TIME 08:11 AM

DATE 10/6/2021

PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name:

Responsible Party (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Soc Sec: Drivers Lic:

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: Address 2:

City: State / Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: Age: Soc Sec: Drivers Lic:

E-mail: ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg:

Section 3

Primary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Secondary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Eaglesoft Medical History

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, c

Question	Answer	
Are you under a physician's care now?	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Are you on a special diet?	◯ Yes ◯ No	
Do you use tobacco?	◯ Yes ◯ No	
Do you use controlled substances?	◯ Yes ◯ No	If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics

Other? ☐ If yes

Do you have, or have you had, any of the following?

Condition		Condition		Condition		Condition	
AIDS/HIV Positive	◯ Yes ◯ No	Cortisone Medicine	◯ Yes ◯ No	Hemophilia	◯ Yes ◯ No	Radiation Treatments	◯ Yes ◯ No
Alzheimer's Disease	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No	Hepatitis A	◯ Yes ◯ No	Recent Weight Loss	◯ Yes ◯ No
Anaphylaxis	◯ Yes ◯ No	Drug Addiction	◯ Yes ◯ No	Hepatitis B or C	◯ Yes ◯ No	Renal Dialysis	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Easily Winded	◯ Yes ◯ No	Herpes	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No
Angina	◯ Yes ◯ No	Emphysema	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No	Rheumatism	◯ Yes ◯ No
Arthritis/Gout	◯ Yes ◯ No	Epilepsy or Seizures	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No	Scarlet Fever	◯ Yes ◯ No
Artificial Heart Valve	◯ Yes ◯ No	Excessive Bleeding	◯ Yes ◯ No	Hives or Rash	◯ Yes ◯ No	Shingles	◯ Yes ◯ No
Artificial Joint	◯ Yes ◯ No	Excessive Thirst	◯ Yes ◯ No	Hypoglycemia	◯ Yes ◯ No	Sickle Cell Disease	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Fainting Spells/Dizziness	◯ Yes ◯ No	Irregular Heartbeat	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No
Blood Disease	◯ Yes ◯ No	Frequent Cough	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Spina Bifida	◯ Yes ◯ No
Blood Transfusion	◯ Yes ◯ No	Frequent Diarrhea	◯ Yes ◯ No	Leukemia	◯ Yes ◯ No	Stomach/Intestinal Disease	◯ Yes ◯ No
Breathing Problems	◯ Yes ◯ No	Frequent Headaches	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
Bruise Easily	◯ Yes ◯ No	Genital Herpes	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No	Swelling of Limbs	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Glaucoma	◯ Yes ◯ No	Lung Disease	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Chemotherapy	◯ Yes ◯ No	Hay Fever	◯ Yes ◯ No	Mitral Valve Prolapse	◯ Yes ◯ No	Tonsillitis	◯ Yes ◯ No
Chest Pains	◯ Yes ◯ No	Heart Attack/Failure	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Cold Sores/Fever Blisters	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No	Pain in Jaw Joints	◯ Yes ◯ No	Tumors or Growths	◯ Yes ◯ No
Congenital Heart Disorder	◯ Yes ◯ No	Heart Pacemaker	◯ Yes ◯ No	Parathyroid Disease	◯ Yes ◯ No	Ulcers	◯ Yes ◯ No
Convulsions	◯ Yes ◯ No	Heart Trouble/Disease	◯ Yes ◯ No	Psychiatric Care	◯ Yes ◯ No	Venereal Disease	◯ Yes ◯ No
						Yellow Jaundice	◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:__________

DENTAL HISTORY

Please check if you have ever had any of the following:

- ○ Sensitivity to cold
- ○ Sensitivity to hot
- ○ Sensitivity when biting (or to pressure)
- ○ Sensitivity to sweets
- ○ Fingernail or cheek biting
- ○ Frequent blisters on lips or mouth
- ○ Jaw/ear pain
- ○ Grinding/clenching teeth
- ○ Clicking or popping jaw
- ○ Worn/chipped teeth
- ○ Mouth breathing
- ○ Use a Water-Pik
- ○ Bleeding gums
- ○ Periodontal treatment
- ○ Loose teeth/broken fillings
- ○ Dark teeth
- ○ Orthodontic treatment. Year: ________
- ○ Fluoridated water/Well water
- ○ Food sticks between teeth
- ○ Mouth sores/growths
- ○ Bad breath/taste
- ○ Hard to floss
- ○ Complications from extractions

How often do you brush? ______________________________

What texture? ○ Soft ○ Medium ○ Hard

What type of tooth brush? ○ Electric ○ Regular

Mouth rinse brand: ______________________________

Fluoride rinse/gel brand: ______________________________

Toothpaste brand: ______________________________

Toothbrush brand: ______________________________

Any other homecare devices you use for your dental care? ______________

____

____

How often do you floss? ______________________________

Is it difficult to brush or floss any areas of your mouth? ○ Yes ○ No
If yes, please explain ______________________________

____

Do you use tobacco (cigarettes or smokeless)? ○ Yes ○ No If yes, how often?______________________________

____

Do your gums bleed when brushing or flossing? ○ Yes ○ No

Do you have dry mouth? ○ Yes ○ No

Do you snack between meals on sweets, gum or soda pop? ○ Yes ○ No

Do you chew on both sides of your mouth? ○ Yes ○ No

Have you been instructed in caring for the health or your gums? ○ Yes ○ No

Have you ever been treated for periodontal disease? ○ Yes ○ No
If yes, when? ______________________________

Where? ______________________________

How was the infection treated? ______________________________

____

Are you anxious about receiving dental treatment? ○ Yes ○ No If yes, what do you dislike about it? ______________________________

