

Heather D. Rorison

COSMETIC & FAMILY DENTISTRY

Patient Number

4400 Colwick Road • Charlotte, NC 28211 • Office: 704.366.6186 • www.HeatherRorisonDentistry.com

NEW PATIENT FORM

Patient's Name: _____ Birthday: _____ Male Female

If Child: Parent's Name _____

How do you wish to be addressed: _____

Mailing Address: _____

Business Address: _____

Telephone: Home _____ Business _____ Cell _____

Email Address: _____

Employer: _____

Present Position: _____

How long have you had this position: _____

Spouse Name: _____

Spouse's Employer: _____ How long in present job position? _____

Who is Responsible for this Account? _____

Social Security Number: _____

Drivers License Number: _____

Method of Payment: Insurance Cash Credit Card

Spouse's Social Security Number: _____

Emergency Contact: _____

Emergency Contact Phone Number: _____

Whom can we thank for referral? _____

DENTAL INSURANCE INFORMATION

Dental Insurance 1st Coverage

Employee Name: _____

Employer Name: _____

Name of Insurance Company: _____

Address: _____

Telephone: _____

Policy Number: _____

Or Group Number: _____

Dental Insurance 2nd Coverage

Employee Name: _____

Employer Name: _____

Name of Insurance Company: _____

Address: _____

Telephone: _____

Policy Number: _____

Or Group Number: _____

CONSENT:

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

I consent to the dentist's use and disclosure of my record's (or my child's records) to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment.

I consent to the disclosure of my records (or my child's records) to the following persons who are involved in my care (or my child's care) or payment for that care.

My consent to disclosure of records shall be effective until I revoke it in writing. I authorize payment directly to the dentist or dental group of insurance benefits otherwise payable to me. I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services no paid, by my dental care payor.

PATIENTS OR GUARDIAN'S SIGNATURE

_____ Date _____

DENTAL HISTORY

Purpose of this visit? _____

How long since your last dental visit? _____ When was your last cleaning? _____

Previous Dentist: _____

Please circle or write the answer when indicated.

Have you made regular visits to the dentist? YES NO

How often did you go to the dentist? _____

Did you have x-rays done? YES NO

Have you lost teeth or had any removed? YES NO Why? _____

Have teeth been replaced? YES NO

How have they been replaced? Fixed Bridge Removable/Partial Bridge Denture Implant

Are you happy with the replacement? YES NO

Would you like information about permanent replacements? YES NO

Have you had any complications with previous dental treatments? YES NO

Do you clench or grind your teeth? YES NO

Does your jaw click or pop? YES NO

Do you experience any pain or soreness in the muscles around your face or ears? YES NO

Do you have frequent headaches, neck aches or shoulder aches? YES NO

Do you use dental floss? YES NO How often do you brush your teeth? _____

Are any of your teeth chipped, loose, tipped or shifted? YES NO

Are you unhappy with the appearance of your teeth? YES NO

How do you feel about your teeth in general? Happy Unhappy Indifferent

Do you feel your breath is offensive at times? YES NO

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DENTAL HISTORY

Have you ever had gum treatment or surgery? YES NO

If yes then: What _____ When _____ Where _____

Have you had orthodontic work? YES NO

Have you ever had any unpleasant dental experiences? YES NO

Do you have any questions or concerns? YES NO You can list your questions or concerns below.

I AGREE THAT ALL INFORMATION IS COMPLETE AND ACCURATE

Patient's/Guardian's Signature: _____ Date: _____

Dentist Signature: _____ Date: _____

MEDICAL HISTORY

Check all that apply to you:

- | | | |
|--|--|--|
| <input type="checkbox"/> Anemia/Blood Disease | <input type="checkbox"/> Fainting/Nervous | <input type="checkbox"/> Joint Replacement |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Migraine Headaches |
| <input type="checkbox"/> Asthma/Hay Fever | <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Mitral Valve Prolapse |
| <input type="checkbox"/> Blood Pressure <input type="checkbox"/> Low <input type="checkbox"/> High | <input type="checkbox"/> Pace Maker | <input type="checkbox"/> Neck/Head Pain |
| <input type="checkbox"/> Cancer/Treatment/X-rays | <input type="checkbox"/> Hepatitis/Liver Disease | <input type="checkbox"/> Pregnant |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Herpes Virus | <input type="checkbox"/> Rheu Fever/Murmur |
| <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> HIV Positive/AIDS | <input type="checkbox"/> Tobacco Use |
| <input type="checkbox"/> TB/Lung Disease | <input type="checkbox"/> TMJ/Clicking Joint | <input type="checkbox"/> Venereal Disease |

Check if you are allergic or if it applies to you:

- | | |
|--|--|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Cardiovascular Disease (Heart Disease) |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Birth Control |
| <input type="checkbox"/> Local Anesthesia | <input type="checkbox"/> Persistent Cough |
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Do you have unexplained fevers or chills? |
| <input type="checkbox"/> Sedative/Tranquilizer | <input type="checkbox"/> Do you have night sweats? |
| <input type="checkbox"/> Premedicate | <input type="checkbox"/> Do you have unexplained fatigue? |
| <input type="checkbox"/> Medical Alert | <input type="checkbox"/> Daily Vitamins |

Please list any other medications you are allergic to _____

Doctor: _____ Phone Number: _____

Are you taking any medications? YES NO If yes, please list below or bring a copy of medication list.

General Health Comments: _____