TIME

DATE

PATIENT REGISTRATION

ID: ________ Chart ID: ____________

First Name: ____________ Last Name: ____________ Middle Initial: ____

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

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

Additional Comments:

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: ______.00 Rem. Deduct: ______.00

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: ______.00 Rem. Deduct: ______.00

MEDICAL HISTORY

PATIENT NAME ______________________ Birth Date ______________________

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, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

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

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs
☐ Other If yes, please explain: ______

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 Problem	◯ 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 ______

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 ______________________ DATE ______

Racine Dental Care
215 Racine Dr. Ste 102
Wilmington NC 28403
(910) 332-0687

Appointment Agreement

Welcome to our practice! Our relationship with our patients is viewed with a deep sense of responsibility. We are seriously concerned about your dental health. We strive to give each patient the best quality dental care possible.

In order to ensure quality care, it is imperative that our patients understand the manner in which we schedule our appointments. We value your time as a patient and make every effort to stay on or ahead of schedule. We reserve your appointment time especially for you. Therefore, we need your help in keeping us on schedule so that you and other patients are not kept waiting unnecessarily. Therefore, patients arriving late for an appointment may have to be rescheduled. Please bear in mind that a missed appointment hurts you, another patient who may need emergency care, and our practice.

If for any reason you cannot keep your scheduled appointment, our request is to have at least 24 hours advance notice of the change. At Racine Dental Care, we reserve the right to assess a $50.00 fee to all our patients for missed appointments or less than 24 hours advance notice give.

X______________________________ ______________
Patient / Guardian Signature **Date**

Financial Policy

Payment Options

We accept cash, personal checks, Visa, MasterCard, American Express, and Discover.

Using CareCredit

CareCredit offers a full range of No Interest and Extended Payment Plans for treatment fees from $1 to over $25,000.

No Interest Payment Plans

- 3, 6, & 12 month plan options
- No interest if the balance is paid within the specified time period
- Low minimum monthly payments

Extended Payment Plans

- 24, 36, & 48 month plan options
- For procedure fees from $1,000 to over $25,000
- Monthly payments as low as $25 for a $1,000 fee balance

With CareCredit, you pay no up-front costs, no pre-payment penalties and no fees. Plus, CareCredit is a revolving credit line for additional treatment or add-on charges, without the need to re-apply. It only takes a few minutes to apply for CareCredit and you'll receive an online decision in seconds! Please see one of our Team Members for more details.

Regarding The Responsible Party's Full Payment or Insurance Deductibles and Co-Payment

Dr. Safia Azizi, D.M.D.
215 Racine Dr. Suite 102
Phone Number: *(910) 332-0687*
Fax Number: *(910) 332-0689*
Contact Person: Jennifer Henderson, CDA

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient name____

Patient address ____

Patient phone number ____

I authorize the professional office of my dentist named above to release health information identifying me [including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services] under the following terms and conditions:

1. Detailed description of the information to be released:

2. To whom may the information be released [name(s)]:

3. The purpose(s) for the release (if the authorization is initiated by the individual, it is permissible to state "at the request of the individual" as the purpose, if desired by the individual):

4. Expiration date or event relating to the individual or purpose for the release:

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to the office contact person listed at the top of this form.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Dated__________________ Patient signature____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient ____________________Print Name____________________________

Source of Authority____

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Dr. Safia Azizi's Notice of Privacy Practices.

Patient Name: ____

Signature: _____________________________ **Date:** __________________

DENTAL HISTORY

Patient Name______________________ Birth Date_________

Racine Dental Care considers your dental history an important tool in treating you today and in future visits. Thank you for taking the time in answering the following questions so we can help you achieve optimum oral health for a lifetime.

1. Purpose of today's Visit: ____
2. How long has it been since your last dental cleaning/exam? _______________
3.

Circle the appropriate answer. If you do not know the correct answer, please write "don't know ", on the line after the question.

3. If you have replacement teeth from extractions, (examples: bridges, dentures, implants, partials) are you happy with the fit? YES NO
4. Would you like to learn about permanent tooth placement? YES NO
5. Do you clench or grind your teeth? YES NO
6. Are your teeth sensitive to: Cold Hot Sweets Biting Pressure
7. Does food get caught in between your teeth? YES NO
8. Do your gums bleed or hurt? YES NO
9. Do you experience dry mouth? YES NO
10. How often do you brush your teeth? ___________________________
11. How often do you use dental floss? ___________________________
12. Are any of your teeth loose, shifted, or chipped? YES NO
13. Are you happy with your smile and the color of your teeth? YES NO
14. Do you feel your breath is offensive at times? YES NO
15. Do you have a family history of gum or teeth problems? YES NO
16. Do you have history of or presently: Smoke Cigarettes Dip Tobacco Drink Alcohol Use Illegal Drugs
17. Have you ever had a "deep cleaning" or gum surgery? YES NO
18. Are you anxious about going to the dentist? YES NO
19. Is there anything you would like to share with us regarding yourself that would help us in making your dental visits a pleasant experience?

____

____

20. What time would work best to accommodate your needs?
Morning _______ Afternoon _________ After 5 _________ Friday ________

21. How did you hear about our office?
Friend ________ Insurance _________Online ________ Phone Book _________

I certify that the above information is complete and accurate.
Patient/Guardian's Signature: ____________________________ Date: _____________

Cash, Personal Checks, Visa, MasterCard, American Express and Discover are acceptable forms of payment. At the appointment that treatment is rendered, payment for these services must be made unless prior financial arrangements have been made and recorded with our treatment coordinator.

If any **dental procedures** require the services of a dental laboratory, a deposit of 50% is required when the first impressions are taken. When the final appointment for cementation or insertion of the prosthesis is completed, the remainder of the balance will be due.

Payment for children's dentistry is the responsibility of the **parent** or adult that brings the pediatric patient to the appointment. Minors who are not with an adult for non-emergency dentistry will be **denied** treatment unless previous arrangements have been made before the appointment date.

Checks that are **returned** to our office from your financial institution are subject to a $25.00 returned check fee. This fee covers the processing fees that are charged to our office.

Regarding Insurance Claims Payment: The **insurance coverage** that your employer provides is an agreement with your insurance provider. We are not a party to this agreement. Most all insurance policies are different and we cannot accurately predict what your specific insurance company will pay for your claims. Therefore, when we accept assignment of the benefits that your insurance should pay and they have not paid within 60 days, we will transfer these unpaid claims to your account for payment.

It is possible that some or all of your treatment may not be covered by your insurance provider or not considered reasonable and customary under their terms. We will provide you with excellent and expert dental care at reasonable and customary fees that are **fair and affordable**. The responsibility for payment of your dental care is yours even if your insurance company refuses to pay these fair and affordable rates.

If you have questions or concerns about our dental financial policy, please let us know.

Please present your **insurance information** when services are rendered. We cannot backdate insurance claims. We will verify your insurance benefits before filing any claims.

Your insurance deductibles and co-payments must be paid when service are rendered. Regardless of insurance, balances are due and payable after 30 days.

We want to provide you with the **very best dentistry** that is available and we're committed to helping you maintain optimum dental health. As a business entity, we must provide you with our **financial** policy to ensure that no misunderstandings arise regarding the payment of your dental care.

Date: ______________________ Signature: ______________________