CAROLINAS
DENTAL CENTER

WELCOME TO OUR PRACTICE

On behalf of the entire team at Carolinas Dental Center, let us welcome you to our practice. We are grateful that you have chosen us to meet your dental needs, and trust that you will find your experience in our office to be pleasant, professional, and extraordinary. You may discover that we are different from the average dental practice. When you visit our office, you will find a unique and relaxing environment. Our team is friendly and attentive. All of our treatment is designed to be comfortable, to be long lasting, and to exceed all your expectations. We use the latest technology and techniques our profession has to offer. Our greatest strength lies in the unequaled advanced training in cosmetic and reconstructive dentistry we have received.

Enclosed in this Welcome Packet are several important documents that will explain our practice philosophy and policies along with selected questionnaires that will assist us in making your transition to our office as smooth as possible. Please have these papers completed and signed prior to your first appointment.

For more information regarding the services we offer and to meet the entire Carolinas Dental Center team, be sure to visit our website at www.CarolinasDentalCenter.com. We look forward to serving all your dental needs.

Yours truly for better dental health,

Christopher Phelps, DMD
Thomas Grimes, DDS

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Thomas Grimes, DDS

428 N. Trade St., Suite 101 • Matthews, NC 28105 • (704) 845-1107
www.CarolinasDentalCenter.com

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REGISTRATION

PATIENT INFORMATION

			M F	S M D W	
Last Name	First	Middle	Sex	Marital Status	Date of Birth

How would you like to be addressed? | Email Address | Social Security Number

Home Address - Street/City/State/Zip

Name of Employer | Occupation | Driver's License Number

Business Address – Street/City/State/Zip

Home Phone Number | Cell Phone Number | Business Phone Number

What are your hobbies or special interests?

How did you hear about Carolinas Dental Center?

INSURANCE INFORMATION - INSURED MEMBER

Last Name | First | Middle | Relationship to Patient

Insured Date of Birth | Social Security number

Name of Employer | Occupation | Business Phone Number

Business Address – Street/City/State/Zip

Dental Insurance Company | Group Number | ID Number

Patient Signature **Date**

If patient was assisted with this form, print name of the person assisting.

CAROLINAS DENTAL CENTER

MEDICAL HISTORY

_____
Patient Name

Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry that you will be receiving. Thank you for answering the following questions.

General health: Excellent ☐ Good ☐ Fair ☐ Poor ☐

Are you currently under the care of a physician? Yes ☐ No ☐ Date of Last Physical_____
Name of physician_____Address_____Phone_____

Do you smoke or use tobacco products? Yes ☐ No ☐ If yes, how much? _____
Are you pregnant or think you may be? Yes ☐ No ☐ If yes, expected delivery date _____
Are you nursing? Yes ☐ No ☐
Are you taking birth control pills? Yes ☐ No ☐
Do you or have you used controlled substances? Yes ☐ No ☐
Do you bruise easily? Yes ☐ No ☐
Do you take any daily blood thinners (e.g. aspirin, Plavix, Coumadin)? Yes ☐ No ☐ If yes, please list below.
Do you take anything for the treatment or prevention of osteoporoses (e.g. Fosamax)? Yes ☐ No ☐ If yes, please list below.

Please list any medications you are taking now:

1)_____taken for_____ 4)_____taken for_____
2)_____taken for_____ 5)_____taken for_____
3)_____taken for_____ 6)_____taken for_____

Have you ever had (check those that apply):

Abnormal blood pressure……	High ☐ Low ☐ No ☐	Heart murmur……	Yes ☐ No ☐
AIDS or HIV……	Yes ☐ No ☐	Heart surgery……	Yes ☐ No ☐
Allergies……	Yes ☐ No ☐	Hepatitis……	Yes ☐ No ☐
Anemia ……	Yes ☐ No ☐	Jaundice……	Yes ☐ No ☐
Arthritis……	Yes ☐ No ☐	Joint replacement or implant (pre-med)……	Yes ☐ No ☐
Asthma or Hay fever……	Yes ☐ No ☐	Kidney trouble……	Yes ☐ No ☐
Back Problems……	Yes ☐ No ☐	Lymph node enlargement/swollen glands……	Yes ☐ No ☐
Blood transfusion……	Yes ☐ No ☐	Mental health care……	Yes ☐ No ☐
Cancer……	Yes ☐ No ☐	Mitral valve prolapse……	Yes ☐ No ☐
Chemical dependency……	Yes ☐ No ☐	Pacemaker……	Yes ☐ No ☐
Chemotherapy for any cancers……	Yes ☐ No ☐	Persistent diarrhea……	Yes ☐ No ☐
Cold sores or Fever Blisters……	Yes ☐ No ☐	Prolonged bleeding……	Yes ☐ No ☐
Congenital heart lesions ……	Yes ☐ No ☐	Rheumatic fever……	Yes ☐ No ☐
Diabetes……	Yes ☐ No ☐	Sexually transmitted disease……	Yes ☐ No ☐
Drastic weight loss……	Yes ☐ No ☐	Sinus trouble……	Yes ☐ No ☐
Eating disorders……	Yes ☐ No ☐	Stroke……	Yes ☐ No ☐
Epilepsy or Seizures……	Yes ☐ No ☐	Thyroid problems……	Yes ☐ No ☐
Excessive urination and/or thirst……	Yes ☐ No ☐	Tuberculosis or lung disease……	Yes ☐ No ☐
Fainting spells……	Yes ☐ No ☐	Ulcers……	Yes ☐ No ☐
Glaucoma……	Yes ☐ No ☐	X-ray treatments for cancer……	Yes ☐ No ☐
Heart disease……	Yes ☐ No ☐		

