ALEX DRAKE, DDS, PA
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Oxford, North Carolina 27565

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We welcome you to Drake Dentistry and thank you for allowing us to provide your dental care! Please take the time to completely fill out both sides of this confidential information form so that we can better serve you.If you have any questions, do not hesitate asking!

Patient Information (Confidential)

Name _____ Birthdate _____ SS# _____
FIRST MI LAST

Physical Address _____ City, State _____ Zip Code _____

Mailing Address _____ City, State _____ Zip Code _____
(if different from above)

Home Phone (___) _____ Cell Phone (___) _____ Marital Status: M S D W

Employer _____ Work Phone (___) _____

Spouse's Name _____ Employer _____ Work Phone (___) _____

Father's Name _____ Employer _____ Work Phone (___) _____
(if patient is under 18 and/or a student)

Mother's Name _____ Employer _____ Work Phone (___) _____
(if patient is under 18 and/or a student)

Contact Person _____ Relationship _____ Day Phone (___) _____
(not living in your household)

Hobbies/Interests _____

Whom May We Thank For Referring You To Us? _____ Relationship _____

Person Responsible for Account (if different from patient)

Name _____ Relationship to patient _____ Birthdate _____

Physical Address _____ City, State _____ Zip Code _____

Mailing Address _____ City, State _____ Zip Code _____
(if different from above)

SS# _____ Home Phone (___) _____ Cell Phone (___) _____

Employer _____ Work Phone (___) _____

Is this person currently a patient in our office? Yes No

Dental Insurance Coverage

Name of Policy Holder/Employee _____

Policy Holder's Social Security Number _____

Policy Holder's Date of Birth _____

Policy Holder's Employer _____

Insurance Company Name _____

Group Policy Number _____

Insurance Company's Telephone Number (____) _____

Insurance Company's Mailing Address for Dental Claims _____

_____

_____

I hereby certify that I have read and understand the information to the best of my knowledge. The questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize radiographs (X-rays), study models and photographs, diagnostic casts or any other diagnostic aids deemed appropriate by the doctor to make a thorough examination. I authorize the doctor to perform dental treatment that we have mutually agreed upon and to employ assistance as required providing proper care. I consent to the use of appropriate medications and therapy as deemed necessary. I fully understand that the use of anesthetic agents embodies a certain risk, which may include parasthesia or other injury.

I hereby give the absolute right and permission to use my audio/visual materials, including photographs/slides for educational or promotional purposes. The undersigned completely and forever releases any right to present or future compensation in connection with the use of said materials.

I authorize the doctor to release any information including the diagnosis and the records of any treatment or examination rendered to my dependents or me during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the doctor the insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. In compliance with the Truth in Lending law, I agree to be financially responsible for payment of all services rendered on my behalf and/or my dependents. **I understand that payment is due at the time of service unless other arrangements have been made prior to treatment.** If I do not pay in full at the time of service, I understand that I will be charged 18% APR on the balance due after 60 days, and after that 60 days if the balance is unpaid, I understand that other collection procedures will be exercised and I will be responsible for all expenses incurred regarding collection of my account.

X _____ _____

SIGNATURE OF PATIENT OR PARENT/GUARDIAN | RELATIONSHIP TO PATIENT

_____ _____

DATE | OFFICE STAFF WITNESS

(Please see other side also)

DENTAL HISTORY

Patient Name	Medical Alert
I prefer to be called (nickname)	Premedication

We are pleased to welcome you to our practice. We are concerned about you and are eager to provide the best care possible. To help us evaluate your desires, concerns and health, please fill out **BOTH** sides of this form. If you are unsure of a question or don't understand, please ask us. All information is completely confidential.

What is the reason for your visit today? _____

What is your main dental concern?
- ❑ overall good health and dental health maintenance
- ❑ taking care of current problem only

Please enter dates of your last.....

