

# Cary Dental Center

3701 NW Cary Parkway  
Preston Plaza, Suite 201  
Cary, NC 27513

Medical Alert For Office Use

Welcome to Cary Dental Center. 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 \_\_\_\_\_ Drivers License \_\_\_\_\_

Birth date \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Phone: Home \_\_\_\_\_ Social Security # \_\_\_\_\_

Work \_\_\_\_\_ May we contact you at work?  Yes  No

Mobile \_\_\_\_\_ Are you married?  Yes  No

E-mail: \_\_\_\_\_  Male  Female

In Case of Emergency:

Name \_\_\_\_\_ Phone \_\_\_\_\_

## INSURANCE INFORMATION

### Primary Dental Carrier

Subscriber Name \_\_\_\_\_ Social Security # \_\_\_\_\_ DOB \_\_\_\_\_

Employer \_\_\_\_\_ Insurance Co. \_\_\_\_\_

Insurance Co. Phone # \_\_\_\_\_ Group # \_\_\_\_\_

Relation to patient \_\_\_\_\_

### Secondary Dental Carrier

Subscriber Name \_\_\_\_\_ Social Security # \_\_\_\_\_ DOB \_\_\_\_\_

Employer \_\_\_\_\_ Insurance Co. \_\_\_\_\_

Insurance Co. Phone # \_\_\_\_\_ Group # \_\_\_\_\_

Relation to patient \_\_\_\_\_

## Insurance Authorization Statement (Sign & Date)

I certify that I, and/or my dependent(s), have insurance coverage with the above named insurance company and assign directly to Cary Dental Center all insurance benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize use of my signature on all insurance submissions. I hereby authorize the Cary Dental Center 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 \_\_\_\_\_

Patient, Parent, Guardian or Personal Representative

## OTHER INFORMATION

How did you hear about us? \_\_\_\_\_

Do you love your smile? \_\_\_\_\_

Is there anything you would like to change? \_\_\_\_\_

Why did you leave your last dentist? \_\_\_\_\_

What did you like most about your last dentist? \_\_\_\_\_

## MEDICAL HEALTH HISTORY

### Conditions

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

### Allergies

- Aspirin
- Codeine
- Dental Anesthetics
- Erythromycin
- Latex
- Metals
- Penicillin
- Sulfa
- Tetracycline

Other \_\_\_\_\_

### If Female

Y N

- Are you taking Birth Control Pills?
- Are you pregnant?  
If yes, # of weeks \_\_\_\_\_
- Are you Nursing?

Y N

- Are you in good health?
- Are you being treated by a physician now? If Yes, For what? \_\_\_\_\_
- Have you ever been told by a physician or dentist that you need to pre-medicate prior to any dental treatment?
- Do you Smoke or use Tobacco?

Medications you are currently taking: \_\_\_\_\_

List any other medical conditions NOT listed above: \_\_\_\_\_

Name of Physician: \_\_\_\_\_

## DENTAL HEALTH HISTORY

Reason for today's visit: \_\_\_\_\_

Have you ever experienced any of the following?

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Bleeding Gums              | <input type="checkbox"/> Clenching or grinding of teeth           | <input type="checkbox"/> Soreness in jaw            |
| <input type="checkbox"/> Bad Breath                 | <input type="checkbox"/> Difficulty opening wide                  | <input type="checkbox"/> Sensitivity to hot or cold |
| <input type="checkbox"/> Bad taste in mouth         | <input type="checkbox"/> Food catching between teeth              | <input type="checkbox"/> Snoring                    |
| <input type="checkbox"/> Burning sensation in mouth | <input type="checkbox"/> Jaw Surgery                              | <input type="checkbox"/> Smoke or chew tobacco      |
| <input type="checkbox"/> Clicking or popping in jaw | <input type="checkbox"/> History or family history of gum disease | <input type="checkbox"/> Wisdom teeth extraction    |

If you could change anything about your smile, which of the following would you want?

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Whiter teeth          | <input type="checkbox"/> Remove silver filling | <input type="checkbox"/> Close space(s)     |
| <input type="checkbox"/> Replace missing teeth | <input type="checkbox"/> Straighter teeth      | <input type="checkbox"/> Replace old crowns |
| <input type="checkbox"/> Remove stains/spots   | <input type="checkbox"/> Reshape/resize teeth  | <input type="checkbox"/> Fix chipped teeth  |

## 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.

Signature: \_\_\_\_\_  
Patient, Parent, Guardian or Personal Representative

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_