PATIENT INFORMATION

First Name: _____ MI: _____ Last: _____ Nick Name: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Date of Birth: _____ ☐ Male ☐ Female SS#: _____

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____

State ID/Driver's License #: _____ E-Mail Address: _____

Name of Physician: _____ Physician Phone: _____

In case of Emergency Contact: _____ Relationship: _____ Phone: _____

How did you hear about our office? _____

Patient Health History

Do you have a history of:

	Yes	No
A.I.D.S/HIV Positive	☐	☐
Alcoholism	☐	☐
Allergies	☐	☐
Alzheimer's Disease/Dementia	☐	☐
Anemia	☐	☐
Angina	☐	☐
Arthritis	☐	☐
Artificial Heart Valve	☐	☐
Artificial Joint	☐	☐
Asthma	☐	☐
Blood Disease	☐	☐
Bone Disease	☐	☐
Breathing Problem	☐	☐
Bruise Easily	☐	☐
Cancer	☐	☐
Chemical Dependency	☐	☐
Chemotherapy	☐	☐
Chest Pain	☐	☐
Circulatory Problems	☐	☐

	Yes	No
Cold Sores/Fever Blisters	☐	☐
Congenital Heart Disorder	☐	☐
Convulsions/Seizures	☐	☐
Diabetes	☐	☐
Easily Winded	☐	☐
Emphysema	☐	☐
Excessive Bleeding	☐	☐
Epilepsy	☐	☐
Frequent Headaches	☐	☐
Genital Herpes	☐	☐
Glaucoma	☐	☐
Hay Fever	☐	☐
Head Injuries	☐	☐
Hearing Impaired	☐	☐
Heart Disease	☐	☐
Heart Pacemaker	☐	☐
Heart Valve, Murmur	☐	☐
Hepatitis/Liver Disease	☐	☐
Type(s)		

	Yes	No
Hepatitis Carrier	☐	☐
High Blood Pressure	☐	☐
Hip or Joint replacement	☐	☐
HPV	☐	☐
Irregular Heart Beat	☐	☐
Kidney Disease	☐	☐
Kidney Dialysis	☐	☐
Latex Sensitivity	☐	☐
Leukemia	☐	☐
Lupus	☐	☐
Low Blood Pressure	☐	☐
Malignancies	☐	☐
Mitral Valve Prolapse	☐	☐
Neck & Back Problems	☐	☐
Nervous Problems/Disorders	☐	☐
Osteoporosis	☐	☐
Pacemaker	☐	☐
Pain in jaw joints	☐	☐
Prosthetic Joints	☐	☐

	Yes	No
Psychiatric Care	☐	☐
Radiation Treatment	☐	☐
Recent Weight Loss	☐	☐
Respiratory Problems/ Disorders	☐	☐
Rheumatic Fever	☐	☐
Rheumatism	☐	☐
Scarlet Fever	☐	☐
Seizures/Fainting Spells	☐	☐
Shingles	☐	☐
Sickle Cell	☐	☐
Sinus Problems	☐	☐
Stomach Ulcers	☐	☐
Stroke	☐	☐
Thyroid Disease	☐	☐
Tuberculosis	☐	☐
Tumors or growths	☐	☐
Ulcers	☐	☐
Venereal Disease	☐	☐
Yellow Jaundice	☐	☐

Medical Questions

List any medications you are taking including nonprescription drugs:

_____

_____

_____

Are you allergic to any medications? ☐Yes ☐ No If yes, please list below:

_____

_____

Are you in good health? ☐Yes ☐ No

Date of last medical exam:

Have you ever been hospitalized? ☐Yes ☐ No If yes, what was the problem?

_____

_____

Do you have any disease/problem you think we should know about? ☐Yes ☐ No

_____

_____

_____

_____

Have you had a transplant operation that has depressed your immune system? ☐Yes ☐ No

Are you pregnant or nursing? If yes, how many weeks? ☐Yes ☐ No

_____

Do you smoke or chew tobacco? ☐Yes ☐ No

Have you had Heart Surgery? ☐Yes ☐ No

Are you currently under the care of an MD? ☐Yes ☐ No

Are you taking or have you ever taken bisphosphonates? (Fosamax or Actonel for osteoporosis, chemotherapy, etc.) ☐Yes ☐ No

Dental History Information

Date of last dental visit?_____

Name of your previous dentist _____

Reason for today's visit?_____

How often do you floss your teeth?_____

Have you or a family member ever been treated for periodontal disease? ☐Yes ☐No

Have you ever had complications from an extraction? ☐Yes ☐No

Have you ever had a popping or clicking near your ear when you chew? ☐Yes ☐No

Are you prone to frequent headaches? ☐Yes ☐No

Do you grind your teeth? ☐Yes ☐No

Do you snore? ☐Yes ☐No

Do you have problems with bad breath? ☐Yes ☐No

Have you ever had an allergic reactions to a crown, metal filling or dental appliance? ☐Yes ☐No

Are your teeth sensitive to hot, cold or pressure? ☐Yes ☐No

On a scale from 1 to 10, with 10 being the highest, how important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

If you could change anything about your smile, what would it be:

- ☐ Whiter
- ☐ Straighter
- ☐ Close Gaps
- ☐ Replace silver mercury fillings
- ☐ Repair chipped teeth
- ☐ Replace missing teeth
- ☐ Less gums showing
- ☐ Replace old crowns or caps that don't match

I certify that I have read and understand the questions above. I acknowledge that my questions have been answered to my satisfaction. I will not hold my dentist or and other members of his/her staff responsible for any errors that I have made in the completion of this form.

