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 understand the insured party and/or guardian signing is financially responsible for any balances due, regardless of what my insurance pays, or does not pay. I also understand that if my insurance company does not pay within 120 days of my date of service then the insured party and/or guardian signing will become responsible to pay at that time.

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. I understand that any credit of $50.00 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 payments have been received from my insurance company.

My form of expected payment will be made by:
CASH, CHECK, VISA, MASTERCARD, WELLS FARGO FINANCING, CARECREDIT

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
1. hospitalization for illness or injury_____	☐	☐
2. an allergic reaction to		
☐ aspirin, ibuprofen, acetaminophen, codeine		
☐ penicillin		
☐ erythromycin		
☐ tetracycline		
☐ sulpha		
☐ local anesthetic		
☐ fluoride		
☐ metals (nickel, gold, silver, _____)		
☐ latex		
☐ other _____		
3. heart problems, or cardiac stent within the last six months __	☐	☐
4. history of infective endocarditis _____	☐	☐
5. artificial heart valve, repaired heart defect (PFO) _____	☐	☐
6. pacemaker or implantable defibrillator _____	☐	☐
7. artificial prosthesis (heart valve or joints) _____	☐	☐
8. rheumatic or scarlet fever_____	☐	☐
9. high or low blood pressure_____	☐	☐
10. a stroke (taking blood thinners) _____	☐	☐
11. anemia or other blood disorder _____	☐	☐
12. prolonged bleeding due to a slight cut (INR > 3.5) _____	☐	☐
13. emphysema, sarcoidosis _____	☐	☐
14. tuberculosis _____	☐	☐
15. asthma _____	☐	☐
16. breathing or sleep problems (i.e. snoring, sinus)_____	☐	☐
17. kidney disease _____	☐	☐
18. liver disease _____	☐	☐
19. jaundice _____	☐	☐
20. thyroid, parathyroid disease, or calcium deficiency _____	☐	☐
21. hormone deficiency _____	☐	☐
22. high cholesterol or taking statin drugs _____	☐	☐
23. diabetes (HbA1c =_____) _____	☐	☐
24. stomach or duodenal ulcer _____	☐	☐
25. digestive disorders (i.e. gastric reflux)_____	☐	☐

	YES	NO
26. osteoporosis/osteopenia (i.e. taking bisphosphonates) __	☐	☐
27. arthritis _____	☐	☐
28. glaucoma_____	☐	☐
29. contact lenses _____	☐	☐
30. head or neck injuries _____	☐	☐
31. epilepsy, convulsions (seizures) _____	☐	☐
32. neurologic problems (attention deficit disorder) _____	☐	☐
33. viral infections and cold sores _____	☐	☐
34. any lumps or swelling in the mouth_____	☐	☐
35. hives, skin rash, hay fever_____	☐	☐
36. venereal disease _____	☐	☐
37. hepatitis (type ___) _____	☐	☐
38. HIV / AIDS _____	☐	☐
39. tumor, abnormal growth_____	☐	☐
40. radiation therapy_____	☐	☐
41. chemotherapy_____	☐	☐
42. emotional problems _____	☐	☐
43. psychiatric treatment_____	☐	☐
44. antidepressant medication _____	☐	☐
45. alcohol / drug dependency _____	☐	☐
ARE YOU:		
46. presently being treated for any other illness _____	☐	☐
47. aware of a change in your general health _____	☐	☐
48. taking medication for weight management (i.e. fen-phen)	☐	☐
49. taking dietary supplements_____	☐	☐
50. often exhausted or fatigued _____	☐	☐
51. subject to frequent headaches _____	☐	☐
52. a smoker or smoked previously _____	☐	☐
53. considered a touchy person _____	☐	☐
54. often unhappy or depressed_____	☐	☐
55. FEMALE - taking birth control pills _____	☐	☐
56. FEMALE - pregnant _____	☐	☐
57. MALE - prostate disorders _____	☐	☐

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
Jack T. Winchester, DMD Trust Experience.

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 _____ Yes _____ No E-Mail Address:_____

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

Spouse/Parent/Step Parent_____

Other Names (please list relationship such as relative, friend, siblings, caretaker, co-worker)

_____ _____

_____ _____

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. For email communications, I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. By providing my email address I elect to receive email communication as requested.

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

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 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. I understand that any credit of $50.00 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.

Print Name_____ Date_____

Patient Signature_____