If you have entered "yes" please explain:_____

Are you allergic to or have you had reactions to:

Local anesthetics like Novocain……	Yes ☐ No ☐	Latex/Rubber……	Yes ☐ No ☐
Penicillin or other antibiotics……	Yes ☐ No ☐	Aspirin……	Yes ☐ No ☐
Sulfa drugs……	Yes ☐ No ☐	Any metal (gold, nickel, etc.)……	Yes ☐ No ☐
Barbiturates, sedatives, sleeping pills……	Yes ☐ No ☐	Other (please list)_____	

Patient Name:_____ **Date:**_____

Signature:_____

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CUSTOMIZED TREATMENT AND PRESENTATION QUESTIONNAIRE FOR

_____
Patient Name

1. If we were sitting here together a year from now, what needs to happen for you to consider our office an excellent choice for you? Examples might be: Being pain free, in great dental health, having whiter teeth, no more silver fillings, cost, etc.

_____

2. When the Dentist or Dental Team Member needs to present you with information about issues or potential issues that may be occurring in your mouth, do you typically:

A. Prefer all of the facts and details of your condition. Why it occurred, how to prevent it from occurring again, etc? Want to see x-rays, photos of the condition, etc. Prefer a line item estimate of every cost involved with your treatment.
B. Prefer some of the details but would rather have a thorough plan created to get your mouth back to good dental health with emphasis on cost and how many visits it will take to complete your treatment as well as how long each treatment appointment will last so we can fit it into your schedule.
C. Prefer a summarized, bullet point version of the findings, highlighting the most important things but not getting too involved with the details or specifics of what needs to happen. You want a bottom line emphasis on cost and time commitment needed to complete treatment.

3. When faced with dental work you need performed, do you prefer:

A. To think about the pros and cons of the treatment recommended, analyze the data presented and then call our office when you are ready to have the work performed.
B. To schedule the appointment today for a future date that better fits your timeline and schedule.
C. Prefer to get the work done today if at all possible so you don't have to return for 2 or 3 more visits.

4. When the Dentist or Dental Team Member needs to talk to you about options to restore your dental health (such as crowns, dentures, implants, etc.), do you prefer:

A. A simplified oral explanation and description of dental treatment needed.
B. Both detailed oral and visual explanations which could include video animations demonstrating the procedure recommended and or photographs of the procedure or photos of other patients mouths who had similar treatment.
C. Have physical models on hand to hold and feel to aid in visualizing the work needed to be performed.

DENTAL HEALTH AND APPEARANCE QUESTIONNAIRE

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

What is your primary concern that you would like us to address first?_____

Has anything ever happened in previous experiences at the dentist that was reason not to return? Yes ☐ No ☐
If yes, please explain _____

Please rate your smile from 1 to 10 (1= I hate my smile, 10=awesome) _____

If you had a magic wand, what, if anything, would you change about your smile?_____

Would you like to see what you would look like with a new and improved smile (at no additional charge)? Yes ☐ No ☐
If yes, check off all that apply:

☐Lighten all front teeth showing	☐Rebuild fracture(s)	☐Straighten rotation	☐Eliminate dark or stained fillings
☐Lighten single tooth	☐Lengthen	☐Straighten angulation	☐Reduce gum showing in smile
☐Close spaces between teeth	☐Shorten	☐Eliminate crowding	☐Repair uneven edges

Please add anything you feel is important:_____

_____

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APPOINTMENT AGREEMENT

At Carolinas Dental Center, we understand that your time is very valuable. We are constantly striving to make your experience here more pleasant than any other place you have previously been. Trying to accommodate every patient's individual needs and work schedule can be challenging. We make every effort to stay on time so that our patients will not have to wait unnecessarily.

Your appointment is a commitment of time between you and our office. We ask that you make every effort to keep that commitment. We do provide a courtesy reminder call one to two days prior to your appointment.

If you find that you cannot keep your appointment, we do require a minimum notice of 24 hours so we are able to assist other patients with their dental needs. If our office is not notified within the 24 hours, you will be subject to a $50 late cancellation charge.

