Lindsey Metcalf DDS PLLC | Date:

PATIENT INFORMATION

Patient's Name ______________________ Preferred Name ______________________

Date of Birth ______________ Social Security # ______________ Marital Status M S W D

If minor, name of parent/guardian ______________________________

Home Address ______________________ City ______________ State ________ Zip ________

Home Phone ______________ Work Phone ______________ Cell Phone ______________

Do you prefer to receive: ☐ calls at home ☐ calls at work ☐ calls on cell

Employer ______________________________

Business Address ______________________________

Name of Spouse ______________________________

Spouse's Employer ______________________________

Business Address ______________________________

Emergency Contact ______________________ Phone ______________

Person responsible for this account ______________________ Social Security # ______________

Address (if different from above) ______________________________

If you have dental insurance, name of insured ______________________ Date of Birth ______________

Name of insurance company ______________________ Policy # ______________

Whom may we thank for referring you to our office? ______________________________

CONSENT AND RESPONSIBILITY

I authorize the dentist to perform all procedures deemed appropriate to make a diagnosis of the patient's dental needs and to render the treatment indicated. I realize that any treatment may embody some risk.

I understand that financial responsibility for services provided for myself or dependents is mine and is due at the time services are rendered unless specific financial arrangements are made. I further understand that a finance charge may be added to any past due balance.

Patient/Guardian Signature ______________________________

DENTAL HISTORY

What brings you to our office today? ______________________________

When was your last visit to the dentist? ______________________________

Do you have any of the following:

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Clenching/grinding teeth
- ☐ Clicking/popping in jaw
- ☐ Cold sores
- ☐ Dental anxiety
- ☐ Dry mouth
- ☐ History of braces
- ☐ Injury to head/neck
- ☐ Sores/lumps in/around mouth
- ☐ Sensitivity to hot/cold
- ☐ Sensitivity to sweets
- ☐ Wear night/occlusal guard
- ☐ Wear replacement teeth

Have you had any serious trouble associated with any previous dental treatment?

____

Do you have any special fears or concerns about your visit? ______________________________

Are you required to take pre-medication before dental treatment? ☐Yes ☐ No ☐ Don't Know

If yes, for what condition? ______________________________

Lindsey Metcalf DDS PLLC Date:

MEDICAL HISTORY

Your mouth is part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Your answers are for our records only and will be considered confidential. If you have any questions, we would be glad to assist you!

Name of Physician ______________________ Physician Phone # ____________

Date of last physical examination ______________________

Your current physical health is: ☐ good ☐ fair ☐ poor

Are you under the care of a physician now? ☐Yes ☐ No If so, what is the condition being treated?

____

Please list any medications, herbal supplements, and/or vitamins

____

____

____

Please describe any serious illnesses and/or operations in the past 5 years

____

____

Are you allergic to, or have you reacted adversely to any of the following:

- ☐ Aspirin
- ☐ Ibuprofen
- ☐ Acetaminophen
- ☐ Penicillin/amoxicillin
- ☐ Other antibiotics
- ☐ Codeine
- ☐ Local anesthetics
- ☐ Metals
- ☐ Latex
- ☐ Other ______________

Do you have or have you had any of the following? (Please check any that apply)

- ☐ Abnormal bleeding
- ☐ Alcohol/drug abuse
- ☐ Allergies
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis
- ☐ Artificial joints
- ☐ Artificial heart valves
- ☐ Asthma
- ☐ Autoimmune disorder
- ☐ Blood pressure high/low
- ☐ Blood transfusion
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Colitis
- ☐ Congenital heart defect
- ☐ Diabetes
- ☐ Difficulty breathing
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting spells
- ☐ Fever blisters
- ☐ Frequent headaches
- ☐ Glaucoma
- ☐ Heart attack/problems
- ☐ Heart murmur
- ☐ Heart surgery
- ☐ Hemophilia
- ☐ Hepatitis A/B/C
- ☐ HIV or AIDS
- ☐ Kidney problems
- ☐ Liver disease
- ☐ Mental Illness
- ☐ Pacemaker
- ☐ Radiation therapy
- ☐ Rheumatic Fever
- ☐ Seizures
- ☐ Sinus problems
- ☐ Sleep apnea
- ☐ Stroke
- ☐ Thyroid problems
- ☐ Tuberculosis
- ☐ Tumor
- ☐ Venereal Disease
- ☐ Other ____________

Do you use tobacco products? ☐Yes ☐ No

Women only: Are you pregnant? _______ If yes, number of weeks _______ Are you nursing _______

Please provide additional information and an explanation for those items checked above:

____

____

I certify that I have read the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold the dentist, or any other member of the staff, responsible for any errors or omissions that I may have made in completion of this form.

Patient/Guardian Signature ______________________________

Lindsey Metcalf DDS PLLC

123 Broad Street, Kernersville, NC 27284

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 ____

Lindsey Metcalf DDS PLLC
Authorization for Release of Information – Compound Release

Name of Patient ____ Date of Birth _____________

____ is authorized to release protected health information about the above named patient in the following manner and to identified persons.

Entity to Receive Information. Check each person/entity that you approve to receive information.	**Description of information to be released.** Check each that can be given to person/entity on the left in the same section.
☐ Voice Mail	☐ Results of lab tests/x-rays ☐ Other___________________________
☐ Other person (s) (provide name and phone number)	☐ Financial ☐ Medical
☐ Email communication-Provide email address* ________________________________ *For email communication to occur, please accept the disclosure below:	☐ Financial ☐ Medical ☐ Appointment reminders ☐ Breach notification
☐ Text communication – Provide number * ________________________________ *For text communication to occur, accept the disclosure below:	☐ Appointment reminder ☐ Other: ________________________________
☐ For **email and/or text communication** I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected.	
☐ Photo of patient received by patient or legal guardian ☐ Photo taken by staff (Example: pre/post procedure) ☐ Other	

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected 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 redisclosure 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 that my treatment will not be conditioned on signing.

This authorization will remain in effect until revoked by the patient.

____Date ___________________

Signature of Patient or Personal Representative

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

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