Drs. Monroe & Monroe, DDS, PA

www.monroeandmonroe.com
12 Regional Drive • Pinehurst, NC 28374--8850 (910)295-4242

Welcome to our Practice

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

Title: _____ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date: _____ **SS#:** ___-__-____ **Prev. Visit:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ _____ _____ _____ _____ _____
Home Mobile Work Ext Fax Other

Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

The following is for: ◯ the patient ◯ the person responsible for payment ◯ both ◯ not applicable

Employer Name: _____ **Phone:** _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Whom may we thank for referring you to our practice?

_____

In an emergency who should be notified? Please enter Name and Phone number below:

_____

_____

Closest relative not living with you? Please enter Name and Phone number below:

_____

_____

Responsible Party Information:

This only needs to be filled out if the insurance subscriber is other than patient, or if patient is under 18.

The following is for: ◯ the patient's spouse ◯ the person responsible for payment ◯ both ◯ neither-not applicable

Name: _____ _____ ___ _____
Last First MI Preferred Name

Title: _____ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date: _____ **SS#:** ___-__-____ **DL#:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ _____ _____ _____ _____ _____
Home Mobile Work Ext Fax Other

Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Primary Dental Insurance:

Name of Insured: _____ _____ ____
Last First MI

Insured's Birth Date: _____ **ID #:** _____ **Group #:** _____

Insured's Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Insurance Company Phone Number:

_____

_____

Insurance Authorization:

☐ **By checking this box,**
I authorize my insurance company to pay the dentist all insurance benefits rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.

Secondary Dental Insurance

Name of Insured: _____ _____ ____
Last First MI

Insured's Birth Date: _____ **ID #:** _____ **Group #:** _____

Insured's Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Insurance Company Phone Number:

Insurance Authorization:

☐ **By checking this box,**
I authorize my insurance company to pay the dentist all insurance benefits rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.

Medical History

Indicate which of the following conditions you have or have had. By checking the box it will indicate a "YES" response, leaving blank will indicate a "NO" response.

- ☐ *PREMED
- ☐ Aids/HIV
- ☐ Allergies/Hives
- ☐ Allergy - Codeine
- ☐ Allergy - Penicillin
- ☐ Anemia
- ☐ Arthritis/Rheumatism
- ☐ Artificial Heart Val
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Bladder
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Cancer
- ☐ Cerebral Palsy
- ☐ Chemotherapy
- ☐ Chest Pain
- ☐ Chronic Cough
- ☐ Cold Sore/Fever Blis
- ☐ Cong Heart Disease
- ☐ Cortisone Meds
- ☐ Developmental Disabi
- ☐ Diabetes
- ☐ Dizziness/Fainting
- ☐ Emphysema
- ☐ Epilepsy/Seizures
- ☐ Excessive Bleeding
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Hearing
- ☐ Heart Disease/Surg
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Trouble
- ☐ Latex Sensitivity
- ☐ Liver Disease
- ☐ Mitral Valve Prolaps
- ☐ Nervous/Anxious
- ☐ Neuro Disorders
- ☐ Other
- ☐ Pacemaker
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Sickle Cell Disease
- ☐ Sinus Problems
- ☐ Sleep Apnea
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease

Covid 19 Vaccine * ◯ Yes ◯ No

- ☐ Hospitalized in the past Two Years
- ☐ Taking medication for weight control (ie fen-phen)
- ☐ Taking dietary supplements
- ☐ Special or Restricted Diet
- ☐ Subject to frequent headaches
- ☐ A smoker/smoked previously or Chew Tobacco
- ☐ Wear contact lenses
- ☐ Bruise Easily
- ☐ Swollen Ankles
- ☐ FEMALE: Taking birth control pills
- ☐ FEMALE: Pregnant
- ☐ FEMALE: Nursing

If any conditions or alerts selected above need further clarification or if you have any Medical Conditions not listed above, please describe below:

Are you taking or have you taken a Biophosphonate (Osteoporosis) Medication? (Fosamax, Boniva, Zometa, Actonel, Aredia, Bonefos, Ostac, etc.) *

◯ Yes ◯ No

Do you use more than two pillows to sleep? * ◯ Yes ◯ No

Have you lost or gained more than ten pounds in the last year? * ◯ Yes ◯ No

Do you take antibiotic premedication for your dental visits? If yes, please explain.

What is your estimate of your general health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Name of your physician, phone number, and your most recent physical exam:

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect you dental treatment.