By signing below, I agree to fulfill my obligation as a patient at Carolinas Dental Center and agree to the "broken appointment" fee should I not give proper notification.

Signature of patient or responsible party **Date**

CAROLINAS
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FINANCIAL POLICY

As a condition of the treatment performed by the providers of the office, financial arrangements must be made in advance for the full cost of proposed treatment. The practice's vitality depends upon payment for services as rendered and it is the responsibility of the patient or patient's parent/guardian to satisfy the costs incurred in dental care. Financial arrangements on the part of each individual must be determined prior to treatment completion.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are rendered. Additionally, a discount can be extended, at the management's discretion, for payments in full with cash or check. (Inquire for more details.)

Individuals who carry dental insurance understand that all dental services furnished are charged directly to the patient and that said patient is personally responsible for payment of all dental services provided, regardless of dental insurance reimbursement. As a customer courtesy, this office will help prepare and submit patients' insurance forms as well as assist in making collections from insurance companies. We will credit any such collections to the appropriate account. However, this dental office cannot render services on the assumption that our charges will be paid in part or in full by an insurance company. (Please understand that the amount to be paid by your particular policy is pre-determined and agreed to by your employer and the insurance company. If you have any questions about the amount the plan will pay or the treatments your plan will cover, you should refer these questions to your employer.) Additionally, there may be a deductible, a co-insurance factor, and a yearly maximum to be considered. Most policies cover what they consider a "usual and customary fee." However, the insurance company sets these fees, and they are not always the same as the fees that may be charged in this or any office. All these factors may combine to reduce the benefits you will ultimately receive. We will do our best to see that you receive your full benefits within the structure of your particular dental plan but any balance that remains on your account, whether your insurance company covered the procedure in question or not, is ultimately your responsibility to pay.

A service charge of 2% per month (24% per annum) on any unpaid balance will be charged on all accounts exceeding 60 days from date of service, unless previously written financial arrangements are agreed upon and satisfied. I understand that the fee estimate listed for any proposed dental care can only be extended for a period of six months from the date of diagnosis and/or examination. I further acknowledge that the proposed treatment plan can shift and/or change from the diagnosed treatment plan once treatment is begun due to unforeseen circumstances beyond the doctors' control.

In consideration for the professional services rendered to me by the doctor, at the provider's recommendation, or at my own request, I agree to pay the reasonable value of said services to said doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time allotted for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition, and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to Carolinas Dental Center and/or Carolinas Dental Center's financial coordinator to telephone me at home or at my place of business to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent or guardian	Date	Relationship to patient
Signature of guarantor of payment/responsible party	**Date**	**Relationship to patient**

AUTHORIZATION FOR RELEASE OF INFORMATION

Name of Patient _____ Date of Birth _____

Carolinas Dental Center is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Check entity/person that you approve to receive information.	**Check description of information to be released to entity/person at left.**
☐ Voice Mail (Home or Mobile)	☐ Appointment Reminders
☐ Email_____ (Provide Email Address)	☐ Appointment Reminders, X-Rays, Financial
☐ Spouse_____ (Provide Name and Phone Number)	☐ Appointment Reminders ☐ Financial ☐ Treatment Plans
☐ Parent_____ (Provide Name and Phone Number)	☐ Appointment Reminders ☐ Financial ☐ Treatment Plans
☐ Other_____ (Grand-parent, Step-parent, Nanny) (Provide Name and Phone Number)	☐ Appointment Reminders ☐ Financial ☐ Treatment Plans

Patient Information

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that 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 understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

_____

Signature of Patient or Personal Representative Date

Authorization to Receive Dental Records

Expires upon one time release

Patient Information:

Name of Patient _____ Date of Birth _____

Address_____

City, State, Zip_____Phone_____

I authorize the practice below to release my dental records (please include phone # if known):

_____

_____

_____

P**lease forward/release my dental records to: MATTHEWSXRAYS@CAROLINASDENTALCENTER.COM**

CAROLINAS DENTAL CENTER
428 NORTH TRADE STREET, SUITE 101
MATTHEWS, NC 28105
PHONE: 704-845-1107 FAX: 704-845-1370

Please describe the Protected Health Information that you would like released.

_____

_____

This authorization shall be in effect until the information has been forwarded as requested.

Patient information

I understand that my treatment will not be conditioned on signing this authorization and that I have the right to refuse to sign this authorization. I understand that information 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 understand that I have the right to revoke this authorization by sending a written notification to the address below and that a revocation is not effective if the information has already been disclosed but will be effective going forward.

I understand that I have the right to inspect or copy the protected health information as described in this document. I can do this by written notification to Carolinas Dental Center, 428 North Trade Street, Suite 101, Matthews, NC 28105.

_____**Date**_____

Signature of Patient or Personal Representative

_____

Description of Personal Representative's Authority (attach necessary documentation)

Carolinas Dental Center

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 _____