MAGNOLIA DENTAL OF PINEHURST

Patient Information

Name: _____/_____/_____ _____
Last First M.I. Preferred Name

D.O.B.: ___/___/_____ Age: _____

Sex assigned at birth: ⬜ Male Female Non-binary Decline to answer

(optional) Gender Identity: _____ (optional) Preferred pronouns: _____

Address: _____ Home Phone: _____

City: _____ State: _____ Zip: _____ Cell: _____

SSN: _____-___-_____ Email: _____

Marital Status: Married Single Divorced Widowed ⬜ Domestic Partner

Employer: _____ Occupation: _____

Emergency Contact: _____/_____/_____
Name Relation Phone Number

Who may we thank for sending you to our office? _____

What is the reason for your appointment? _____

Responsible Party Information

Personal Responsible for Account: _____/_____/_____
Last First M.I.

Relation to Patient: _____ D.O.B.: ___/___/_____ SSN: _____-___-_____

Address: _____ Home Phone: _____

City: _____ State: _____ Zip: _____ Cell: _____

Responsible Party Employer: _____ Occupation: _____

Primary Insurance Information

Name of Insured: _____/_____/____ D.O.B. ____/____/_____
Last First M.I.

Insured's SSN: _____-____-_____ Is Insured a Patient? (circle) Yes / No

Insurance Company and Plan Name: _____

Subscriber I.D. #: _____ Group #: _____

Insured's Employer Name: _____

Patient's Relationship to Insured: ☐ Self Spouse Child Other: _____

Additional Insurance Information

Name of Insured: _____/_____/____ D.O.B. ____/____/_____
Last First M.I.

Insured's SSN: _____-____-_____ Is Insured a Patient? (circle) Yes / No

Insurance Company and Plan Name: _____

Subscriber I.D. #: _____ Group #: _____

Insured's Employer Name: _____

Patient's Relationship to Insured: Self Spouse Child ☐ Other: _____

Assignment of Insurance Benefits and Release of Information

I, the undersigned, certify that I (or my dependents) have dental insurance coverage with _____ and assign directly to Magnolia Dental of Pinehurst
Name of Insurance Company
all 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, and for all services rendered on my behalf or my dependents. I hereby authorize the doctor and/or any provider or supplier of services in this office to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance whether manual or electronic.

Responsible Party Signature: _____ Date: _____

Staff Initials: _____

MAGNOLIA DENTAL OF PINEHURST

Authorization to Release Health Information

Communications between Patients and their Families, Friends, or Caregivers

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This form allows Magnolia Dental of Pinehurst to communicate information about your care (e.g., appointments, labs, medication, treatment plans, billing information) to you and those you list on this form. Signing this form is optional, is not required to receive treatment, and does not expire until you end it in writing.

Patient Name: _____

Date of Birth: _____ **Main Contact Number:** (____) _____

mm/dd/yyyy ⬜ Home Cell Work

Mailing Address: _____

City: _____ **State:** _____ **Zip:** _____

COMMUNICATING WITH YOU

Phone	**Detailed Messages Permitted**		
Main Contact Number Above	Text	Voicemail	None
Other: (____) _____	Text	Voicemail	None
Home Cell Work			

EMAIL

Email Address: _____

All information from this practice

Appointment information only ⬜ Billing information only

COMMUNICATING WITH FAMILY, FRIENDS, OR CAREGIVERS

If you would like Magnolia Dental of Pinehurst to discuss your personal health information with another individual, please select with whom and what information we may discuss.

⬜ Spouse Family Friend Other _____

Please provide their name(s): _____

_____

Information to be disclosed: (please check all that apply)

Appointment dates and times Treatment plans and referrals

Financial and billing information ⬜ Any other pertinent dental health information

COMMUNICATING WITH OTHER HEALTHCARE PROVIDERS

Providing quality dental care in a safe and effective manner sometimes requires collaboration with other healthcare professionals, such as medical doctors and other dental specialists. By signing below, you authorize Magnolia Dental of Pinehurst to share information relating to your dental care with other healthcare professionals via email or phone communication.

