



COMPREHENSIVE DENTAL CENTER

Jack T. Winchester, DMD  Trust Experience.

3705 Symi Circle, Morehead City, NC 28557 (252) 247-3510 Fax: (252) 247-6197 www.moreheadcitydental.com

We are committed to excellence in dentistry and appreciate you taking the time to complete this confidential questionnaire. The better we communicate, the better we can care for you. If you have any questions or need assistance, please ask us - we will be happy to help.

Tell Us How Did you hear about us? _____

Mr. Ms. Miss Mrs. Dr. **ABOUT YOU**
 Name: _____ I prefer to be called _____ [] Male [] Female
 [] Single [] Married [] Child [] Other Birth date: ___/___/___ Age: _____ S.S. #: _____
 Home Address: _____ City _____ State _____ Zip _____
 Home Phone: (____) _____ Work: (____) _____ ext. ____ Pager: (____) _____
 Cell: (____) _____ E-mail Address: _____
 Employer: _____ How long there? _____ Occupation: _____
 Employer's Address: _____ City _____ State _____ Zip _____
 Emergency Contact Person:(Name) _____ (Phone) _____ (Relationship) _____

PERSON RESPONSIBLE FOR ACCOUNT

[] Same as above Name: _____ Birth date: ___/___/___ Relation: _____
 Billing Address: _____ City _____ State _____ Zip _____
 Home Phone: (____) _____ Work: (____) _____ S.S. #: _____
 Employer: _____ How long there? _____ Occupation: _____

SPOUSE INFORMATION

[] Same as above Name: _____ Birth date: ___/___/___
 Employer: _____ Work Phone: (____) _____ ext. _____

DENTAL INSURANCE INFORMATION

Primary Insurance
 Insurance Co. Name: _____ Phone: (____) _____ Group/Policy #: _____
 Insured's Name: _____ Insured's Birth date: ___/___/___ Relation: _____
 Insured's Social Security #: _____ Insured's Employer: _____

Secondary Insurance
 Insurance Co. Name: _____ Phone: (____) _____ Group/Policy #: _____
 Insured's Name: _____ Insured's Birth date: ___/___/___ Relation: _____
 Insured's Social Security #: _____ Insured's Employer: _____

ASSIGNMENT & RELEASE:

I hereby authorize my insurance benefits to be paid directly to the dentists. I am financially responsible for any balances due, regardless of what my insurance pays, or does not pay.

I authorize that my records can be used by the doctor if he so determines to the making of videotapes, photographs, and x-rays before, during or after treatment, and to use of the same by the doctor in scientific papers or demonstrations for educational purposes.

I also have signed Consent of Dr. Winchester's Notice Of Privacy Practices. (A full copy may be obtained by the office upon request). This allows Dr. Winchester's office to use my personal information from office to office, to an insurance company, for payment or to acquire records concerning your treatment both past and present.

I acknowledge that payment is due at the time services are rendered in full, minus insurance estimates, if benefits are available. If Insurance cannot be verified, you will be asked for payment in full.

My form of expected payment will be made by: CASH CHECK VISA MASTERCARD CARE CREDIT

Signature: _____ Date: _____

MEDICAL HISTORY

Patient Name _____ Nickname _____ Age _____

Name of Physician/and their specialty _____

Most recent physical examination _____ Purpose _____

What is your estimate of your general health? Excellent Good Fair Poor

DO YOU HAVE or HAVE YOU EVER HAD:

