Elite Dental

1619 Providence Road S
Waxhaw, Nc 28173
(704) 627-8327

WELCOME TO OUR PRACTICE!

Thank you for trusting our team with your dental care! We pride ourselves in excellence and offer a full array of services for you and your whole family. Care can begin for your family from the age of 2 and up. You can be assured that our highly qualified staff, as well as our advanced facility offer the finest care available. Personal care and attention to your case are always provided in abundance as **we look forward to keeping you as a patient for years to come!** We strive to make your time with us today a pleasant experience, so please let us know if you have any special requests!

For patients without insurance, full payment is due the day of treatment. Should you require treatment that spans over several appointments like crowns, bridges, partials or dentures, you may pay half on the day treatment begins, and the other half at completion. A deposit is required at the time of making the appointment.

Please understand that our office is appointment driven. When you reserve an appointment, trained personnel, time and dental equipment are set aside exclusively for you and your procedure. Missed appointments add cost to dental care when reserved facilities are left empty. If you cannot make an appointment you must give our office at least 24 hours of advance notice or a $50.00 broken appointment fee may be charged to your account and your ability to make future appoinments will be limited. We respect your time, be assured that we will make every effort to see you at your scheduled time and complete procedures in a timely manner.

We Thank you for respecting our office policies and procedures and look forward to helping you maintain your healthy smile!

Sincerely,

G. Abrams & R. Cohen II PC

_____ _____

Patient Signature **Date**

PATIENT NAME

PATIENT NAME _____ TODAY'S DATE _____

HOME ADDRESS _____ DATE OF BIRTH _____

CITY, STATE, ZIPCODE _____ HOME PHONE _____

E-MAIL _____ CELL PHONE _____

EMPLOYER _____ BUSINESS PHONE _____

INSURANCE CO. _____ SS#/SIN _____

GENDER ☐MALE ☐FEMALE

PATIENT MEDICAL HISTORY

PHYSICIAN _____ OFFICE PHONE _____ DATE OF LAST EXAM _____

	YES	NO
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness?	☐	☐
3. Are you taking any medication(s) including non-prescription medicine?	☐	☐
If yes, what medication(s) are you taking? _____		
4. Have you ever taken Fen-Phen/Redux?	☐	☐
5. Do you use tobacco?	☐	☐
6. Do you use alcohol or other drugs?	☐	☐
7. Are you wearing contact lenses?	☐	☐

8. Are you allergic to or have you had any reactions to the following?

YES	NO		YES	NO		YES	NO	
☐	☐	Local anesthetics (eg. novocaine)	☐	☐	Barbiturates	☐	☐	Aspirin
☐	☐	Penicillin	☐	☐	Sedatives	☐	☐	Other _____
☐	☐	Sulfa Drugs	☐	☐	Iodine			

9. WOMEN ONLY:

	YES	NO
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking birth control pills?	☐	☐

10. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)? ☐ ☐

11. Do you have or have you had any of the following?

YES	NO		YES	NO		YES	NO	
☐	☐	High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pains
☐	☐	Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Easily Winded
☐	☐	Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Stroke
☐	☐	Swollen Ankles	☐	☐	Angina (Heart Related)	☐	☐	Hay Fever / Allergies
☐	☐	Fainting / Seizures	☐	☐	Frequently Tired	☐	☐	Tuberculosis
☐	☐	Asthma	☐	☐	Anemia	☐	☐	Radiation Therapy
☐	☐	Low Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma
☐	☐	Epilepsy / Convulsions	☐	☐	Cancer	☐	☐	Recent Weight Loss
☐	☐	Leukemia	☐	☐	Arthritis	☐	☐	Liver Disease
☐	☐	Diabetes	☐	☐	Joint Replacement or Implant	☐	☐	Mitral Valve Prolapse
☐	☐	Kidney Diseases	☐	☐	Hepatitis / Jaundice	☐	☐	Respiratory Problems
☐	☐	AIDS or HIV Infection	☐	☐	Sexually Transmitted Disease	☐	☐	Other _____
☐	☐	Thyroid Problem	☐	☐	Stomach Troubles / Ulcers	☐	☐	_____

REASON FOR TODAY'S VISIT?

_____

_____

_____

HOW DID YOU HEAR ABOUT US?

_____

_____

PATIENT DENTAL HISTORY

	YES	NO
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have you ever experienced any of the following problems in your jaw?		
a) Clicking?	☐	☐
b) Pain (joint, ear, side of face)?	☐	☐
c) Difficulty in opening or closing?	☐	☐
d) Difficulty in chewing?	☐	☐
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you ever had any difficult extractions in the past?	☐	☐
12. Have you had any orthodontic treatment?	☐	☐
13. Have you ever had prolonged bleeding following extractions?	☐	☐
14. Have you ever had instruction on the correct method of brushing your teeth?	☐	☐
15. Have you ever had instructions on the care of your gums?	☐	☐

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

SIGNATURE X _____ _____

PATIENT, PARENT OR GUARDIAN DATE

HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND 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: _____

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 Patient **signature** / Guardian of Patient

_____ _____

Legal Representative / Guardian Relationship of Legal Representative / Guardian

Your comments regarding Acknowledgements or Consents: _____

_____

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

☐ First Name Only ☐ Proper Surname ☐ Other _____

PLEASE LIST ANY OTHER PARTIES 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
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of the Above**

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

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email 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.

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

Date: _____

Welcome to Elite Dental

We will now be using email and text messaging to remind you of:

*appointments

*when you are due for cleanings

*special offers

Please include your email address and mobile telephone number below to help you access this great new feature!

EMAIL:_____@_____

MOBILE TELEPHONE #: _____ - _____ - _____

We would also appreciate knowing *how you learned of us!*

Please check the appropriate box below:

□ Patient Referral: (Who referred you?) _____

□ Friendly Dental Employee Referral: (Who referred you?) _____

□ Website/Internet □ TV □ Radio □ Newspaper

□ Office Sign □ Event/Festival/Show □ Friendly Dental Phone Call

□ Other Advertisement □ Other: _____

If you have checked more than one, please circle the most influential in your decision to come in.