Inspire Dentistry of the Carolinas

We would like to get to know you better!

Patient Name: _____ Date: _____ ◊ Male ◊ Female

Address: _____ City/State: _____ Zip:_____

Cell: _____ Work: _____

Date of Birth: _____ Email : _____

Patient (or Responsible Party) Social Security #: _____

IF CHILD:

Parent Name:_____ Work Phone: _____ Parents SS # _____

Parent Employer: _____ Parent Occupation: _____

SELF: Employer: _____ Occupation: _____

SPOUSE: Name: _____

Whom may we thank for referring you in our office:

_____

EMERGENCY:

Person to contact in case of emergency _____ Relationship_____ Phone Number _____

DENTAL HISTORY:

Former Dentist: _____ Last Visit: _____ Date of Last Dental X-rays _____

Reason for today's visit: _____

How often do you brush? _____ Floss? _____ Use Mouthwash? _____

Please check any of the following conditions that apply to you:

☐ Bad Breath	☐ Grinding Teeth	☐ Periodontal (Gum) Disease	☐ Bleeding Gums
☐ Mouth Sores	☐ Clicking or Popping Jaw	☐ Loose Teeth or Broken Fillings	☐ Sensitivity when Chewing
☐ Sensitivity to Hot	☐ Sensitivity to Cold	☐ Food Collects Between Teeth	☐ Sensitivity when Biting

	YES	NO	COMMENTS
Are you happy with your Smile?	☐	☐	_____
Have you had Orthodontics (Braces)	☐	☐	_____
Do you think you will eventually need dentures?	☐	☐	_____
Have you ever had a reaction to anesthetic?	☐	☐	_____
Do you avoid brushing part of your mouth?	☐	☐	_____
Do you smoke or use smokeless tobacco?	☐	☐	_____
Have you ever had any teeth removed?	☐	☐	_____

If you could make one change to your teeth what would it be? _____

If it has been more than 1 year since your last dental visit what kept you from going to the dentist?_____

If you could eliminate one part of the dental visit, what would it be ? _____

Inspire Dentistry of the Carolinas

Office Polices

Thank you for choosing Inspire Dentistry for your Dental needs.

OFFICE HOURS:

Monday through Friday from 8am to 5pm.

CANCELLING / BREAKING APPOINTMENTS:

If you cancel an appointment with ***less than 24 hours notice you will be charged a fee***.
If you no show an appointment you will be charged a fee. If you no show an appointment a 2nd time Inspire Dentistry may refuse to continue to offer treatment.

The fees for Canceling / Breaking appointments are as follows:
0-1hr appointment - $35
1-2hr appointment - $75
2 or more hour appointment - $50+ and may be required to prepay for next appointment.

*****ALL CO-PAYS FOR SERVICES RENDERED ARE DUE AT THE TIME OF SERVICE*****

INSURANCE FILING:

We will make every attempt to get your claims paid. Insurance companies will not guarantee payment or eligibility but we will make every attempt to be as accurate as possible with estimations. ***If an insurance company refuses payment on a claim you will be responsible for any remaining balance not covered***.

Most common denial by insurance companies:

Alternate Benefit: This is when an insurance company decides to down grade a filling or crown. Resin filling (tooth colored) to an amalgam filling (silver) or a tooth colored crown to a silver crown. ***If your insurance company chooses to pay the alternate benefit you will be responsible for the difference.***

***** WE DO NOT DO AMALGAM FILLINGS (SILVER) at Inspire Dentistry *****

INSURANCE ASSIGNMENT:

I authorize and request my insurance company to pay directly to the dentist or dental group my insurance benefits that would otherwise be payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or for my dependents.

Print Name: _____ Date: _____

Signature: _____

Relationship to Patient: _____

Inspire Dentistry of the Carolinas

Acknowledgement of Receipt
Of Notice of Privacy Practices

Patient Name & Address: _____
_____
_____

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

_____ _____
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 & a signature was not possible at the time.
- ❑ The individual refused to sign.
- ❑ A copy was mailed with a request for a signature by return mail.
- ❑ Unable to communicate with the patient for the following reason:
  _____
- ❑ Other:_____
  _____

Prepared By _____

Signature _____

Date _____