	YES	NO		YES	NO
1. hospitalization for illness or injury _____	<input type="checkbox"/>	<input type="checkbox"/>	26. osteoporosis/osteopenia (i.e. taking bisphosphonates) __	<input type="checkbox"/>	<input type="checkbox"/>
2. an allergic reaction to			27. arthritis _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> aspirin, ibuprofen, acetaminophen, codeine			28. glaucoma _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> penicillin			29. contact lenses _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> erythromycin			30. head or neck injuries _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> tetracycline			31. epilepsy, convulsions (seizures) _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> sulpha			32. neurologic problems (attention deficit disorder) _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> local anesthetic			33. viral infections and cold sores _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> fluoride			34. any lumps or swelling in the mouth _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> metals (nickel, gold, silver, _____)			35. hives, skin rash, hay fever _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> latex			36. venereal disease _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> other _____			37. hepatitis (type __) _____	<input type="checkbox"/>	<input type="checkbox"/>
3. heart problems, or cardiac stent within the last six months __	<input type="checkbox"/>	<input type="checkbox"/>	38. HIV / AIDS _____	<input type="checkbox"/>	<input type="checkbox"/>
4. history of infective endocarditis _____	<input type="checkbox"/>	<input type="checkbox"/>	39. tumor, abnormal growth _____	<input type="checkbox"/>	<input type="checkbox"/>
5. artificial heart valve, repaired heart defect (PFO) _____	<input type="checkbox"/>	<input type="checkbox"/>	40. radiation therapy _____	<input type="checkbox"/>	<input type="checkbox"/>
6. pacemaker or implantable defibrillator _____	<input type="checkbox"/>	<input type="checkbox"/>	41. chemotherapy _____	<input type="checkbox"/>	<input type="checkbox"/>
7. artificial prosthesis (heart valve or joints) _____	<input type="checkbox"/>	<input type="checkbox"/>	42. emotional problems _____	<input type="checkbox"/>	<input type="checkbox"/>
8. rheumatic or scarlet fever _____	<input type="checkbox"/>	<input type="checkbox"/>	43. psychiatric treatment _____	<input type="checkbox"/>	<input type="checkbox"/>
9. high or low blood pressure _____	<input type="checkbox"/>	<input type="checkbox"/>	44. antidepressant medication _____	<input type="checkbox"/>	<input type="checkbox"/>
10. a stroke (taking blood thinners) _____	<input type="checkbox"/>	<input type="checkbox"/>	45. alcohol / drug dependency _____	<input type="checkbox"/>	<input type="checkbox"/>
11. anemia or other blood disorder _____	<input type="checkbox"/>	<input type="checkbox"/>			
12. prolonged bleeding due to a slight cut (INR > 3.5) _____	<input type="checkbox"/>	<input type="checkbox"/>	ARE YOU:		
13. emphysema, sarcoidosis _____	<input type="checkbox"/>	<input type="checkbox"/>	46. presently being treated for any other illness _____	<input type="checkbox"/>	<input type="checkbox"/>
14. tuberculosis _____	<input type="checkbox"/>	<input type="checkbox"/>	47. aware of a change in your general health _____	<input type="checkbox"/>	<input type="checkbox"/>
15. asthma _____	<input type="checkbox"/>	<input type="checkbox"/>	48. taking medication for weight management (i.e. fen-phen)	<input type="checkbox"/>	<input type="checkbox"/>
16. breathing or sleep problems (i.e. snoring, sinus) _____	<input type="checkbox"/>	<input type="checkbox"/>	49. taking dietary supplements _____	<input type="checkbox"/>	<input type="checkbox"/>
17. kidney disease _____	<input type="checkbox"/>	<input type="checkbox"/>	50. often exhausted or fatigued _____	<input type="checkbox"/>	<input type="checkbox"/>
18. liver disease _____	<input type="checkbox"/>	<input type="checkbox"/>	51. subject to frequent headaches _____	<input type="checkbox"/>	<input type="checkbox"/>
19. jaundice _____	<input type="checkbox"/>	<input type="checkbox"/>	52. a smoker or smoked previously _____	<input type="checkbox"/>	<input type="checkbox"/>
20. thyroid, parathyroid disease, or calcium deficiency _____	<input type="checkbox"/>	<input type="checkbox"/>	53. considered a touchy person _____	<input type="checkbox"/>	<input type="checkbox"/>
21. hormone deficiency _____	<input type="checkbox"/>	<input type="checkbox"/>	54. often unhappy or depressed _____	<input type="checkbox"/>	<input type="checkbox"/>
22. high cholesterol or taking statin drugs _____	<input type="checkbox"/>	<input type="checkbox"/>	55. FEMALE - taking birth control pills _____	<input type="checkbox"/>	<input type="checkbox"/>
23. diabetes (HbA1c = _____)	<input type="checkbox"/>	<input type="checkbox"/>	56. FEMALE - pregnant _____	<input type="checkbox"/>	<input type="checkbox"/>
24. stomach or duodenal ulcer _____	<input type="checkbox"/>	<input type="checkbox"/>	57. MALE - prostate disorders _____	<input type="checkbox"/>	<input type="checkbox"/>
25. digestive disorders (i.e. gastric reflux) _____	<input type="checkbox"/>	<input type="checkbox"/>			