PATIENT RIGHTS & SIGNATURE

You can end this authorization at any time in writing. See our Notice of Privacy Practices for exceptions. A termination will not apply to any releases of information that happen before we receive a written termination from you. The recipient of the information could use or release it in a way that federal or state laws do not protect. This practice is not responsible for the privacy or security of your health information after it is sent to those listed on this authorization. You can review or copy the information that will be used or released as described in this authorization. You do not have to sign this authorization to receive treatment from this practice. You understand that the information that will be used or released might include a communicable disease diagnosis such as HIV or a diagnosis related to mental health or substance abuse. All changes or updates to this form must be made in writing and signed by you (patient) or your personal representative. Minor edits (e.g., new phone number) can be made on this form, initialed, and dated instead of requiring a new form.

Patient Signature: _____ **Date:** _____

Staff Initials: _____

MAGNOLIA DENTAL OF PINEHURST

Medical and Dental History

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 receive.

Do you have, or have you had, any of the following? (Check all that apply)

- ☐ AIDs / HIV Positive
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis / Gout
- ☐ Artificial Heart Valve
- ☐ Artificial Joint
  Joint: _____
  Date: _____
  Orthopedist: _____
- ☐ Asthma
- ☐ Back Problems
- ☐ Bleeding Abnormally with Extractions or Surgery
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Breathing Problem
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Chest Pain
- ☐ Cold Sores / Fever Blisters
- ☐ Congenital Heart Disorder
- ☐ Cortisone Treatments
- ☐ Convulsions
- ☐ Dementia or Alzheimer's Disease
- ☐ Diabetes: Type _____
  HbA1c: _____
  Date: _____
- ☐ Drug Addiction or Chemical Dependence
- ☐ Easily Winded
- ☐ Emphysema
- ☐ Epilepsy of Seizures
- ☐ Excessive Bleeding
- ☐ Fainting or Dizziness
- ☐ Frequent Cough
- ☐ Frequent Diarrhea
- ☐ Frequent Headaches
- ☐ Glaucoma
- ☐ Heart Attack
- ☐ Heart Failure
- ☐ Heart Murmur
- ☐ Heart Pacemaker
- ☐ Heart Trouble
- ☐ Hemophilia
- ☐ Hepatitis A
- ☐ Hepatitis B or C
- ☐ Herpes
- ☐ High Blood Pressure
  Usual BP: _____/_____
- ☐ Hives or Rash
- ☐ Hypoglycemia
- ☐ Irregular Heartbeat
- ☐ Kidney Problems
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Mitral Valve Prolapse
- ☐ Osteoporosis
- ☐ Psychiatric Care
- ☐ Radiation Therapy
- ☐ Recent Weight Loss
- ☐ Renal Dialysis
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Seasonal Allergies
- ☐ Sexually Transmitted Infection (STI / STD)
- ☐ Shingles
- ☐ Sickle Cell Disease
- ☐ Sinus Issues
- ☐ Stomach / Intestinal Disease
- ☐ Stroke
- ☐ Swelling of Limbs
- ☐ Swollen Neck Glands
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Tumors or Growths
- ☐ Ulcers

Do you have allergies to any of the following?

⬜ Acrylic Aspirin Codeine Latex Local Anesthetics Metal

Penicillin Sulfa Drugs ⬜ Other: _____

Women: are you... (circle those that apply)

Pregnant Trying to get pregnant Taking birth control Nursing

Physician's Name: _____ Date of Last Visit: _____

Physician's office: _____ Phone: _____

Are you currently under medical treatment? If yes, please explain: **Yes / No**

Explain: _____

Have you been hospitalized or had any serious illness or operations? **Yes / No**

Explain: _____

Have you ever had a serious head or neck injury? **Yes / No**

Explain: _____

Do you take, or have you taken, bisphosphonates (a medication for bone health), such as Alendronate (Fosamax), Risedronate (Actonel), Ibandronate (Boniva), Pamidronate (Aredia), or Zoledronic acid (Reclast, Zometa) **Yes / No**

Do you use controlled substances or recreational drugs? **Yes / No**

Do you smoke or vape? **Yes / No**

Do you use smokeless tobacco or nicotine products? **Yes / No**

Do you consume alcohol? **Yes / No**

Please list all medications and supplements you are currently using and their purpose:

