Alamance Family
DENTISTRY
Emily L. Dornblazer, DMD, PA

2960 Professional Park Drive, Burlington, NC 27215
(336) 228-8159 office • (336) 226-1936 fax
www.alamancefamilydentistry.com • info@alamancefamilydentistry.com

Name: _____
Last First MI Title

Preferred Name: _____ o Male o Female

Address: _____ City _____ State _____ Zip _____

SSN: _____ DOB: _____

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

Preferred method of contact: _____ E-mail Address: _____

Employer: _____ Occupation: _____

Marital Status: o Single o Married o Divorced o Widowed o Separated o Domestic Partner

How did you hear about our office? _____

Insurance – Primary

Subscriber Name: _____ Relationship to Patient: _____ Subscriber DOB: _____

Subscriber SSN/ID: _____ Subscriber Employer: _____

Insurance Company Name: _____

Insurance Company Address: _____

Insurance Company Phone: _____ Group Number: _____

Insurance – Secondary

Subscriber Name: _____ Relationship to Patient: _____ Subscriber DOB: _____

Subscriber SSN/ID: _____ Subscriber Employer: _____

Insurance Company Name: _____

Insurance Company Address: _____

Insurance Company Phone: _____ Group Number: _____

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Emily Dornblazer, DMD, PA all insurance benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: _____

Relationship: _____ Date: _____

Consent: I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

Patient or Parent/Guardian Signature: _____

Medical History

General health (please check): o Excellent o Good o Fair o Poor
Do you have a personal physician? oYes o No
Physician's Name: _____ Physician's Phone: _____
Date of last visit: _____ Reason for last visit: _____
Are you currently under the care of a physician? o Yes o No
Please explain: _____

Do you use tobacco in any form?.....o Yes o No
Have you had a blood transfusion?.... o Yes o No
Have you ever taken Fen-Phen or Redux? o Yes o No
Are you wearing contact lenses? ..... o Yes o No
Do you or have you used controlled substances? o Yes o No

Are you taking any medications? o Yes o No
If "Yes," please list names of medications and problems for which they are taken:

1) _____ taken for _____
2) _____ taken for _____
3) _____ taken for _____
4) _____ taken for _____
5) _____ taken for _____
6) _____ taken for _____
7) _____ taken for _____
8) _____ taken for _____

Have you had any surgical procedures? o Yes o No
If "Yes," please list each one: _____

- Please check if you have any of the below conditions -

Yes	No	Condition	Yes	No	Condition	Yes	No	Condition
o	o	Abnormal bleeding	o	o	Eating Disorder	o	o	Mitral valve prolapse
o	o	Abnormal BP o High o Low	o	o	Emphysema	o	o	Organ transplant
o	o	Acid reflux	o	o	Epilepsy	o	o	Osteoporosis
o	o	Alcohol abuse	o	o	Fainting spells	o	o	Pacemaker
o	o	Allergies	o	o	Fever blisters	o	o	Psychiatric condition(s)
o	o	Anemia	o	o	Frequent headaches	o	o	Radiation therapy
o	o	Angina pectoris	o	o	Glaucoma	o	o	Rheumatic fevers
o	o	Arthritis	o	o	Heart attack	o	o	Seizures
o	o	Artificial heart valve	o	o	Heart disease	o	o	Sexually Transmitted Disease
o	o	Asthma or hay fever	o	o	Heart murmur	o	o	Shingles
o	o	Cancer	o	o	Heart surgery	o	o	Sickle Cell Disease
o	o	Chemotherapy	o	o	Hemophilia	o	o	Sinus problems
o	o	Cognitive impairment	o	o	Hepatitis	o	o	Stroke
o	o	Congenital heart defect	o	o	Jaundice	o	o	Thyroid problems
o	o	Diabetes	o	o	Joint replacement	o	o	Tuberculosis
o	o	Dementia	o	o	Kidney problems	o	o	Ulcers
o	o	Difficulty breathing	o	o	Liver Disease	o	o	Other _____
o	o	Drug Abuse	o	o	Lymph node enlargement			

Do you take any type of blood thinners (ie. Coumadin / Warfarin, Pradaxa, Xarelto)? o Yes o No