List all medications, drugs, pills or herbal remedies, including regular dosages of aspirin.

List all medications, substances, foods, supplements you have had an allergic (or adverse) reaction to.

☐ * **By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes.**

Dental Information

How would you rate the condition of your mouth?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

How often do you brush your teeth?

How often do you floss your teeth?

CHILDREN: Any mouth habits- thumb sucking, nursing bottle habits, pacifier, ect.? ◯ Yes ◯ No

Any unusual speech habits? ◯ Yes ◯ No

Is prescription fluoride taken in any form? ◯ Yes ◯ No

Is household on well water? ◯ Yes ◯ No

Is household on town water? ◯ Yes ◯ No

If yes, which town?

_____

_____

What other dental aids do you use? (Interplak, toothpick, etc.)

_____

_____

Do you have any dental problems now?

_____

_____

What is your immediate concern?

_____

_____

Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) _____

Previous Dentist name and how long have you been a patient there:

_____

_____

Date of most recent dental exam and x-rays

_____

_____

I routinely see my dentist every:

☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

Personal History, Check all that apply:

- ☐ Had an unfavorable dental experience
- ☐ Had complications from past dental treatment
- ☐ Had trouble getting numb
- ☐ Had any reactions to local anesthetic
- ☐ Had/have braces, orthodontic treatment
- ☐ Had your bite adjusted
- ☐ Had any teeth removed including wisdom teeth
- ☐ Had a serious injury to the mouth or head
- ☐ Are you a mouth breather

Smile Characteristics, Check all that apply:

- ☐ Is there anything about the appearance of your teeth that you would like to change?
- ☐ Have you ever whitened (bleached) your teeth?
- ☐ Have you felt uncomfortable or self conscious about the appearance of your teeth?
- ☐ Have you been disappointed with the appearance of previous dental work?

Bite and Jaw Joint, Check all that apply:

- ☐ You have problems with your jaw joint
- ☐ You have problems chewing
- ☐ Your teeth changed in the last 5 years, become shorter, thinner, or worn
- ☐ Your teeth are crowding or developing spaces
- ☐ You chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits
- ☐ You clench your teeth in the daytime or make them sore
- ☐ You have problems with sleep or wake up with an awareness of your teeth
- ☐ You wear or have worn a bite appliance

Tooth structure, Check all that apply:

- ☐ Cavities within past 3 years
- ☐ The amount of saliva in your mouth seems too little or you have difficulty swallowing any food
- ☐ You notice or have holes (i.e. pitting, crates) on the biting surface of your teeth
- ☐ Any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth
- ☐ Grooves or notches on your teeth, chipped teeth, or had a toothache or cracked filling
- ☐ Food gets caught between any teeth

Gum and Bone, Check all that apply:

- ☐ Gums bleed when brushing or flossing
- ☐ Treated for gum disease or were told you have lost bone around your teeth
- ☐ Noticed an unpleasant taste or odor in your mouth
- ☐ History of periodontal disease in your family
- ☐ Experienced gum recession
- ☐ Had any teeth become loose on their own (without injury), or have difficulty eating an apple
- ☐ Experienced a burning sensation in your mouth

If any of the checked boxes need further explanation, please describe:

Consent for Services and Financial Policy

1. I hereby authorize doctor or designated staff to take radiographs, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis.

2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

4. Payment for service is due at the time services are rendered. We are not a contract provider for any insurance plan. We accept cash, checks, MasterCard, Visa, Discover, and Care Credit. A fee schedule for major dental treatment will be established before treatment begins. Returned checks and balances older than 30 days may be subject to additional collection fees and interest charges of 1.5% per month. Charges are made for missed appointments and appointments canceled without 24 hours advance notice ($50.00). I will notify you of any changes in my health history or the above information. I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance on my account and for any professional service rendered. Unpaid accounts >90 days may result in dismissal as a patient from the practice.

☐ * **By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the Administration Form.**

HIPAA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality,

☐ * **By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the HIPAA Disclosure Form.**

Consent for Internet Communications

I grant my permission to the dental practice to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured web site for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the dental practice web site with my ID and password. I also agree to immediately notify the dental practice of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns.

I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

☐ ***I have read the information above regarding the secured uploading of patient information to the web site for the dental practice, and grant the dental practice permission to securely upload my patient information to the web site.**

Response Date: _____