_____

_____

_____

Have you ever had any serious illness or condition not listed above? **Yes / No**

Explain: _____

Additional Comments: _____

_____

_____

Dental Health Information:

Former Dentist: _____ City, State: _____

Date of last dental visit: _____ Date of last X-Rays: _____

Are you currently having any discomfort? Explain: _____

Have you had any complications associated with previous dental procedures? **Yes / No**

Explain: _____

Have you ever been treated for periodontal disease, or gum disease? **Yes / No**

If so, when? _____

How often do you brush your teeth? _____

How often do you floss your teeth? _____

Do you have, or have you had, any of the following? (Check all that apply)

- ☐ Bad breath
- ☐ Bleeding, sore gums
- ☐ Burning tongue or lips
- ☐ Cheek or lip biting
- ☐ Clicking or popping jaw
- ☐ Clenching or grinding
- ☐ Difficulty chewing
- ☐ Difficulty opening or closing
- ☐ Difficulty swallowing
- ☐ Food impaction
- ☐ Frequent oral blisters
- ☐ Loose or mobile teeth
- ☐ Pain around ear
- ☐ Sensitivity to biting
- ☐ Sensitivity to cold
- ☐ Sensitivity to hot
- ☐ Sensitivity to sweets
- ☐ Shifting in bite
- ☐ Swelling or bumps in mouth
- ☐ Tooth pain
- ☐ Unpleasant taste

Are you happy with the color of your teeth? **Yes / No**

Are you happy with the shape of your teeth? **Yes / No**

Are you happy with your smile? **Yes / No**

If no to any of the above, please explain: _____

_____

_____

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 my medical status.

Patient Signature: _____ Date: _____

MAGNOLIA DENTAL OF PINEHURST

General Informed Consent for Dental Procedures

Be assured that we follow all ADA, CDC and OSHA infection control procedures for the protection of our patients and dental team.

I give consent for myself/my child to receive dental treatment recommended by the providers at Magnolia Dental of Pinehurst. Before beginning dental treatment, I provided my dental practice with accurate information and will continue to update them during and after treatment.

The procedures addressed by this general consent are considered routine, low-risk procedures targeted at diagnosis, prevention, and restorative treatment (e.g. Oral exams, radiographs, dental cleanings, fluoride treatment, administration of local anesthesia, and dental fillings).

Prior to accepting treatment, I have discussed the risk and benefits of having treatment and also discussed the risk of not having dental treatment. I have carefully considered all anticipated benefits and commonly known risks of dental procedures. I have been advised of the importance of following my dental providers advice and recommendations regarding medications, pre and post treatment, referral to other dentists and specialists, and returning for follow-up/scheduled appointments. All options have been given and I have assisted in the decision for dental treatment.

I understand that if I fail to follow the advice of my dental provider I may increase the risk of poor outcomes.

While risk of complications with dental treatment is rare, it is possible that complications can occur with your treatment. Included are the complications from the use of dental instruments, aspiration, medications, allergies, drugs, anesthetics and injections.

I understand that the use of local anesthetics carries a small risk for swelling, bruising, allergic reaction, changes in pain perception, and temporary or permanent paresthesia or anesthesia.

I have been properly informed that during treatment it may be necessary to change or add procedures because of the conditions found while working on the teeth that were discovered during examination or treatment. For example, the most common change to treatment is the need for root canal therapy following routine restorative procedures.

Patient Signature: _____ **Date:** _____

Staff Initials: _____

MAGNOLIA DENTAL OF PINEHURST

305 Page Rd. N. #2 Pinehurst, NC 28374
Phone: (910) 295-1010 Fax: (910) 295-1367

Notice of Privacy Practices Acknowledgement

You may refuse to sign this acknowledgement

I, _____, have received a copy of the Notice of Privacy Practices for the above named practice.

Patient/Guardian Signature: _____ **Date:** _____

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- ☐ An emergency existed and a signature was not possible at the time.
- ☐ The individual refused to sign.
- ☐ A copy was mailed with a request for signature by return mail.
- ☐ Unable to communicate with the patient for the following reason:

  _____

  _____
- ☐ Other: _____

  _____

Prepared By: _____

Signature: _____

Date: _____