Peele Family Dentistry
Makani D. Peele, D.M.D.
2038 NC Hwy 345 South
Wanchese, North Carolina 27981
Ph: 252-473-5774
Fax: 252-473-5774

WE ARE PLEASED TO WELCOME YOU TO OUR PRACTICE. PLEASE TAKE A FEW MINUTES TO FILL OUT THESE FORMS AS COMPLETELY AS YOU CAN.

All information is completely confidential.

Patient Information

Date:_____

Full Name:_____ Phone: _____ _____

Sex: M: ☐ F: ☐ D.O.B: _____

Soc. Sec. #_____ Driver License #:_____

Child: ☐ Single: ☐ Married: ☐ :

Address:_____City_____ State:_____ Zip: _____

Employed by:_____ Occupation: _____

Work Phone: _____ _____ Mobile: _____ _____

Insurance Name: _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____

Relationship:_____ Emergency Contact Phone Number: _____ _____

If Patient is a Child:

Responsible Person: _____ Relationship to Patient:_____

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DENTAL HISTORY

Welcome! Please complete this dental history form so that we may provide you with the best possible dental care.

All information is completely confidential.

Patient Name: _____

What is the reason for your visit today? _____

_____

Date of Last Dental Visit? _____ Last Dental Cleaning: _____ Last X-rays: _____

What was done at your last dental visit? _____

Previous Dentist's Name: _____ Telephone: _____ _____

How often do you have dental examinations? _____

How often do you brush your teeth? _____ How often do you floss? _____

Have you ever used or are you currently using topical fluoride? **YES:** ☐ **NO** ☐

What other dental aids do you use (Waterpik, Toothpick, etc.)? _____

Have you ever had to take Antibiotics for dental treatment? _____

Are any of your teeth sensitive to:

Hot or Cold?----------**YES**☐ **NO**☐
Sweets?----------**YES**☐ **NO**☐
Biting or Chewing?----------**YES**☐ **NO**☐
Have you noticed any mouth odors
or bad taste?----------**YES**☐ **NO**☐
Do you frequently get cold sores,
blisters or any other oral lesions?----------**YES**☐ **NO**☐
Do your gums bleed or hurt?----------**YES**☐ **NO**☐

Have you ever had:

Orthodontic treatment?----------**YES**☐ **NO**☐
Oral surgery?----------**YES**☐ **NO**☐
Periodontal treatment?---------- **YES**☐ **NO**☐
A bite plate or mouth guard?----------**YES**☐ **NO**☐
A serious injury to the mouth or head?----------**YES**☐ **NO**☐
If yes, please describe, including cause_____

Do you:

Clench or grind your teeth while
awake or asleep?----------**YES**☐ **NO**☐
Snore or have any other sleeping disorders?----------**YES**☐ **NO**☐
Smoke/chew tobacco or use other
tobacco products?---------- **YES**☐ **NO**☐
Do you use a CPAP machine?----------**YES**☐ **NO**☐

Have you experienced:

Clicking or popping of the jaw?---------- **YES**☐ **NO**☐
Pain (joint, ear, side of face)?---------- **YES**☐ **NO**☐
Difficulty in opening or closing the mouth?---------- **YES**☐ **NO**☐
Difficulty in chewing on either side of mouth?---------- **YES**☐ **NO**☐
Headaches, neck aches or shoulder aches?----------**YES**☐ **NO**☐
Are you satisfied with your teeth's appearance?----------**YES**☐ **NO**☐
Would you like to keep all your teeth all your life?--------**YES**☐ **NO**☐
Do you feel nervous about having dental treatment?----**YES**☐ **NO**☐
If so, what is your biggest concern? _____
Have you ever had an upsetting dental experience?------**YES**☐ **NO**☐
If yes, please describe _____

Have you ever been told to take a pre-medication prior to dental treatment?----------**YES**☐ **NO**☐
Is there anything else about having dental treatment that you would like us to know?---------- **YES**☐ **NO**☐

If yes, please describe _____

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MEDICAL HISTORY

Welcome! Please complete this medical history form so that we may provide you with the best possible dental care

Patient Name: _____

Physicians Name: _____ Phone: _____ _____

Have you had any illness, operation or been hospitalized in the last five years? ----------YES☐ NO☐

If yes, please explain:_____

Do you have, or have had, any of the following diseases, medical conditions, or procedures?

