CARLTON DENTAL

Welcome. *Thank you for selecting our dental healthcare team! We will Strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out the form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.*

Patient Information (CONFIDENTIAL)

Name_____ Birthdate_____ Date_____

Address_____ City_____ State_____ Zip_____

Cell Phone_____ Email_____ SS#_____ DL#_____

Minor ☐ Single ☐ Married ☐ Other ☐

Employer_____ Phone_____

Business Address_____ City_____ State_____ Zip_____

Spouse or Parents Name_____ Employer_____ Contact Phone_____

Whom may we thank for referring you?_____

Responsible Party (If different from above)

Name of person responsible for this account_____ Birthdate_____

Address_____ City_____ State_____ Zip_____

Contact Phone_____ Email_____ SS#_____ DL#_____

Employer_____ Address_____ City_____ State_____ Zip_____

Insurance Information

Name of Insured_____ Relation to Patient_____

Birthdate_____ SS#_____ Name of Employer_____ Work Phone_____

Address of Employer_____ City_____ State_____ Zip_____

Insurance Company_____ Group #_____ Policy/ID #_____

Ins. Co. Address_____ City_____ State_____ Zip_____

DO YOU HAVE SECONDARY INSURANCE? Yes ☐ No ☐ IF YES, COMPLETE THE FOLLOWING:

Name of Insured_____ Relation to Patient_____

Birthdate_____ SS#_____ Name of Employer_____ Work Phone_____

Address of Employer_____ City_____ State_____ Zip_____

Insurance Company_____ Group #_____ Policy/ID #_____

Ins. Co. Address_____ City_____ State_____ Zip_____

Over Please

Medical History

I consider my health to be (Please check one) ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you or have you had any of the following? (Check if applicable)

____ Heart Disease
____ Heart Murmur/ Valve Prolapse
____ Pace Maker
____ Stroke
____ Congenital Heart Lesions
____ Rheumatic Fever
____ Ulcers
____ Abnormal Blood Pressure
____ Anemia
____ Tuberculosis or Lung Disease
____ Asthma
____ Hay Fever
____ Sinus trouble
____ Epilepsy/Seizures
____ Implants/Artificial Joints
____ Prolonged Bleeding Disease
____ Take an antibiotic prior to dental treatment.
____ Have you ever taken Fen-Phen or Redux?

____ Liver Disease
____ Hepatitis Type____
____ Diabetes
____ Excessive Urination and/or Thirst
____ Herpes
____ AIDS
____ Infection Mononucleosis (Mono)
____ Arthritis
____ Sexually Transmitted Disease
____ Kidney Disease
____ Tumor or Malignancy
____ Cancer/Chemotherapy
____ Radiation Treatment
____ History of Drug Addiction
____ Alcohol use
____ Recreational Drugs
____ Tobacco use. If yes, how much per day? _____ How many years? _____

____ Immune Suppressed Disorder
____ Hearing Loss
____ Fainting Spells
____ Glaucoma
____ History of Emotional or
____ Nervous Disorders

Women

____ Are you taking Birth Control Medications?
____ Are you or could you be pregnant or nursing

____ Have you ever taken Fosamax, Boniva, Actonel or any other cancer medication containing Bisphosphonates?
____ I have had major Surgery: Year_____ Type of operation_____ Year_____ Type of operation_____

Any other medical problem or medical history NOT listed on this form?_____

Check if you allergic to any of the following:

____ Aspirin
____ Ibuprofen
____ Sulfa Drugs/Sulfites/Sulfides
____ Penicillin
____ Codeine
____ Latex, Metals, Plastics
____ Local Anesthetics (Novocaine)

Please list all medications you are currently taking:

Medication_____Condition_____
Medication_____ Condition_____
Medication_____ Condition_____
Medication_____ Condition_____
Physician_____ Phone_____

Dental Health

Why have you come in to see us today? (e.g.: pain, checkup, etc.)_____
When was your last dental visit/cleaning?_____
Have you had any problems with past dental treatment?_____
Are you nervous about seeing a dentist? (circle one) YES NO If yes, please tell us why:_____
How often do you brush? _____ Do you floss? (circle one) YES NO How often?_____

Check if applicable:

____ Tooth pain
____ Sensitive to hot/cold/sweet
____ Gums bleed while brushing or flossing
____ Gums feel tender or swollen
____ Clench or grind during the day or while sleeping

____ Problems eating
____ Jaw pain or problems
____ Facial or jaw injury
____ Difficult/ prolonged bleeding

____ I have had orthodontics
____ I want my teeth straight
____ I want my teeth whiter
____ I like my smile

What are you dental priorities?_____
(e.g.: dental health, cosmetic, financial considerations, etc.)

In the event of an emergency please contact:

Name_____ Relationship_____ Phone_____

Name_____ Relationship_____ Phone_____

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

X_____ ____/____/____
Signature of Patient (or parent/guardian if minor) Date

Periodic medical/dental health reviewed by: (Office use only)

X_____ ____/____/____ X_____ ____/____/____
Doctor's Signature Date Patient's Signature Date

X_____ ____/____/____ X_____ ____/____/____
Doctor's Signature Date Patient's Signature Date

X_____ ____/____/____ X_____ ____/____/____
Doctor's Signature Date Patient's Signature Date

CARLTON DENTAL

OFFICE POLICIES AND DISCLOSURES REQUIRED BY FAIR CREDIT BILLING ACT

OFFICE HOURS:

Office hours are available by appointment. Presently our office is open **Monday** 9:00am to 6:00pm, **Tuesday** 9:00am to 6:00pm, **Wednesday** 9:00am to 6:00pm, **Thursday**, 9:00am to 6:00pm. These times are subject to change without notice. After hour appointments may be subject to an additional fee.