Dental Visit:	Cleaning:	Full mouth X-ray:

What was done at your last visit? _____

Previous dentist's name & location: _____

If patient is a child, do you anticipate any behavior problems or difficulties? _____

Would you like your smile to be better, brighter, or different? _____

Are any of your teeth sensitive to:	
Hot or Cold?	**YES NO**
Sweets?	**YES NO**
Biting or chewing?	**YES NO**
Have you noticed any bad odors or tastes?	**YES NO**
Do your gums bleed or hurt?	**YES NO**
Does food become caught between your teeth?	**YES NO**
Is gum disease or tooth loss common in your family?	**YES NO**
Would you like to keep all your teeth all your life?	**YES NO**
What might prevent you from receiving proper dental care?	
Lack of desire for good health ...	**YES NO**
Inability to miss work/school ...	**YES NO**
Cost of quality care ...	**YES NO**
Do you feel nervous about having dental treatment? If so, what is your biggest concern? _____ _____	**YES NO**
Have you ever had an upsetting dental experience? If yes, please describe: _____ _____	**YES NO**

Have you ever had:	
Orthodontics (Braces)	**YES NO**
Oral Surgery	**YES NO**
Periodontal (gum) Treatment	**YES NO**
A bite adjustment, occlusal splint or mouth guard	**YES NO**
An injury to your mouth or head. If yes, explain below.	**YES NO**
Have you ever experienced:	
Clicking or popping of the jaw	**YES NO**
Pain (ears, joints, side of face)	**YES NO**
Difficulty in opening or closing mouth	**YES NO**
Grinding or clenching your teeth	**YES NO**
Sore or tired jaws in the morning	**YES NO**
Do You:	
Clench or grind your teeth while awake or asleep?	**YES NO**
Bite your lips or cheeks regularly?	**YES NO**
Hold foreign objects with your teeth? (pencils, etc.)	**YES NO**
Mouth breathe while awake or asleep?	**YES NO**
Smoke or chew tobacco?	**YES NO**
Frequently get cold sores, blisters, or other lesions?	**YES NO**

Are you satisfied with the appearance and function of your teeth ❑ Yes ❑ No Please Comment _____

Is there anything else about your dental treatment you feel we should know? _____

(PLEASE COMPLETE OTHER SIDE)

(Please see other side also)

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____

Are you on a special diet? ◯ Yes ◯ No
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs
☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
			Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

(PLEASE COMPLETE OTHER SIDE)

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New Patient Interview

Name: _____ Date: _____

1. What expectations do you have of a dental practice?

2. What is the key in having you remain as a long-term patient in our practice?

3. Who may we thank for your referral?

4. Can you tell me about some good experiences you have had in a dental office?

5. Are there any experiences that have been negative? If so, can you describe them?

6. On a scale of 1 to 10, where would you place the value of keeping your teeth and oral health in optimum condition?
   1 2 3 4 5 6 7 8 9 10

7. If I had a magic wand and gave it to you to change your smile, what would your smile look like?

919-693-9555 myoxforddentist.com
919-693-9559 (fax) info@myoxforddentist.com (email)

NO SHOW/CANCELLATION POLICY

If you have an appointment for dental treatment that you are unable to keep, you must give us at least 24 business hours' notice for us to accommodate other patient needs.

If notice of the cancellation is not received within a **24 hour** time frame, we reserve the right to charge a **$25.00 cancellation fee**.

If you have an appointment and do not show up or call, you may be charged a **$50.00 NO SHOW FEE**.

Any such fees will be automatically charged to your account.

We regret the need to implement this policy, but it allows us to provide the highest quality of dental care in the most efficient manner possible.

I have read and understand the above stated NO SHOW/CANCELLATION Policy.

Patient Signature:_____Date:_____

Parent Signature:_____Date:_____

(if patient under 18)

FINANCIAL POLICY

We are not currently in network with any insurance companies, but will gladly file any insurance you have excluding Medicaid and NC Health Choice. For our patients with insurance, we do ask that you pay 50% at the time of service for any restorative appointments. Because Delta Dental and Federal BCBS send payment directly to the patient, we do require patients with these plans to pay at the time of service. For our patients without insurance, we do ask for payment in full at the time of service for all appointments. We gladly accept Visa, MasterCard, personal checks and cash. We do not do any in house financing and ask any balances be cleared by sixty days. For our patients that may need to finance treatment over a longer period of time, we are glad to offer Care Credit, which is an outside finance company that allows patients to finance their treatment interest free.

I have read and understand the above stated Financial Policy.

Responsible Party Signature:_____Date:_____