Welcome to Carolina Prothodontics

Date: _____

Patient Information

Mr./Mrs./Ms. First Name: _____ M.I. _____ Last Name: _____ Date of Birth: _____

SSN#: _____ Email: _____ Home Phone: _____Work Phone: _____

Address: _____ City: _____ State: ____ Zip: _____

Referred By: _____

Responsible Party

Name of Responsible Party: _____ Relationship: _____

Residential Address: _____ City: _____ State: ____ Zip: _____

Date of Birth: _____ SSN#: _____ Email: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Employer: _____ Occupation: _____

Dental Insurance Information

Subscriber's Name: _____ SSN#: _____ Date of Birth: _____

Insurance Carrier: _____Group #: _____ Ins. Phone #: _____

Insurance ID #: _____ Address to Send Claims: _____

Fees & Payments

We make every effort to keep down the cost of your dental care. You can help us by upon the completion of each visit. Other arrangements can be made with our office manager depending upon special circumstances.

If you have any dental insurance, we will file it for you as a courtesy. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. To avoid misunderstanding regarding dental insurance, we wish our patients to know that all professional services rendered are charged directly to the patient and that patients are personally responsible for payment of fees, We will prepare necessary forms or reports to help you obtain your benefits from insurance companies. If your balance is paid in full, benefits will be payable to you. In the event you have a balance, benefits will be payable to the office.

Personal Payment Type: Cash ____ Check ____ Credit Card ____

This signature on file is my authorization for the release of information necessary to process my claim regarding payment

Signature of Patient: _____ Date: _____

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any question I may have regarding this Notice.

Signature of Patient: _____ Date: _____

Health History

Medical Physician's Name: _____ Date of Last Physical: _____

Allergies To:		Medications – Are you now taking or have you taken			Current Medications
Aspirin	Penicillin	Blood Thinners (Coumadin, Plavix, Aspirin, Vitamin E, Ginko, Bilopia)	Yes	No	
Sulfa	Barbiturates				
Codeine	Local Anesthetic	Any Bone density meds (Aredia, Zometa, Fosamax, Actonel)?	Yes	No	
Latex	Iodine				
Other:					

Do you have or have you ever had any of the following:

Chest Pain	**Y**	**N**	Any Type of Transplant	**Y**	**N**
Heart Failure	**Y**	**N**	Hepatitis, Jaundice, or Liver Disease	**Y**	**N**
Any Type of Implant	**Y**	**N**	Artificial Joints	**Y**	**N**
Heart Disease	**Y**	**N**	Arthritis	**Y**	**N**
Heart Attack	**Y**	**N**	Thyroid Disease	**Y**	**N**
Angina Pectoris	**Y**	**N**	Kidney Disease	**Y**	**N**
Pacemaker/Defibrillator	**Y**	**N**	Diabetes	**Y**	**N**
Congenital Heart Problem	**Y**	**N**	Ulcers	**Y**	**N**
Heart Surgery	**Y**	**N**	Cancer (Type:)	**Y**	**N**
Heart Murmur	**Y**	**N**	Radiation Therapy	**Y**	**N**
Mitral Valve Prolapse	**Y**	**N**	Chemotherapy	**Y**	**N**
Rheumatic Fever	**Y**	**N**	Sickle Cell Disease	**Y**	**N**
High/Low Blood Pressure	**Y**	**N**	Tuberculosis	**Y**	**N**
Blood Tranfusion	**Y**	**N**	Drug Addiction/Alcoholism	**Y**	**N**
Hemophilia	**Y**	**N**	Psychiatric Treatment	**Y**	**N**
Anemia	**Y**	**N**	Mentally Challenged	**Y**	**N**
Stroke	**Y**	**N**	Epilepsy or Seizures	**Y**	**N**
Glaucoma	**Y**	**N**	Fainting or Dizzy Spells	**Y**	**N**
Asthma	**Y**	**N**	Herpes	**Y**	**N**
Emphysema	**Y**	**N**	Eating Disorder	**Y**	**N**
Persistent Cough	**Y**	**N**	Sinus Trouble	**Y**	**N**
Tobacco Use	**Y**	**N**	Excessive Bleeding after Surgery	**Y**	**N**
Shortness of Breath	**Y**	**N**	HIV Positive, ARC, or AIDS	**Y**	**N**
Sores, Lumps, or Growths in or near your mouth	**Y**	**N**	Any Clicking, popping, or discomfort in the jaw area, Difficulty chewing	**Y**	**N**
Women: Pregnant or Nursing	**Y**	**N**	Women: Taking Oral Contraceptives	**Y**	**N**

Are there any other medical issues, past or present not indicated above? _____

Do you wish to speak with the doctor privately about anything? Yes or No

I certify that I have answered the above question to the best of my knowledge. I under thank providing incorrect information can be dangerous to my health.

Signature of Patient: _____ Date: _____

Dr. Robert Rosenheimer

Import Information For Our Patients

We welcome you to our practice and will be happy to answer any questions that you may have

Payment Options:

This office is a "Fee for Service" practice. **All fees are due, in full, at the time services are rendered.** For your convenience, we accept all major credit cards, cash, and personal checks (with proper identification). Outside financial arrangements can be made to assist you with your budget through Care Credit (ask for details of which fee plans are available in this office). For any treatment over $1,000, we offer a courtesy savings of 5% when all fees are paid in full at the beginning of treatment with cash or check (Only).

Dental Insurance:

We are glad to assist you in obtaining the maximum benefit from your dental insurance plan. All services other than standard, regular hygiene appointments are due in full at the appointment. We file insurance, as a courtesy, for reimbursement back to patient. We will accept assignment of payment from your insurance company for hygiene for patients of record with accounts in good standing. Once insurance payment has been made, any uncovered amount is the patient's responsibility and that amount is due within 15 days of statement of account. Continued failure by the patient to pay amounts due that insurance did not cover will result in the loss of that patient's privilege of being allowed to have insurance filed and rendered as payment on account. Patient will than be required to pay in full for hygiene appointments. Insurance would still be filed as a courtesy but no longer accepted as payment towards account.

Appointments:

Our appointments are scheduled to respect your time. We reserve a specofic time for your care and we make every effort to see you at the time of your appointment. We appreciate your promptness and consideration in not changing your scheduled time. Appointments that are changed, cancelled, or missed without prior notification of at least 24 hours (minimum), will be considered as a "Broken Appointment". After 2 broken appointments, the 3rd time will incur $58 non-refundable broken appointment fee. In addition, after the 3rd failed appointment, a $77 office fee will required in advance to hold any future appointments. The $77 fee will be applied towards any fees for services rendered at that appointment. Should that appointment be broken also, that $77 fee will not be refunded and patient will be dismissed from the practice for failure to comply with office appointment policy.

I have read, understand and agree to adhere to the policies of this dental practice.

Signature of Patient Date Signed

Note: Patients with insurance also sign below for your file, Thank you.

I hereby authorize the release of all information from my records to my insurance company. I authorize payment of all dental payments payable to me to go directly to my dental provider for any services not paid in full at time of service.

Signature of Patient Date Signed