request and/or receive information about my dental care:

Name: _____ Relation: _____
Date of Birth: _____

Name: _____ Relation: _____
Date of Birth: _____

Patient Signature _____ Date: _____

Print Name _____