

MASHBURN, ZSAMBEKY, ROGERS & ASSOCIATES

5000 Hwy. 49 South • Harrisburg, NC 28075 • Office 704-455-3333

PATIENT INFORMATION

Patient Name: _____ Date: _____

Male Female Married Single Child Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Cell: _____

Address: _____
Street Apartment #

City State Zip Code

SPOUSE OR RESPONSIBLE PARTY INFORMATION

The following is for: the patient's spouse. the person responsible for payment

Name: _____

Male Female Married Single Child Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Cell: _____

Address: _____
Street Apartment #

City State Zip Code

EMPLOYMENT INFORMATION

The following is for: the patient's spouse the person responsible for payment

Employer's Name: _____ Occupation: _____

Address: _____
Street City State Zip Code

DENTAL INSURANCE INFORMATION

Primary

Name of Insured: _____ Is insured a patient? Yes No

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

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1 1/2% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

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

DENTAL HISTORY

Reason for Today's visit: _____

Former Dentist: _____

Address: _____

Date of last dental care: _____ Date of last dental X-rays: _____

Check (✓) if you have or have had any of the following:

- | | | |
|--|---|---|
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Sensitivity to hot |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Sensitivity to sweets |
| <input type="checkbox"/> Clicking or popping jaw | <input type="checkbox"/> Periodontal treatment | <input type="checkbox"/> Sensitivity when biting |
| <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Sensitivity to cold | <input type="checkbox"/> Sores or growths in your mouth |

How often do you floss?: _____ How often do you brush?: _____

MEDICAL HISTORY

Physician's Name: _____ Date of Last Visit: _____

Have you had any serious illnesses or operations? _____ If yes, describe _____

Have you ever had a blood transfusion? Yes No If yes, give approximate dates _____

(Women) Are you pregnant? Yes No Nursing? Yes No Taking birth control pills? Yes No

Check YES or NO to the following: Describe any YES answers: _____

- | | | | |
|--|--|---|---|
| YES NO | YES NO | YES NO | YES NO |
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Cough, Persistent | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Skin Rash |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cough up Blood | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Swelling of Feet or Ankles |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Fainting | <input type="checkbox"/> Nervous Problems | <input type="checkbox"/> Tobacco Habit |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Headaches | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Recent Surgery (last 2 yrs.) | |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Respiratory Disease | |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic Fever | |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Scarlet Fever | |
| <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Shortness of Breath | |

MEDICATIONS

List medications you are currently taking:

Pharmacy Name: _____

Phone: _____

ALLERGIES

- | | |
|--|--------------------------------------|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Barbiturates (Sleeping pills) | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Local Anesthetic | |
| | <input type="checkbox"/> None |

SIGNATURE

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date _____ Signature _____

Acknowledgment of Receipt of Notice of Privacy Practices

I have read the Notice of Privacy Practices for the above named practice.

Signature: _____ Date: _____