TRYON FAMILY DENTISTRY

2720 Lake Wheeler Rd. | Suite 125 | Raleigh, NC 27603

Hello and welcome to our office:

One of the goals of our practice is to do everything we can to make your dental visit just as pleasant as possible. If you have a dental insurance plan please do not hesitate to ask any questions about your plan or any aspect of the treatments we are advocating. In order for us to make your dental plan to work successfully, we must emphasize several important areas:

- We will be happy to file your insurance as a courtesy to you. Please be aware that insurance is a contract between you, your employer and the insurance company. We will gladly do our best to help you obtain your maximum insurance benefits, deductibles and co-insurance amounts. All out-of pocket fee quotes are ESTIMATES, based on the best available information provided by your insurance company. These quotes could change at anytime according to your insurance plan and their decision to cover or deny any procedure. If for any reason your insurance denies coverage; in part or in full, you will be responsible for the balance due.
- Regarding scheduled appointments, **THERE WILL BE A $25 PER HALF HOUR CHARGE FOR ANY BROKEN/CHANGED APPOINTMENTS UNLESS A 48 HOUR (2 BUSINESS DAYS) NOTICE IS GIVEN. THIS CHARGE MUST BE PAID PRIOR TO ANY FUTURE APPOINTMENTS. AFTER TWO BROKEN/ CHANGED APPOINTMENTS WITHOUT 48 HOUR NOTICE, WE WILL ASK THAT YOU SELECT ANOTHER DENTAL PROVIDER.**
- **We require all patients scheduling an appointment requiring more than one hour of schedule time to prepay a deposit of $50, towards their co-pay, to reserve the appointment.**
- **As an incentive to our patients, a 5% discount will be given to patients that prepay their out-of-pocket portion for the scheduled appointment, AT LEAST one week in advance. Otherwise, your out-of-pocket amount is due in full at the time service is rendered.**
- If you are late for your appointment by more than 15 minutes, we may reschedule your appointment. If this occurs often, you may be asked to select another dental provider.
- If your account becomes past due by more than 60 days, there will be an 18% finance charge added to your account.
- If you come in for an emergency appointment, please note that 100% of these fees will be due at the time of service.

We are happy that 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 front office staff. It's our sincere goal to give all of our patients a high quality and pleasant dental experience.

AGREED AND ACCEPTED:

Patient Signature

Date

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Patient Registration

Patient Information:

First Name: _____ Middle Initial: _____ Last Name: _____

Nickname: _____ Home Phone: (_____) _____

Address: _____ Work Phone: (_____) _____

City: _____ State/Zip: _____ Cell Phone: (_____) _____

Birth Date: _____ Age: _____ Sex: Male Female Marital Status: _____

Social Security Number: _____ Pharmacy Phone Number: _____

E-mail: _____ Who may we thank for referring you to our office? _____

Which form of confirmation for your scheduled appointments would you like to receive? ___Voice Mail/Phone Call ___Text ___Email

EMERGENCY CONTACT: _____ Relationship: _____

Phone number: _____ Is patient a full or part time student? _____

Primary Dental Insurance Information:

Subscriber Name: _____ Relationship to patient: PLEASE CIRCLE: SELF / SPOUSE / CHILD / OTHER

Employer who provides the insurance coverage: _____ Subscriber ID# _____

Name of Dental Insurance Company: _____ Group # _____

Address of Dental Insurance Company: _____ SS # _____

_____ Date of Birth: _____

Dental Insurance Company Phone Number: _____

Secondary Dental Insurance Information:

Subscriber Name: _____ Relationship to patient: PLEASE CIRCLE: SELF / SPOUSE / CHILD / OTHER

Employer who provides the insurance coverage: _____ Subscriber ID# _____

Name of Dental Insurance Company: _____ Group # _____

Address of Dental Insurance Company: _____ SS # _____

_____ Date of Birth: _____

Responsible Party (If someone other than patient)

Name: _____

Address: _____ Date of Birth: _____

_____ SS #: _____

Home #: _____ Work #: _____ Cell #: _____

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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 will receive. Thank you for answering the following questions.

	YES	NO	If you answer yes to any of the following questions please explain here:
Are you under a physician's care now?			
Have you ever been hospitalized or had a major operation?			
Have you ever had a serious head or neck injury?			
Are you taking any medications, pills, or drugs?			
Do you take or have you taken Phen-Fen or Redux?			
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?			
Are you on a special diet?			
Do you use tobacco (past or present)?			
Do you use controlled substances?			

Women: Are you	YES	NO		YES	NO		YES	NO
Pregnant or Trying to get pregnant?			Taking oral contraceptives?			Nursing?		

Are you allergic to the following? Indicate which of the following allergy you have?

Aspirin ☐	Penicillin ☐	Codeine ☐	Acrylic ☐	Metal ☐	Latex ☐	Local Anesthetics ☐

Are you allergic to anything not previously mentioned? _____

	YES	NO		YES	NO		YES	NO		YES	NO
Abnormal Bleeding			Congenital Heart Defect			Hemophilia			Seizures		
Alcohol Abuse			Diabetes			Hepatitis			Shingles		
Allergies			Difficulty Breathing			High Blood Pressure			Sickle Cell Disease/Trait		
Anemia			Drug Abuse			Kidney Problems			Sinus Problems		
Angina Pectoris			Emphysema			Liver Disease			Stroke		
Arthritis			Epilepsy			Low Blood Pressure			Surgery		
Artificial Bones/Joints			Fainting Spells			Mitral Valve			Thyroid Disease		
Artificial Heart Valve			Fever Blisters/Cold Sores			Pacemaker			Tuberculosis		
Asthma			Fever			Pneumocystis			Ulcers		
Blood Transfusion			Frequent Headaches			Pre-med			Yellow Jaundice		
Cancer			Glaucoma			Psychiatric Care					
Chemotherapy			HIV+ AIDS			Radiation Therapy					
Colitis			Heart Attack			Rheumatic/Scarlet Fever					

Have you ever had any serious illness not listed above? YES or NO if yes 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 medical status.

Signature of Patient, Parent, or Guardian: _____ DATE: _____

Print Patient Name: _____