# Carolina Dental Arts

Timothy Cox, DDS, PA

## Patient Registration

**Patient Information:**

First Name: _____ Middle Initial: _____ Last Name: _____

Address: _____ Apt#_____ Home Phone: (___) _____

City: _____ State/Zip: _____ Work Phone: (___) _____

Birth Date: _____ Age: _____ Cell Phone: (___) _____

Sex: ○Male ○Female Marital Status: _____ Social Security Number: _____

Email address: _____

EMERGENCY CONTACT: _____ Phone Number: _____

How would you prefer to receive appointment reminders? Please choose one.
○Phone Call – If so, which number: _____ ○Email ○Text Message

How did you hear about our office? _____

**Dental Insurance Information:**

Person responsible for account: _____
Last name First name Initial

Relationship to patient:_____ Date of Birth:_____ Soc. Sec. #:_____

Responsible party's employer: _____ Business phone:_____

Insurance company: _____ Phone number: _____

Group number: _____ Patient ID: _____

**Responsible Party (If someone other than patient)**

Name: _____ Date of Birth: _____

Address: _____ SS#: _____

_____

Home #: _____ Work #: _____ Cell #: _____

**Regarding HIPAA:**

We are required by applicable federal and state laws to maintain the privacy of your health information. We are also required to give you information about our privacy practices. By signing below, you are acknowledging you have reviewed a copy of our HIPAA privacy handout.

**Signature:** _____

**Date:** _____

**Carolina Dental Arts of Ballantyne**

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, 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 |
| 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? If yes, please describe. | ◯ Yes ◯ No | If yes |
| Do you use tobacco? | ◯ Yes ◯ No | |

Women: Are you...

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

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic

☐ Latex ☐ Sulfa Drugs ☐ Dental Anesthetics ☐ Metal/Jewelry

☐ Tetracycline

Other Allergies? Please list. ☐ If yes

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

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| AIDS/HIV Positive ◯ 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 |
| 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 |
| 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 | Drug use/abuse ◯ Yes ◯ No | Pain in Jaw Joints/TMJ ◯ Yes ◯ No |
| Colitis ◯ Yes ◯ No | Abnormal Bleeding ◯ Yes ◯ No | Reflux/Gerd ◯ Yes ◯ No | |

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

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.

I request and authorize Dr. Timothy L. Cox and/or his associates and assistants to examine, clean and provide my/the patient's dental treatment as necessary. I further request and authorize the taking of dental x-rays and photographs as may be considered necessary for diagnostic or eductional purposes. I understand that this office only uses composite (tooth-colored) filling material to restore teeth and amalgam (silver) is not available. I will be responsible for any charges incurred on this account.

Signature of Patient, Parent or Guardian:

X

Date:_____

# CAROLINA DENTAL ARTS

*of Ballantyne Village*

Timothy L. Cox, DDS, PA

## Our Financial Policy

Thank you for choosing **Carolina Dental Arts** for your dental care, where we are committed to the success of your treatment. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we request you read and sign.

**FULL PAYMENT IS DUE AT THE TIME OF SERVICE.**

WE ACCEPT CASH OR VISA/MC. PERSONAL CHECKS ARE NOT ACCEPTED.
*WE OFFER CARE CREDIT, AN AFFORDABLE FINANCING OPTION FOR TREATMENT.*

**Regarding insurance:**
Our practice participates with the following insurance plans: Aetna, Ameritas, BCBS, Cigna, Delta Dental, Guardian, MetLife, United Concordia, United Healthcare and many more. If you have any questions whether or not our practice participates with your particular plan, please speak directly with the patient coordinator. 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.

If we do not participate with your insurance plan, we will submit your dental claim form as a courtesy to you. Although your insurance company may pay at a higher rate, a payment of 60% is required at the time of service for all treatment other than routine cleaning appointments. For cleaning appointments, a payment of 30% is required.

We will do all that we can to get the most benefits possible reimbursed for you, however we cannot bill your carrier for your reimbursement unless you provide us with current insurance information. Please be aware that some of the services provided may not be covered or may be considered above the "usual and customary procedures." Our practice is committed to providing the best treatment for our patients, while charging what is reasonable and customary for our area. You are responsible for payment of your account, regardless of any insurance company's arbitrary determination of usual and customary fees. If insurance has not responded to a claim within 60 days of submittal, the full account balance becomes the account holder's responsibility.

(Past due balances are subject to a finance charge of 1.5% per month = 18% APR. In the event that your account is placed in the hands of a collection agency, the costs involved (including any attorney's fees), will be at the expense of the patient.)

**Regarding Missed Appointments:** We do not "double book" appointments. When we schedule an appointment, the time is reserved just for you. If you must change an appointment, please give us at least 48 hours notice. There is a fee of $75 for missed appointments or for appointments that are canceled without a 48 hours notice. In some cases, we reserve the right to charge the full value of the missed time. Please help us serve you and our entire family of patients better by keeping scheduled appointments.

Thank you for reading and understanding our Financial Policy. Please let us know if you have any questions or concerns.

X _____ Date _____

Signature of patient or responsible party