Do you take a daily aspirin? o Yes o No

Have you ever taken bisphosphonates?..... o Yes o No
If "Yes", were they o oral or o intravenous ?
How recently did you take them? _____

Have you ever had osteoporosis, Paget's disease, multiple myeloma, primary hyperparathyroidism, or osteogenesis imperfecta? o Yes o No
If "Yes", please state which one: _____
If you have osteoporosis, do you take any medications for osteoporosis? o Yes o No

If you are diabetic, how well controlled is your diabetes? o Poorly o Adequately o Well
If you remember, what was your most recent A1C value? _____

Do you have any artificial heart valves? .....o Yes o No
Have you ever had an episode of infective (bacterial) endocarditis?.....o Yes o No
Do you have a congenital heart defect? ..... o Yes o No
Have you ever had a heart transplant & developed a valve problem?.... o Yes o No

Have you had a joint replaced? (example: knee, shoulder, hip) o **Yes** o **No**

If "Yes," how recent was the surgery? _____

Does your orthopedic surgeon want you to take antibiotics prior to dental treatment? o Yes o No o Not Sure

ALLERGIES: Are you allergic to any of the following?

Yes	No	
o	o	Penicillin
o	o	Codeine
o	o	Amoxicillin
o	o	Dental Anesthetics
o	o	Erythromycin
o	o	Jewelry
o	o	Latex
o	o	Metals (gold, nickel, etc.)
o	o	Aspirin
o	o	Tetracycline
o	o	Sulfa Drugs
o	o	Iodine

Please list any other allergies:

_____

FOR FEMALE PATIENTS

	Yes	No
Are you taking birth control pills?	o	o
Are you pregnant?	o	o
If so, # of weeks _____		
Are you nursing?		

Emergency Contact:

Name: _____ Relationship: _____

Address: _____

Phone number: _____

I understand that the information that I have given is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in medical status.

Signature: _____ Date: _____

Dental History

Reason for visit: _____ Approximate date of last dental visit: _____

Have you ever had a serious problem associated with previous dental treatment or any dental emergencies?……..
o Yes o No *If "Yes," please explain:* _____

What, if anything, has happened in previous experiences at the dentist that was the reason not to return? _____
_____

What do you feel is your current dental health: o Good o Fair o Poor

Do you require antibiotics before dental treatment? o Yes o No

Are you currently in any pain? o Yes o No *If "Yes," please explain:* _____

Do you often lose fillings or break fillings? o Yes o No

Do you usually have many cavities? o Yes o No

Do your gums ever feel tender or swollen? o Yes o No

Have you ever had periodontal (gum) treatment? o Yes o No

Do you clench or grind your jaws while sleeping or during the day? o Yes o No

Do your jaws ever feel tired? o Yes o No

Do you now or have you had pain/discomfort in your jaw joint (TMJ)? o Yes o No

Are your teeth chipped? o Yes o No

Are your teeth wearing on the biting surfaces? o Yes o No

Have you had orthodontic work in the past? o Yes o No

Do you currently wear an orthodontic retainer(s) or occlusal guard? o Yes o No *If "Yes," please explain:*_____

Have you thought about improving the appearance of your smile? o Yes o No

What would you change about your teeth? (circle all that apply)

Color Shape Size Straighten Other: _____

Alamance Family
DENTISTRY
Emily L. Dornblazer, DMD, PA

Photography Release

I _____, hereby authorize Emily L. Dornblazer, DMD, PA to take photographs, slides, and / or videos of my face, jaws, and teeth.

I understand that the photographs, slides, and / or videos will be used as a record of my care, and may be used for educational purposes in lectures, demonstrations, advertising (including website publication, newspapers, magazines, phone books, television), and professional publications (dental magazines and journals).

I further understand that if the photographs, slides, and / or videos are used in any publication or as a part of a demonstration, my name or other identifying information will be kept confidential. I do not expect compensation, financial or otherwise, for the use of these photographs.

_____ _____

Signature Date

Alamance Family
DENTISTRY
Emily L. Dornblazer, DMD, PA

Authorization for Release of Information

Name: _____ DOB: _____
Last First MI

I authorize Emily L. Dornblazer, DMD, PA or any member of her office to release protected health information about the above named patient in the following manner and to the identified person(s).

