107 Windel Drive - Suite 101 - Raleigh NC 27609 - (919) 787-5599 - www.northraleighdental.com

Welcome!

We are pleased to have you as a guest in our practice. Please take a few moments to fill out this form as completely as you can. If you have any questions, please feel free to ask. We look forward to being of service to you!

Patient Information

Name: ____ Soc Sec #: _____________________

Address: ____

City: ____ State: _____ Zip: ____________

Home phone: _______________ Work phone: _____________ Cell phone: _______________

Email address: ____

Sex: ☐M ☐F Age:____ Date of birth:______ ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed

Employer: _______________ Emergency Contact: _________________ Ph#:______________

How do you plan to pay for today's visit? ☐Cash/Check ☐Mastercard/Visa ☐0% Financing

How did you hear about us? ☐Phonebook ☐Internet ☐Referral – whom?_________________________
☐Insurance website ☐Other_______________________________________

Dental Insurance

Person responsible for account: ____
(last name) (first name) (middle initial)

Relationship to patient:_____________ Date of birth:__________ Soc Sec #:______________

Responsible party's employer:________________________ Business phone:________________

Insurance company:____

Name(s) of other dependents under this plan:____

Please complete below if patient is a minor (under 18 years of age)

Mother's name:______________ Soc Sec #:__________ Date of birth:________ Work phone:___________
Father's name:_______________ Soc Sec #:__________ Date of birth:________ Work phone:___________

Nicole Williams
DDS PA

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Patient Medical History

Please take a moment to answer the following important health-related questions so that we may provide the best possible patient care for you.

Patient Name: ____

Your Primary Physician's Name: _________________________ Phone #: __________________________

Have you ever had any of the following diseases or medical problems?

☐Y ☐N Abnormal Bleeding
☐Y ☐N Allergies
☐Y ☐N Anemia
☐Y ☐N Angina Pectoris
☐Y ☐N Arthritis
☐Y ☐N Artificial Bones/Joints
☐Y ☐N Artificial Heart Valve
☐Y ☐N Asthma
☐Y ☐N Blood Transfusion
☐Y ☐N Cancer/Chemotherapy
☐Y ☐N Congenital Heart Defect
☐Y ☐N Diabetes
☐Y ☐N Difficulty Breathing
☐Y ☐N Drug/Alcohol Abuse
☐Y ☐N Emphysema
☐Y ☐N Fainting Spells

☐Y ☐N Fever Blisters
☐Y ☐N Frequent Headaches
☐Y ☐N Glaucoma
☐Y ☐N Hay Fever
☐Y ☐N Heart Attack/Date:______
☐Y ☐N Heart Murmur
☐Y ☐N Hemophilia
☐Y ☐N Hepatitis A
☐Y ☐N Hepatitis B
☐Y ☐N Hepatitis C
☐Y ☐N Herpes
☐Y ☐N High Blood Pressure
☐Y ☐N HIV +/AIDS
☐Y ☐N Kidney Problems
☐Y ☐N Liver Disease
☐Y ☐N Low Blood Pressure

☐Y ☐N Mitral Valve Prolapse
☐Y ☐N Pace Maker/Heart Surgery
☐Y ☐N Pre Med
☐Y ☐N Psychiatric Problems
☐Y ☐N Radiation Therapy
☐Y ☐N Reflux
☐Y ☐N Rheumatic/Scarlet Fever
☐Y ☐N Seizures/Epilepsy
☐Y ☐N Shingles
☐Y ☐N Sickle Cell Anemia/Traits
☐Y ☐N Sinus Problems
☐Y ☐N Stroke/Date___________
☐Y ☐N Thyroid Problems
☐Y ☐N Tuberculosis
☐Y ☐N Ulcers/Colitis
☐Y ☐N Venereal Disease/STDs

☐Y ☐N Do you require antibiotics before dental treatment?
☐Y ☐N Do you smoke or use tobacco?
☐Y ☐N Have you ever used the drug "Fen-Phen"?
☐Y ☐N Have you ever taken Fosamax, Actonel, Boniva, or any other bisphosphonate?
☐Y ☐N Have you ever been hospitalized for any reason? If so, what? ________________________________
Any other condition not listed, please describe here: ____

Do you have any of the following allergies?

