501 Health Park Dr. #110
Garner, NC 27529
919-772-1811

Medical Alert For Office Use

Thank you for visiting Moore Family Dentistry. We want your visit to be pleasant and comfortable. Please help us by completing this form.

Patient Information

Name ____
LAST FIRST MIDDLE INITIAL NICKNAME

Address ____
STREET

____
CITY STATE ZIP

Employer ____________________ Social Security# ____________________

Birth date ____________________ Email Address ____________________

Phone: Home ( ) ____________________ What is the best method to contact you? ____________________

Work ( ) ____________________

Mobile ( ) ____________________ ❑ Male ❑ Female

Emergency: Name ____________________ Phone ( ) ____________________

May we **email** you an appointment reminder? (Yes) (No)

Insurance

Primary Dental Carrier

Subscriber Name ____________________ Social Security # ____________ DOB ________

Employer ____________________ Insurance Co. ____________________

Insurance Co. Phone # ____________________ Group # ____________________

Relation to patient ____________________

Treatment Authorization Statement (Sign & Date)

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history is correct to the best of my knowledge.

Signature______________________________ **Date** ____________________

If Patient is Under 18

Responsible Party ____________________ Relation to Patient ____________________

Address ____________________ Phone____________________

Other Information

How did you hear about us? ______________________________

What is the reason for today's visit? ______________________________

Do you love your smile? ______________________________

When was your last dental visit? ______________________________

Why did you leave your last dentist? ______________________________

What did you like *most* about your last dentist? ______________________________

Do you require pre-medication prior to dental treatment? ______________________________

Medical History and Information

Conditions

- ❑ Abnormal Bleeding
- ❑ Acid Reflux
- ❑ Allergies
- ❑ Anemia
- ❑ Angina Pectoris
- ❑ Arthritis
- ❑ Artificial Heart Valve
- ❑ Asthma
- ❑ Blood Transfusion
- ❑ Cancer
- ❑ Chemotherapy
- ❑ Colitis
- ❑ Congenital Heart Defect
- ❑ Diabetes
- ❑ Difficulty Breathing
- ❑ Drug Abuse
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Facial Surgery
- ❑ Fainting Spells
- ❑ Fever Blisters
- ❑ Frequent Headaches
- ❑ Glaucoma
- ❑ HIV+ Aids
- ❑ Heart Attack
- ❑ Heart Murmur
- ❑ Heart Surgery
- ❑ Hemophilia
- ❑ Hepatitis A
- ❑ Hepatitis B
- ❑ Hepatitis C
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ Joint Replacement
- ❑ Kidney Problems
- ❑ Liver Disease
- ❑ Low Blood Pressure
- ❑ Mitral Valve Prolapse
- ❑ Pace Maker
- ❑ Psychiatric Problems
- ❑ Radiation Therapy
- ❑ Rheumatic Fever
- ❑ Seizures
- ❑ Sexually Transmitted Disease
- ❑ Shingles
- ❑ Sickle Cell Disease
- ❑ Sinus Problems
- ❑ Stroke
- ❑ Thyroid Problems
- ❑ Tuberculosis
- ❑ Ulcers

Allergies
Please Choose One

- ❑ None
- ❑ Aspirin
- ❑ Codeine
- ❑ Erythromycin
- ❑ Latex
- ❑ Metals
- ❑ Penicillin
- ❑ Sulfa
- ❑ Tetracycline
- ❑ Local Anesthetics
- ❑ Other- ______________

____

Y N

❑ ❑ Do you Smoke or use Tobacco?
If yes, how much? ______

If Female

Y N

❑ ❑ Are you taking Birth Control Pills?

❑ ❑ Are you pregnant?
If yes, # of weeks______

❑ ❑ Are you nursing?

Please list any medications you are currently taking: ______________________________

____

Are you currently taking Fosamax, Actonel, or Boniva? Yes No if so, for how many years? ________

Treatment Authorization Form

I authorize and give consent to perform dental services agreed between doctor and patient and/or parent or guardian to be necessary or advisable including the use of local anesthesia and other medication as indicated. I certify to the above statements regarding my medical condition.

Payment for all treatment and services rendered are my responsibility.

______________________________ ______________

PATIENTS SIGNATURE DATE

If patient is a child or requires a guardian:

______________________________ ______________

PARENT/GUARDIAN SIGNATURE DATE

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*You May Refuse To Sign This Acknowledgement

I, ____, have received a copy of this office's Notice of Privacy Practices.

____
Please Print Name

____
Signature

____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice Of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communication barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (Please specify)

____

Office Policies

Insurance: We file to the insurance company as a courtesy to our patients. Insurance is an agreement between you the subscriber and the insurance company. Insurance policies generally cover only a portion of the total treatment cost. This is due to coinsurance as well as "usual, customary and reasonable fees" established by the insurance company. We will ESTIMATE your patient portion that will be due at the time services are rendered. It will be your responsibility to pay any balance not paid by your insurance company within 60 days.

Financial Agreement: Payment is due at time of service. We accept Visa, MasterCard, Discover, and American Express as well as Cash or Check. As a service to our patients we also offer Care Credit, to those who qualify. These plans provide you with many payment options, including interest free options. A charge of $25.00 will be added to your account for any returned checks. **A deposit of $50.00 will be required for scheduling treatment that requires a co-pay or out of pocket cost of $100.00 or greater.**

Appointments: In order to provide quality dental care in an efficient manner, we need 2 business days' notice of a cancellation or to reschedule your appointment. **Cancellations with less than 2 business days' notice may be subject to a $50.00 charge to one's account**.* If you or your family accrue multiple broken appointments we reserve the right of dismissal from the practice. We will make every effort to see you at your appointed time. If you are 10 minutes late for your scheduled appointment, we may reschedule you to another day to be fair to the patients after you who come at their scheduled appointment time.

I am aware of the $50 Cancellation and Deposit Policy_________ (initial here)

We are happy you have chosen us to provide you and your family with excellent dental care. If you have any questions regarding any of our office policies please don't hesitate to ask one of our team members. It is our sincere goal to give our patients a high quality and pleasant dental experience.

Signature____Date____________________

*we will take unforeseen circumstances into account when determining the application of a broken appt. charge