____

Has fear of discomfort kept you from regular dental visits in the past? ○ Yes ○ No

Have you ever had a reaction to a dental product or procedure? ○ Yes ○ No If yes, please explain ______________________________

____

____

How do you feel about the appearance of your teeth? ______________

____

____

Do you like the way your smile looks? ○ Yes ○ No if no, what dissatisfies you? ______________________________

____

Are your teeth white enough? ○ Yes ○ No

Are there fillings or dental work that looks bad to you? ○ Yes ○ No

Are your teeth straight enough? ○ Yes ○ No

Do you have spaces between your teeth that you don't like? ○ Yes ○ No

Has cost prevented you from enhancing your smile in the past? ○ Yes ○ No

Previous Dentist: ______________________________

Date of Last visit: ______________________________

Date of last Full-Mouth X-ray: ______________________________

Date of last Bitewing X-ray: ______________________________

Do you have any concerns about getting your mouth in excellent health?
○ Yes ○ No If yes, what concerns you? ______________________________

____

____

____

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the information inquired above, have been answered in satisfaction. If my health history or medicine changes I understand that it is my responsibility to inform the dentist, hygienist, or a member of the staff. I will not hold my dentist, registered dental hygienist, or any member of his staff, responsible for any errors or omissions that I may have made in the completion of this form.

SIGNATURE: ______________________________ DATE: ______________

DR. JOHN C CARTER DDS 4907 BRAMBLETON AVENUE ROANOKE VA, 24018 PH: (540) 774-3143 FAX: (540) 774-0928

OFFICE POLICIES
PATIENT CONSENT & AGREEMENTS

Authorization and Release Agreement

All patients or guarantors (if the patient is a minor) are responsible for the full payment of services rendered by Dr. John C. Carter and/or his dental practice group. By signing this agreement, I agree to pay at the regular rates and terms of Dr. John C. Carter and any remaining balance due after my insurance company processes my claim(s) and makes payment or in some cases denies my claims and does not make a payment. I authorize and request that my insurance company remits payments directly to Dr. John C. Carter. I agree to present my insurance card at the time of my appointment along with any information required and necessary for any insurance claims to be filed. I authorize Dr. John C. Carter to release my diagnosis, records, treatment notes, x-rays, and any other information pertaining to my treatment or exams to a third party payer and/or health practitioner whenever necessary. I acknowledge if I give incorrect insurance or no insurance information that I will be responsible for submitting to my insurance company on my own and I will be responsible for my full out of pocket expenses at the time of service.

Financial Agreement

I understand scheduled appointments that I do not appear for or cancel 24 hours prior to my appointment time with Dr. John C. Carter it will be considered a "No Show." I understand a $25.00 charge will be added to my account for each of these occurrences. I understand in the event that the account becomes delinquent (balance still due more than 60 days from the date(s) of service), a finance charge of 1.5% per month (18% annually) will be added to my account, and I will be responsible for paying the amount of these accruing finances charges until my account is settled and at a zero dollar balance. In the event that my account is turned over to a collection attorney, I agree that I will be responsible for an attorney fee equal to 35% of my outstanding balance due at the time my account is turned over for collection.

Dr. John C. Carter's practice is in-network (contracted) with the following insurance companies: Delta Dental Premier, Anthem, Metlife, and Aetna. Our office will submit to all insurance companies (regardless if we are in or out of network with them), with the exception of Medicare and Medicaid. Our office accepts payments by cash, check, Visa, MasterCard, and Discover. We do not accept American Express credit cards. We also accept payments CareCredit, which is a third party finance company we participate with. Depending upon your balance and credit history with our office we might consider allowing you to pay the amount due in equal installments over a 90-day period. This option is a case-by-case situation and requires the patient to sign a financial agreement prepared by our office and for a copy of the patient's credit card in order for us to run automatic payments for the agreed payment amount each month.

PLEASE CONTINUE READING AND SIGN ON BACK

Dental Treatment Patient Consent

I acknowledge that no guarantee or assurance has been made by anyone regarding my dental treatment other then Dr. John C. Carter's guarantee to stand behind the dental work he provides and in the event the patient is dissatisfied with services rendered Dr. John C. Carter will do everything possible to fix the issue with no duplicate charges for the same service. I understand I have the right and opportunity to ask questions regarding my treatment at every visit, and that Dr. John C. Carter and staff will answer any questions I might have. I understand that proposed treatment may change based on conditions found during the course of treatment that were not visible during the initial examination. I also understand that the treatment rendered may be different than traditional treatment due to considerations of the patient's age, medical condition, and out of office treatment environment. I understand the risks of refusing and not having recommended treatment performed. I also give my consent to any advisable and necessary dental procedures, medications, or anesthetics to be administered by the attending dentist for diagnostic purposes or dental treatment. I give my consent and authorization for Dr. John C. Carter, and his assigned associates to provide dental treatment to the named patient below. I also accept full financial responsibility, regardless of insurance coverage, for the dental treatment rendered on this patient. I am legal guardian or authorized agent of the patient.

HIPAA Policy

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g. insurance company)
- The day-to-day healthcare operations of your practice

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice. I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction. I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

My signature below indicates that I understand, agree to, and have completely read all of the above policies and agreements for Dr. John C. Carter's practice.

Patient Name *(print)*: ______________________________ Date: ______________

Responsible Party *(print)*: ______________________________ Date: ______________
(if different than patient)

Patient/Responsible Party Signature: ______________________________ Date: ______________

Witnessed By: ______________________________ Date: ______________