PATIENT INFORMATION

____

Last Name First Name Middle Name DOB

PATIENT INFORMATION

Social Security #: ______________________ Driver's License #: ______________________

Home Address: ____

City: ______________________ State: __________ Zip: __________

Cell Phone: ______________________ Home Phone: ______________________

Work Phone: ______________________ Other Phone: ______________________

Email Address: ____

Marital Status: [ ] Minor [ ] Married [ ] Single [ ] Divorced [ ] Widowed

Patient/Guardian's Employer: ______________________ Occupation: ______________________

Spouse/Guardian's' Name: ______________________ Contact Number: ______________________

RESPONSIBLE PARTY [ ] Same as above

Name of Person Responsible for Account: ______________________ Relationship: __________

Social Security #: ______________ Driver's License #: ______________ DOB: __________

Home Address: ____

City: ______________________ State: __________ Zip: __________

Cell Phone: ______________________ Home Phone: ______________________

Work Phone: ______________________ Other Phone: ______________________

Email Address: ____

INSURANCE INFORMATION

Name of Insured: ______________________ Relationship to Patient: __________

Policy Holder's DOB: ______________________ Social Security #: ______________

Policy Holder's Employer: ______________________ Work Phone: ______________

Insurance Co.: ______________ Group # ______________ Policy/ID#: ______________

Do you have any additional dental insurance? [ ] Yes [ ] No

Authorization and Release of Information

I agree that Castor Family Dentistry may bill my insurance carrier for the service provided, as a courtesy to me, and that all payments will come directly to C. Brandon Castor, DDS at Castor Family Dentistry. I understand that I am solely responsible for the cost of my dental treatment. I hereby give authorization for the release of any information requested/ required by my insurance company with respect to any insurance claims.

Patient/ Guardian Signature: ______________________________ Date: __________

Acknowledgement of Receipt of
NOTICE OF PRIVACY PRACTICES

1430 East Cone Blvd.
Greensboro, NC 27405
(336) 621-4927
www.castorfamilydentistry.com

Patient Name & Address: ____

____

____

I have received a copy of the Notice of Privacy Practices for Castor Family Dentistry

____ ______________________________

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: ____

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AUTHORIZATION FOR RELEASE OF INFORMATION

Name of Patient: ____ Date of Birth: ______________

CASTOR FAMILY DENTISTRY is authorized to release protected health information about the above-named patient to the entities named below.

Check each person/entity approved to receive information	**Check type of information that can be given to person/entity on the left of the same section.**
[ ] Voice Mail	[ ] Results of lab tests/ x-rays [ ] Other: ________________________________
[ ] Other person(s) (provide name & 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 notification 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 (ex: pre/post procedure) [ ] Other	[ ] May be posted in office [ ] May be posted on website [ ] 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.

____ ________________________________

Signature of Patient or Personal Representative Date

CASTOR FAMILY DENTISTRY

FINANCIAL POLICY

We believe that your dental care and treatment is an investment in yourself and your future.
In an effort to control fees, payment in full is due at the time of service. For patients without dental insurance, we offer several payment options and discounts described below. If you have dental insurance, our staff will do our best to estimate your benefits and collect your estimated patient portion when treatment is provided. We accept cash, checks ($25 returned check fee), credit cards (VISA, MasterCard, Discover and American Express), and CareCredit.

Patients with Dental Insurance:
Please be sure to bring your most updated insurance card to each appointment and inform us if there have been any changes to your coverage. We are in-network with Ameritas, BCBS, Cigna, Delta Dental, MetLife and United Concordia; however, we will still help you to file with other insurance providers. Our staff will happily assist you to file the necessary paperwork so that you can receive the full benefits of your coverage. Remember that dental insurance is an agreement between the carrier and patient. As such, we make no guarantee of the estimated coverage or payment; however, we will do everything possible to see that you receive the full benefits of your policy. We will be happy to file for a pre-determination of benefits for your treatment plan; these estimates of coverage are not an actual guarantee of insurance payment, however. Pre-determinations may be required by insurance carriers for more extensive work (i.e.; crowns, periodontal cleanings, etc).

Payment Options:
Payment is due in full at the time of service. Due to the fact that we cannot guarantee your exact insurance coverage, there may be a balance remaining on your account after the insurance payment is received. This balance will be due 30days after the insurance payment is posted. Credits greater than $100 will be reimbursed to you immediately, while smaller amounts may be left on your account for future treatment at the patient's discretion.

CareCredit is a health care credit option, offering "same as cash," interest-free credit lines (6-24 months) for qualifying patients. Information and applications are available at the front desk or online.

Patients without dental insurance may receive a 5% discount on any services paid in full with cash or personal check.

Separate financial plans may be offered to patients in good standing with balances over $300 with approval by office staff and Dr. Castor.

A $40 charge will be applied for any missed/ canceled appointments without 24hours advanced notice.