CANCELLATION:

When we reserve an appointment for you, it is not possible to schedule other patients or procedures at the same time. If you cannot keep your appointment time that was reserved for you, our team will be idle. Thus affecting the cost of dental care. Consequently, **YOU SHOULD TRY TO CANCEL YOUR APPOINTMENT WITH A MINIMUM OF 24-HOURS OR A FEE MUST BE CHARGED TO COVER THIS TIME. THIS CHARGE IS DUE AND PAYABLE BY YOU.** Your insurance company will not be billed for this charge. Our office may wave this fee in the event of certain circumstances.

STATEMENTS:

We will furnish you a monthly statement of your account, showing the amounts billed and credited to you, by us for the month, with a breakdown of the length of time you have had an outstanding balance on your account. After your insurance has paid the agreed contracted percentage of treatment, procedures, you are responsible for and will be billed for the balance.

FEES AND FINANCIAL POLICIES:

WE WILL NOT FINANCE IN OFFICE ACCOUNTS OVER $500.00.

Payment of fees is **YOUR** direct responsibility. We encourage payment at the time of service. All charges are due and payable within **30** days after billing, unless you have talked to our office manager to arrange a payment plan. In the event any balance is not paid within **60** days, the undersigned jointly and severally agreed to pay all attorney's fees, court costs, up to 50% of the amount owing which may be assessed by any collection agency retained to pursue the matter. I/We further agree to pay **INTEREST** at the rate of **1.5% per month on the unpaid balance** (18% per year). the amount on which the periodic rate is applied shall be the outstanding balance 30 days or more old as the date of each monthly statement, after deducting all current payments shown on each statement. All payments shall be applied to the oldest charge first.

INSURANCE INFORMATION:

Our office will bill your insurance company for you as a service to you. We will assist you in any way that we can to complete the insurance forms for prompt reimbursement. However, our office cannot accept the responsibility of collecting your dental insurance claims or negotiating a settlement on an account within the limits of our credit policy. We expect regular co-insurance payments even though you have an insurance claim pending. **REMEMBER: Your** dental insurance is a contract between **you** and **your** dental insurance company. If we are not currently listed as a provider with your dental insurance company, the payment for service is your responsibility. It is also **YOUR RESPONSIBILITY TO DETERMINE IF DR. CARLTON IS CURRENTLY A PROVIDER ON YOUR INDIVIDUAL INSUANCE PLAN. YOU ARE RESPONSIBLE FOR ALL CHARGES YOU INCUR REGARDLESS OF INSURANCE COVERAGE.** I authorize the dentist or his designees to release financially identifiable information and treatment descriptions and information, either electronically, by facsimile or in paper form to my insurance carrier or any related entities that require such information to be submitted.

AUTHORIZATION AND ACKNOWLEDGEMENT:

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf of my dependents. I furthermore acknowledge receipt of a copy of this disclosure and the information regarding billing errors and inquiries prior to extension of credit. A photographic copy of this authorization shall be as valid as the original. I grant my permission to you or your assignee to telephone me at home or at my workplace to discuss matters related to this form. I also agree to let this office leave messages concerning appointments and/or results on my answering machine or with a family member. Please sign and date this form after reading it, saying that you understand all of the above information.

SIGNATURE:_____ **DATE:**_____

CARLTON DENTAL

CONSENT TO PROCEED

I authorize Dr. Carlton and/or such associates or assistants as s/he may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any sedative (including nitrous oxide) analgesic, therapeutic or surgical treatments.

I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to bruising, hematoma, cardiac stimulation, muscle soreness, and temporary irritation.

I understand that as a part of the dental treatment, including preventative procedures such as cleanings and basic dentistry, including fillings of all types, teeth may remain sensitive or even possibly quite painful both during and after completion of treatment. After lengthy appointments, jaw muscles may also be sore or tender. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment. Although rare, it is also possible for the tongue, cheek or other oral tissues to be inadvertently abraded or lacerated (cut) during routine dental procedures. In some cases, sutures or additional treatment may be required.

I understand that as part of dental treatment items including, but not limited to crowns, small dental instruments, drill components, etc. may be aspirated (inhaled into the respiratory systems) or swallowed. This unusual situation may require a series of x-rays to be taken by a physician or hospital and may, in rare cases, require bronchoscopy or other procedures to ensure safe removal.

I understand the need to disclose to the dentist any prescription drugs that are currently being taken or that have been taken in the past, such as Fen-Phen. I understand that taking the class of drugs prescribed for the prevention of osteoporosis, such as Fosamax, Boniva, or Actonel, may result in complications of non-healing of the jawbones following oral surgery or tooth extractions.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general, preventative and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

I understand that during the course of the procedure/s unforeseen conditions may be revealed that resuscitate an extension of the original procedure/s than those set forth.

I have been given a copy of the HIPAA Privacy Statement.

Patient Name:_____

Signature:_____ **Date**:_____

(Patient, legal guardian or authorized agent of patient)