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment.

List all medications, supplements, and or vitamins taken within the last two years

Drug	Purpose	Drug	Purpose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Ask for an additional sheet if you are taking more than 6 medications

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

Comprehensive Dental Center

Dr Jack T. Winchester, DMD

Dental Insurance Disclaimer

Our goal is to help you maximize your dental insurance benefits. We are happy to bill your dental plan for services. When we call your insurance and verify benefits it is not a guarantee of payment by the insurance company and may vary according to your individual plan when the actual claim is submitted. Any treatment plan that our office proposes to you is an estimate of what your insurance coverage will be, it is not a guarantee. We will always work to maximize your insurance benefits for you. Our team will work with you to determine financial arrangements that work for both parties.

Please remember that the contract itemizing your dental benefits is between you, your employer and the insurance company. Although we call and get benefits for you we suggest that you call your insurance company to reconfirm any waiting periods, deductibles or benefits payable concerning your treatment plan. Regardless of coverage, your estimated co-payment, deductions, exclusions and unpaid balances are due in full the day of treatment. If your insurance plan does not pay within 120 days of treatment, you must pay any outstanding balances and seek reimbursement from your dental plan. Also remember dental insurance plans are not designed to cover all of your dental needs.

I have chosen to allow Comprehensive Dental Center to file my insurance and I accept full responsibility for this account and for all dentistry performed upon myself and my family in this dental office. **I understand this office cannot guarantee my insurance company will cover all services rendered and it is only an estimate of benefits.** I understand that any credit of \$25.00 or less will not be issued unless used for procedures or I leave the office. I understand that refund checks will not be issued until all insurance checks have been received from my insurance company. I also understand that if my insurance company does not pay within 120 days of my date of service then I will become responsible to pay at that time.

Print Name _____ Date _____

Patient Signature _____



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REQUEST FOR CONFIDENTIAL COMMUNICATIONS REGARDING PATIENT INFORMATION

I request that the Comprehensive Dental Center communicate with me confidentially about dental matters in the following manner:

(It is the office policy of Comprehensive Dental Center – Jack T. Winchester, DMD and staff to not release confidential and/or unauthorized dental or medical or account information by home telephone, answering machine, work telephone, email address, voice mail, cell phone and/ or pager. Whenever returning phone calls and answering machine picks up, we will not leave a message if the name or telephone number is not on the recorded message to identify the residents. Information will also not be left with an unauthorized person who may answer the telephone.)

I authorize this Dental Provider and/or staff to leave dental or account information pertaining to my care by the following methods and will assume responsibility to notify whenever this information changes:

Home Telephone: Yes No Work Telephone: Yes No

Answering Machine Yes No Work Voice Mail Yes No

Cell Phone/Voice Mail Yes No

E-Mail Address: _____

If you would like to have information released to someone other than yourself, please complete the following:

Name : _____ Phone: _____

RIGHTS OF THE PATIENT

I understand I have the right to revoke this authorization and that I have the right to inspect or copy the protected health information to be disclosed in this document or by sending a written notice to Comprehensive Dental Center. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that the information used or disclosed as a result of the authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that any treatment will not be conditioned on signing this authorization.

This authorization shall be in force and effect until revoked by the patient or representative, by signing in the authorization. This may not be a verbal notification, but must be done in written

Patient Printer Name

Patient/Patient Representative Signature

Date

If Patient Representative, Relationship to Patient