Entity to Receive Information **Check each person/entity that you approve to receive information**	**Description of Information to be released.** Check what type of information can be given to person/entity.
☐ **Voice Mail**	☐ Appointment Reminders ☐ Results of lab tests/x-rays
☐ **E-mail communication** **Email address:** _____	☐ Appointment Reminders ☐ General Office Information
☐ **Text Message**	☐ Appointment Reminders
☐ **Work**	☐ Appointment Reminders ☐ General Office Information
☐ **Person 1** **Name:** _____	☐ Financial Information ☐ Medical Information
☐ **Person 2** **Name:** _____	☐ Financial Information ☐ Medical Information

Patient Rights

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protect health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and my treatment is not conditional upon signing.

The Information is released at the patient's request and this authorization will remain in effect until revoked by the patient.

_____ _____
Patient Signature **Date**

Alamance Family
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Emily L. Dornblazer, DMD, PA

Acknowledgement of Receipt of Notice of Privacy Practices

I have been given the opportunity to review the Notice of Privacy Practices of Emily L. Dornblazer, DMD, PA and, if requested, have been given a copy.

_____ _____
Signature of Patient 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: _____

Alamance Family
DENTISTRY
Emily L. Dornblazer, DMD, PA

Practice Policies

Name: _____ Date of birth: _____
Last First Middle Initial

We believe that you deserve the best care, that is why we always present you with the best dental solution possible to treat your personal situation. Each year we provide outstanding dental care to hundreds of patients. Some have dental benefits but some do not. Here are some important things you should know:

Initial

_____ ● Your dental benefits are based upon a contract made between you or your employer and an insurance company. **If you have any questions regarding your dental benefits, please contact your employer or insurance company directly.** Dental benefits will never completely pay for your dental care. Dental benefits are only meant to assist you.

_____ ● We currently accept all private care insurance plans. This means that we work with literally thousands of insurance companies. Although we can maintain computerized histories of payment given by an insurance company, they change frequently; therefore, it is impossible to give you a guaranteed quote at the time of service. We estimate your portion based on the most up-to-date information we have, but it is **ONLY AN ESTIMATE**. If you would like to know your insurance benefit, we will be happy to file a "pre-treatment authorization" with your insurance company prior to treatment. However, keep in mind that this *is not a guarantee of coverage*. This does delay treatment but will give you a more accurate out of pocket figure.

_____ ● We will bill your insurance company as a courtesy. If insurance does not pay within 90 days, we reserve the right to request payment in full for services from you and let you collect the insurance funds that are due to you. This is rare, but it is important that you recognize the insurance you have is a *legal contract between YOU and your insurance company*. Our office is not, and cannot be part of that legal contract. Ultimately, you are responsible for all charges incurred in our office. Unpaid balances over 30 days will be due immediately or considered a delinquent account to be handled by our collections manager, and a *$35 collection fee* will be charged to your account.

_____ ● We require payment in full for your portion at the time of service. We accept MasterCard, Visa, Discover, cash and checks (for existing patients with established payment history). **We do not accept checks for over $500 for any patient**. If you are in need of an extended finance option, we also work with CareCredit. CareCredit offers 6, 12, 18 and 24 months "same as cash" or longer terms with an interest bearing, revolving charge designed to meet your treatment needs on approved credit.

_____ ● A specific amount of time is reserved especially for you, and we strongly encourage all patients to keep their appointments. **If you fail to keep your scheduled appointment, or do not provide at least 24 hours notice to reschedule or cancel, you will incur a $50 cancellation fee, and a deposit may be required to schedule a future appointment.** This deposit will be applied to your treatment as long as you abide by the cancellation policy stated previously. Should you again miss your appointment, or provide less than 24 hours notice to reschedule or cancel the appointment, this deposit will be charged to your account. Please keep in mind that insurance does not cover cancellation fees.

_____ ● There is a **$35.00 fee for any returned check.**

_____ ● In the event of an emergency after regular hours, a $75 emergency fee will be charged for established patients in addition to the necessary treatment fees. Patients who are not established in the practice, will be charged a $125 after hours emergency fee.

If you have any questions about our Office Policies, please do not hesitate to ask.

I agree to comply with the Office Policies stated above.

Print Name: _____ Date: _____

Patient/Parent (Guardian) Signature: _____