**Welcome to Cary Lee Family Dentistry**

**1500 Piney Plains Rd. Suite 101**

**Cary, NC 27518**

**We are pleased to have you as a patient in our practice.**

**Please take a few moments to fill out this from as completely as you can.**

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| **PATIENT INFORMATION** | | | | | | | | | | |
| **🞎 Mr.**  **🞎 Mrs.**  **🞎 Ms.** | **Patient’s (Last) (First) (Middle)**  **Legal**  **Name :** | | | | | | | **Preferred Name (Optional) :** | | |
| **Marital Status :**  **🞎 Single 🞎 Married 🞎 Divorced 🞎 Separated 🞎 Widowed** | | | | | | **Date of Birth (MM/DD/YYYY) :**  **/ /** | | | **Age :** | **Gender :**  **🞎 M 🞎 F** |
| **Street Address :** | | | | | | **Home Phone Number :**  **( ) -** | | | **Cell Phone Number :**  **( ) -** | |
| **City :** | | **State :** | | **ZIP Code :** | | **Social Security Number :**  **- -** | | **※ Your social security number will be used for insurance verification and patient identification purposes only.** | | |
| **Email :** | | | | | | | | | | |
| **How can we contact you? Please check one or more methods of communication.** | | | | | | | | | | |
| **🞎 Text messages or KakaoTalk** | | | **🞎 Email** | | **🞎 Cell Phone** | | **🞎 Home Phone** | **🞎 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | |
| **Whom may we thank for referring you to our practice? (Please check one box) :**  **🞎 Referred by Dr. \_\_\_\_\_\_\_\_\_\_\_ 🞎 Family 🞎 Friend 🞎 Newspaper 🞎 Web Search 🞎 Other : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | |

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| **DENTAL INSURANCE INFORMATION** | | | | | |
| **Please give your insurance card and a valid photo I.D. to the receptionist.** | | | | | |
| **Primary Insurance (Please check one box) :**  **🞎 Aetna 🞎 Ameritas 🞎 Blue Cross Blue Shield 🞎 Cigna 🞎 Delta Dental 🞎 Guardian 🞎 HealthSmart**  **🞎 Medicaid / Medicare 🞎 Metlife 🞎 United Concordia 🞎 United HealthCare 🞎 Other : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | |
| **Policy Holder’s Name :** | **Date of Birth (MM/DD/YYYY) :**  **/ /** | | **Policy Holder’s S.S.N. :**  **- -** | | **※ Your social security number will be used for insurance verification and patient identification purposes only.** |
| **Employer :** | | **Policy Group Number :** | | **Policy Number or Subscriber ID :** | |
| **Relationship to Policy Holder : 🞎 Self 🞎 Spouse 🞎 Child 🞎 Other : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | |

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| **IN CASE OF EMERGENCY** | | | | | | | | |
| **Name of local friend or relative (not living at the same address) :** | | | | **Relationship to the patient :** | | | | **Phone Number :**  **( ) -** |
| **The information I have provided above is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the practice. I understand that I am financially responsible for any remaining balance. I also authorize the dental office or my insurance company to release the information required to process my claims.**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  ***Patient or Guardian’s Signature Today’s Date*** | | | | | | | | |
| **HEALTH INFORMATION** | | | | | | | | |
| **Your health information will be kept confidential and will be used so we may serve you better.** | | | | | | | |
| **Today’s Date :** | | | | **When was your last dental visit?** | | | |
| **What is the primary reason for your visit today?**  **🞎 Check-up 🞎 Cleaning 🞎 Pain 🞎 Cavities 🞎 Other concerns (Please explain) : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | |
| **Do you have any allergies?**  **🞎 I do not have any allergies.**  **🞎 Aspirin 🞎 Acrylic 🞎 Codeine 🞎 Latex 🞎 Metal 🞎 Penicillin 🞎 Sulfa Drugs 🞎 Other : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | |
| **Please mark all of the conditions you have had or are receiving treatment for :** | | | | | | | |
| **🞎 None** | |  | | |  | |  |
| **🞎 AIDS / HIV** | | **🞎 Asthma** | | | **🞎 Anemia** | | **🞎 Arthritis** |
| **🞎 Blood Pressure Conditions (Please specify: 🞎 High 🞎 Low)** | | | | | **🞎 Cancer** | | **🞎 Chest Pain** |
| **🞎 Depression** | | **🞎 Diabetes** | | | **🞎 Fibromyalgia** | | **🞎 High Cholesterol** |
| **🞎 Heart Disease** | | **🞎 Hepatitis A** | | | **🞎 Hepatitis B or C** | | **🞎 Kidney Problems** |
| **🞎 Liver Disease** | | **🞎 Osteoporosis** | | | **🞎 Stroke** | | **🞎 Thyroid Disease** |
| **🞎 Tuberculosis** | | **🞎 Other (Please specify) :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | |
| **Are you taking any of the following medications :** | | | | | | | |
| **🞎 None** |  | | | | |  | |
| **🞎 Antibiotics** | **🞎 Anticoagulants (Blood thinners)** | | | | | **🞎 Aspirin** | |
| **🞎 Cortisone or other steroids** | **🞎 High blood pressure medication** | | | | | **🞎 Insulin, Orinase, or other drugs for diabetes** | |
| **🞎 Nitroglycerin** | **🞎 Osteoporosis (Bone density) medication** | | | | |  | |
| **🞎 Other prescribed or over the counter medications : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | |
| **FOR WOMEN: Are you currently :**  **🞎 Trying to get pregnant or pregnant (Expected delivery date : \_\_\_\_\_\_\_\_\_\_\_\_\_) 🞎 Nursing 🞎 Taking oral contraceptives**  **🞎 None of the above** | | | | | | | |
| **Is there anything else you would like us to know about? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | |
| **I understand the need for these questions to be answered truthfully. To the best of my knowledge, the answers I have given are accurate. I also understand it is very important to report any changes or updates in my medical status to my doctor. I give permission to obtain from my physician any additional information regarding my medical history needed to provide me with the best treatment and care possible.**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  ***Patient’s Name (Please print)***  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  ***Patient or Guardian’s Signature Today’s Date*** | | | | | | | |