☐Y ☐N Aspirin
☐Y ☐N Codeine
☐Y ☐N Dental Anesthetics
☐Y ☐N Erythromycin
☐Y ☐N Latex
☐Y ☐N Metals / Jewelry
☐Y ☐N Penicillin
☐Y ☐N Sulfa
☐Y ☐N Tetracycline
Other?_________________

For females only:

☐Y ☐N Are you taking birth control pills?
☐Y ☐N Are you nursing?
☐Y ☐N Are you pregnant?
# of weeks:______________

Please list any medications that you are currently taking: ____

I understand that the information that I have given today is correct to the best of my knowledge. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Signature: ____ Date: __________________________

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PAYING FOR TREATMENT

Thank you for choosing Nicole Williams DDS PA for your dental care. We are committed to the success of your treatment. Please read through our Financial Policy, which we request that you sign and return.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE.

☑ WE ACCEPT CASH, CHECKS, VISA or MASTERCARD
☑ WE ALSO OFFER FLEXIBLE FINANCING OPTIONS
**Provided through CareCredit, who offer a variety of financing options to suit your needs. Please see the receptionist for details.*

Insurance Coverage:
Our practice participates with the following insurance plans: Delta Dental, Cigna PPO, GEHA/Connection Dental, United Health Care, Humana, Met Life, United Concordia, Dental Benefit Providers, and Tricare/United Concordia. If you have any questions whether or not our practice participates with your specific plan, please ask the receptionist. If your plan is one with which we participate, we will bill and collect according to your plan. All deductibles, co-payments and disallowed charges will be due at the time of service. NOTE: Since many insurance types only cover basic fillings, the cost of our fillings may exceed your coverage, and if so you will be responsible for paying the balance.

If we do not participate with your insurance plan, we will submit your dental claim form as a courtesy to you. You may also inquire about our financing options available through CareCredit.

Regarding Missed Appointments:
When we schedule an appointment, that time is reserved for you. If you must change or cancel an appointment, please give us 24 hours notice. There is a fee for both missed appointments and ones cancelled without 24-hours notice ($50 for operative appts, $100 for crown/bridge appts). After more than 1 missed appointment we will not be able to provide you with another appointment and will ask that you find another dentist. Missed *new patient appointments* are also cause for dismissal. Please help us serve you better by keeping scheduled appointments.

Thank you for reading our Financial Policy. If you have any questions about it, please feel free to ask us.

X____ Date ___________________
Signature of patient or responsible party

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Consent for Use and Disclosure of Health Information & Notice of Privacy Practices

Name: ____

Address: ____

City: _______________________________________ State: _____ Zip: ___________

Phone #:________________________________Social Security #: ______________________

Please Read the Following Statements Carefully

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and health-care operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent form. Our Notice describes the ways in which we may use your protected health information. We reserve the right to change our privacy practices as described in the Notice. If we institute changes, we will have a revised version of the Notice. If you wish to obtain a copy of our Notice of Privacy Practices, you may ask the receptionist at the front desk for a copy, call us anytime at (919) 787-5599, or mail a written request to Chris Williams at 107 Windel Dr, Suite 101, Raleigh NC, 27609.

Right to Revoke: You have the right to revoke this Consent at any time by giving us written notice of your revocation to the front desk. Please understand that revocation of this Consent will not affect any action we took in reliance of this consent before we received your revocation, and that we may decide to treat you or continue treating you if you decide to revoke this Consent.

Please Sign Here:

I,__________________________, have had the full opportunity to read and consider the contents of this Consent Form and your Notice of Privacy Practices. I understand that by signing this form, I am giving my consent to your use and disclosure of my health information as described above.

Signature:____ Date: ___________________

If this Consent is signed by personal representative on behalf of the patient, please complete the following:

Representative's Name and Relationship:____