____
Patient Name   Date

____
Patient Signature

CASTOR FAMILY DENTISTRY

MEDICAL HISTORY

____

Last Name First Name M.I. DOB

1. Have you been under the care of a medical physician within the past 2 years? Y N
   If yes, for what? ____
   Physician's Name: ______________________ Phone: ______________________
   Address: ____
2. Do you take any drugs or medications (prescription and/or over-the-counter)? Y N
   Please list all drugs/medications including dosages on the attached page.
3. Have you ever had a substance abuse/ addiction issue? Y N
   ____
4. Do you have any allergies to any medications or substances? Y N
   If yes, please list and/or describe: ____
   ____
5. Have you been hospitalized for a surgery or serious illness within the last 5 years? Y N
   If yes, please describe: ____
   ____
6. Alcohol Consumption: _____ drinks per day OR _____ drinks per week
7. Smoking/ Tobacco _____ packs per day _____ years of use Other: ______________________
8. Women: Are you pregnant? Y N ___ months Nursing? Y N On Birth Control? Y N
9. Do you use more than 2 pillows to sleep at night? Y N
10. Have you lost or gained more than 10 pounds in the past year? Y N
11. Please indicate whether or not you have had, or currently have the following conditions:

Condition	Y/N	Condition	Y/N	Condition	Y/N
Heart (Surgery, Disease, Attack)	Y N	Ulcers	Y N	Hepatitis A B C	Y N
Chest Pain	Y N	Diabetes	Y N	Venereal Disease	Y N
Congenital Heart Disease	Y N	Thyroid Problems	Y N	HIV/ AIDS	Y N
Heart Murmur	Y N	Glaucoma	Y N	Cold Sores/ Fever Blisters	Y N
High Blood Pressure	Y N	Contact Lenses	Y N	Blood Transfusion	Y N
Mitral Valve Prolapse	Y N	Emphysema	Y N	Hemophilia	Y N
Artificial Heart Valve	Y N	Chronic Cough	Y N	Sickle Cell Disease/ Trait	Y N
Heart Pacemaker	Y N	Tuberculosis	Y N	Bruise Easily	Y N
Rheumatic Fever	Y N	Asthma	Y N	Liver Disease	Y N
Arthritis	Y N	Hay Fever	Y N	Yellow Jaundice	Y N
Cortisone Medication	Y N	Latex Sensitivity	Y N	Neurological Disease	Y N
Swollen Ankles	Y N	Allergies or Hives	Y N	Epilepsy or Seizures	Y N
Stroke	Y N	Sinus Trouble	Y N	Fainting or Dizzy Spells	Y N
Diet (restricted, specialized, etc.)	Y N	Radiation Therapy	Y N	Nervous/ Anxious	Y N
Artificial Joints (hip, knee, etc.)	Y N	Chemotherapy	Y N	Psychiatric/ Psychological Care	Y N
Kidney Trouble	Y N	Tumors	Y N		

12. Any other conditions, concerns, or issues not listed that you feel are important to address? Y N
    ____
    ____

I understand that the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient/ Guardian Signature: ______________________________ Date: ______________

CASTOR
FAMILY DENTISTRY

MEDICATION LIST

____
Last Name First Name M.I. DOB

Drug/Medication Name	Dosage	Frequency	Use/Purpose

Patient/ Guardian Signature: ___________________________________ Date: ______________________

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CASTOR FAMILY DENTISTRY

DENTAL HISTORY

____

Last Name First Name M.I. DOB

Purpose of your visit today: ___________________________

____

____

Are you receiving routine dental care? Y N

Date of last dental visit: ___________________________

Name of previous dentist: ___________________________

Have any of the following prevented you from seeking dental care?

___ Fear or anxiety
___ Lack of time
___ Lack of funds/ cost
___ No insurance
___ Other: ______________________________

Have you ever had problems/ complications with past dental care? Y N

If yes, describe: ____________________________________

____

Did you drink fluoridated water as a child (age 1-12)? Y N

What is your current primary water source?

_____ City _____ Well _____ Bottle

HYGIENE PRACTICES

Tooth Brush: _____ Electric _____ Manual

_____ Soft _____ Medium _____ Hard

Brush: _____ # times per day

Floss: _____ # times per day

Rinse: _____ # times per day

Other home care: ______________________________

____

____

Do you use bleaching products? Y N

Describe: ____

____

DENTURES/ PARTIALS

How long have you worn them? ____________________

Any current problems? ____________________________

____

Indicate any past dental treatment:

_____ Orthodontics (braces)
_____ Oral surgery (extractions, biopsy)
_____ Periodontics (gum treatment or surgery)

Are your teeth sensitive to:

_____ Sweets
_____ Hot
_____ Cold
_____ Pressure (chewing/ biting)
_____ Other

Do you have any swelling(s) in your mouth? Y N

Are your teeth shifting? Y N

Are your teeth loose? Y N

SALIVARY FUNCTION

Does your saliva feel thick? Y N

Does your mouth often feel dry? Y N

Do you have difficulty chewing food? Y N

Do you have difficulty swallowing? Y N

Do you have difficulty speaking? Y N

Do you have excess saliva? Y N

TMJ/ JAW PROBLEMS

Clicking/Popping jaws? Y N

Pain? Y N

Locked open or closed? Y N

OTHER CONCERNS: ________________________________

____

____

____

____

____

SMILE EVALUATION

1. Are you satisfied with the appearance of your teeth? Y N

____

2. Are your teeth straight? Y N

____

3. Do you like the color of your teeth? Y N

____

4. Are there old fillings or other dental work that you don't like the look of? Y N

____