Heather D. Rorison
COSMETIC & FAMILY DENTISTRY

Patient Number

3541 Randolph Road, Suite 300 • 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? ______________________

Heather D. Rorison
COSMETIC & FAMILY DENTISTRY

3541 Randolph Road, Suite 300 • Charlotte, NC 28211 • Office: 704.366.6186 • www.HeatherRorisonDentistry.com

Patient Number

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 ______________________

Heather D. Rorison
COSMETIC & FAMILY DENTISTRY
3541 Randolph Road, Suite 300 • Charlotte, NC 28211 • Office: 704.366.6186 • www.HeatherRorisonDentistry.com

Patient Number ______

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

Patient Number

Heather D. Rorison

COSMETIC & FAMILY DENTISTRY

3541 Randolph Road, Suite 300 • Charlotte, NC 28211 • Office: 704.366.6186 • www.HeatherRorisonDentistry.com

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: ______________

Patient Number

Heather D. Rorison

COSMETIC & FAMILY DENTISTRY

3541 Randolph Road, Suite 300 • Charlotte, NC 28211 • Office: 704.366.6186 • www.HeatherRorisonDentistry.com

MEDICAL HISTORY

Check all that apply to you:

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

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

- ☐ Aspirin
- ☐ Codeine
- ☐ Local Anesthesia
- ☐ Penicillin
- ☐ Sedative/Tranquilizer
- ☐ Premedicate
- ☐ Medical Alert
- ☐ Cardiovascular Disease (Heart Disease)
- ☐ Birth Control
- ☐ Persistent Cough
- ☐ Do you have unexplained fevers or chills?
- ☐ Do you have night sweats?
- ☐ Do you have unexplained fatigue?
- ☐ Daily Vitamins

Please list any other medications you are allergic ______________________________

____

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: ______________________________