Y N	Y N	Y N	Y N
☐/☐ Heart Murmur	☐/☐Respiratory Problems	☐/☐ Stroke	☐/☐ Delay in Healing
☐/☐ High Blood Pressure	☐/☐ Blood Transfusion	☐/☐ Diabetes	☐/☐ Skin Rash/Eczema
☐/☐ Chest Pain/Angina	☐/☐ Blood Disorder	☐/☐ Frequent Headaches	☐/☐ Rheumatic Fever
☐/☐ Heart Attacks	☐/☐ Bruise Easily	☐/☐ History of Alcohol	☐/☐ Seasonal Allergies
☐/☐ Irregular Heartbeat	☐/☐ Bleed Easily	☐/☐ Abuse	☐/☐ Scarlet Fever
If yes, what type?	☐/☐ Easily Winded	☐/☐ History of Drug Abuse	☐/☐ Tuberculosis
_____	☐/☐ Jaundice/Liver	☐/☐ Arthritis/Joint	☐/☐ Thyroid Problems
☐/☐ Cardiac Pacemaker	Disease	Disease	☐/☐ Cold Sores
☐/☐ Heart Surgery	☐/☐ Hepatitis	☐/☐ Artificial Joints	☐/☐Radiation or
☐/☐ Damaged Heart	☐/☐ HIV/AIDS	☐/☐ Kidney Problems	Chemotherapy
Valves	☐/☐ Convulsions/Epilepsy	☐/☐ Cancer	☐/☐ Problems with
☐/☐ Artificial Heart Valves	☐/☐ Osteoporosis	If yes,	Immune System
☐/☐ Asthma	☐/☐ Pregnant		
☐/☐ Antibiotic/Pre-Med	Due Date?_____	What kind?_____	Other _____
☐/☐ Use a CPAP Machine			

Medications

Are you now taking:

Blood Thinners (Coumadin, Aspirin, Xarelto, Eliquis)?----------YES☐ NO☐

Any bone density medications or Bisphosphonates (Boniva, Fosamax)? ----------YES☐ NO☐

Please list all medications you are taking: _____

Allergies

Are you allergic to any of the following?

Penicillin/Amoxicillin----------YES☐ NO☐

Sulfa Drugs----------YES☐ NO☐

Local Anesthetics----------YES☐ NO☐

Codeine or any other Narcotics----------YES☐ NO☐

Aspirin ----------YES☐ NO☐

Metal ----------YES☐ NO☐

Latex ----------YES☐ NO☐

Other:_____

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 GURDIAN: _____ DATE: _____

HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT FORM FOR RECEIPT OF NOTICE OF PRIVACY PRACTICES CONSENT/LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.

Date: _____ Patient Name: _____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM RECEPTION AREA:

❑ First Name Only ❑ Proper Surname ❑ Other _____

PLEASE LIST ANY OTHER PARTIES WHO ARE ACTIVELY INVOLVED IN YOUR HEALTH CARE AND WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION: (This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

❑ Cell Phone Confirmation
❑ Text Message to my Cell Phone
❑ Home Phone Confirmation
❑ Email Confirmation
❑ Work Phone Confirmation
❑ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

❑ Cell Phone Confirmation
❑ Text Message to my Cell Phone
❑ Home Phone Confirmation
❑ Email Confirmation
❑ Work Phone Confirmation
❑ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

❑ Phone Message
❑ Text Message
❑ Email
❑ **Any of the Above**
❑ **None of the Above** (opt out)

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original. **MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.**

_____ _____
Please ***print*** name of Patient Please ***sign*** Patient / Guardian of Patient

_____ _____
Legal Representative / Guardian Relationship of Legal Representative / Guardian

OFFICE USE ONLY

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

❑ It was emergency treatment
❑ I could not communicate with the patient
❑ The patient refused to sign
❑ The patient was unable to sign because
❑ Other (please describe) _____

Signature of Privacy Officer _____

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Cancellation/No Show policy for doctor/hygiene appointment

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much-needed treatment. Conversely, the situation may arise where another patient calls to cancel and we are unable to schedule you for a visit, due to a seemingly "Full" schedule. Canceled appointments/no shows are a major financial burden for this and every dental practice and cannot be tolerated. If an appointment is not canceled at least 24 hours in advance, you will charge a $50 fee; this will not be covered by your insurance company. This fee will need to be paid in full before you can have another appointment. Chronic cancellation/no shows will result in the patient being discharged from the practice.

Scheduled Appointments

We understand that delays can happen, however, we must try to keep the other patient providers on time. If the patient is 15 minutes or more past their scheduled time, we reserve the right to reschedule the appointment to another day or move the appointment to a later time slot on the same day if the provider's schedule allows.

Account Balance

We will require that patients with self- pay balances bring their account balance to zero prior to receiving further service by our practice. Patients who have questions about their bills, or who would like to discuss a payment plan option, may call and ask to speak to a billing associate to discuss their options. Patients who have received 3 consecutive billing statements without making any payments will also be required to bring their account balance to zero. Any patient that has an account in collections will NOT be allowed to have an appointment until all balances and fees are paid in full.

PRINT NAME: _____

SIGNATURE: _____ **DATE:** _____