**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*** |