Patient: _____ Date: _____

Parent/Guardian (if patient is a minor):_____ Date: _____

Reviewed by: _____ Date: _____

Doctor Signature:_____ Date: _____

CURLEY
IMPLANT & GENERAL
DENTISTRY

Thank you for choosing Curley Implant & General Dentistry. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of this mission is making the cost of optimal care as easy and manageable as possible for our patients. We offer convenient payment options and accept most dental insurance.

We accept the following forms of payment:

- **Cash**
- **Credit Card (Visa, Mastercard, Discover & American Express)**
- **Check ($31 fee charged for returned checks by the bank)**
- **CareCredit**

Dental Insurance:

- We accept many dental insurance plans and are in-network with several of them. In preparation for your appointment with us, we will contact your insurance company to verify your eligibility and obtain a breakdown of benefits.
  - At your appointment, we will provide a written treatment plan with an **ESTIMATE** of your current insurance coverage and your expected out of pocket portion (co-payment). We will file the claim with supporting information to your insurance company for you.
  - All co-payments are due at the time the service is provided. It is important to provide us with accurate insurance information and keep us updated on any changes so claims process smoothly. ***NOTE: If your insurance company pays less than estimated or denies benefits, you are responsible for the balance.**

- If you have a secondary dental insurance plan, please provide us with this information. We will bill services to the secondary insurance on your behalf. We will have your insurance company send any reimbursement for services directly to you.

- If we are **OUT OF NETWORK** with your insurance company, we will collect **in full** at the time services are rendered.
  - We will provide a written cost to you at your appointment and bill services to your insurance company with supporting information on your behalf. Your insurance will send any reimbursement directly to you.

- If you are uninsured or self pay, we will provide you with an estimate for the total expected cost of services prior to services being rendered. Payment is due at the time the service(s) is rendered.

- We do not accept medicaid, medicare or bill services to medical insurance plans.

Appointment Confirmations & Cancellations:

Our goal is to provide treatment in a timely manner with as few visits as necessary. We understand your time is very valuable. We will be placing a phone call and/or a text message to you prior to your scheduled appointment. We require a return call or text to confirm your appointment. This is also a great time to ask us any questions regarding your visit and provide updated information as necessary. If we do not receive confirmation of your appointment within 24 hours of your appointment, your appointment will be cancelled. We understand that unforeseen circumstances may arise, which may result in you canceling your appointment. We require at least a 24 hour notice if you need to cancel your appointment.

Acknowledgement:

I hereby acknowledge and accept the terms and conditions as described herein by Curley Implant & General Dentistry.

_____ _____

Patient, Parent or Guardian Signature Date

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT (PARENT OR GUARDIAN IF PATIENT IS A MINOR)

NAME: _____

ADDRESS: _____

TELEPHONE: _____ EMAIL: _____

SOCIAL SECURITY#: _____ DATE OF BIRTH: _____

SECTION B: TO THE PATIENT - PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide to sign this Consent. Our Notice provides a description of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of this Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

CONTACT PERSON: Joseph Curley, DMD, FAGD
TELEPHONE: 910-463-2267
FAX: 910-660-8135
E-MAIL: drcurley@drcurley.dental
ADDRESS: 143 Poole Road, Suite C, Leland, NC 28451

Right To Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgment

_____ I have read a copy of this office's Notice of Privacy Practices and am aware that a copy of this Notice is available upon request.
initial

_____
PLEASE PRINT NAME

_____
SIGNATURE

SECTION C: MESSAGES

☐ Please call _____ ☐ Please Text # _____

if unable to reach me: ☐ You may leave a detailed message ☐ Please leave a message asking me to return your call

☐ Other _____

SECTION D: Authorization to disclose to Third Party. I authorize Dr. Curley & Associates, PA to disclose my protected health information to the following individual or company.

NAME: _____ RELATIONSHIP: _____

COMPANY OR ENTITY: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: _____ FAX: _____

Dr. Curley & Associates P.A.
143 Poole Rd
Suite C
Leland, NC 28451
910-463-2267 phone
910-660-8135 fax
info@drcurley.dental

X-RAY/Dental Records REQUEST AND RELEASE FORM

Date: ____/____/____

Patient Name: _____ D.O.B___/____/_____

Exam Date(s) Requested:_____

X-Rays to be sent/emailed from:

Dr./Office Name: _____

Phone Number: _____

X-rays to be sent/emailed to:

Dr./Office Name :_____

Email Address: _____

I _____ authorize the release of the X-Rays/Dental Records requested above.

You have the right to revoke this consent. However you must revoke this consent in writing. Any revocation would not pertain to information already used or disclosed pursuant to this consent during the time frame within which this consent is effective.

_____ _____
Signature Date

_____ _____
Signature of Parent or Guardian Date