

Kari H. Langley, DMD
FAMILY DENTISTRY

PATIENT INFORMATION FORM
PLEASE FILL OUT COMPLETELY

First Name: _____ MI _____ Last Name: _____

Date of Birth ____/____/____ Age: ____ Gender M / F

Drivers Lic. # (We require copy) _____ SSN: _____ - _____ - _____

Home address: Street: _____

City: _____ State: _____ Zip Code _____

Telephone: Home: _____ Work: _____

Cell: _____ Email: _____

Employer: _____

Employment address: Street: _____

City: _____ State: _____ Zip Code _____

Marital Status ____ Spouse Name: _____ Children's names _____

Responsible Party: Myself Other: _____ Relation to Patient: _____

Emergency Contact: _____ Phone (H) _____ (W) _____ (C) _____

• How did you hear about our office? Yellow Pages Drove by Internet Referral

• Who can we thank? _____

Dental Insurance Yes No WE REQUIRE A COPY OF YOUR CARD

Dental Insurance Company:
Address:
Policy #:
Group #:
Name of Insured (Policy Holder):
Patient's Relation to Insured: Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/>
Insured Address:
Insured Phone: (H) _____ (W) _____ (cell) _____
Insured Employer:
Insured Employer's Address:
Insured Date of Birth:
Insured SSN: _____ Carrier/Plan ID: _____

Kari H. Langley, DMD, PA does not participate with any insurance plans.
We will gladly file your insurance with your insurance company for your convenience.

I certify that the information on this form is correct. I understand that I am responsible for any balance on this account, even if I have dental coverage. I authorize that Kari H. Langley, DMD, PA can release your information to your insurance company.

Patient's Signature _____ Date: _____

Parent's Signature (if patient is a minor) _____ Date: _____

10720 S. Tryon Street • Suite H • Charlotte • North Carolina • 28273
Phone 704.583.0966 • Fax 704.583.0520

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 _____

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? Nursing?

Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics

Other If yes, please explain: _____

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

- | | | | | |
|---|--|--|--|---|
| <input type="checkbox"/> AIDS/HIV Positive | <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Genital Herpes | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Cortisone Medicine | <input type="checkbox"/> Heart Attack/Failure | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Arthritis/Gout | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Stomach/Intestinal Disease |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Heart Pace Maker | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> Easily Winded | <input type="checkbox"/> Heart Trouble/Disease | <input type="checkbox"/> Pain in Jaw Joints | <input type="checkbox"/> Swelling of Limbs |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Parathyroid Disease | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Hepatitis B or C | <input type="checkbox"/> Radiation Treatments | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Breathing Problem | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Herpes | <input type="checkbox"/> Recent Weight Loss | <input type="checkbox"/> Tumors or Growths |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Fainting Spells/Dizziness | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Renal Dialysis | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Frequent Cough | <input type="checkbox"/> Hives or Rash | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Frequent Diarrhea | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Yellow Jaundice |

Have you ever had any serious illness not listed above? Yes No If yes, please explain: _____

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 _____

Kari H. Langley, DMD, PA

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Phone 704.583.0966

IMPORTANT INFORMATION FOR OUR PATIENTS

Part of our mission at Kari H. Langley Family Dentistry is to provide you with quality, state-of-the-art dental care. It is our goal to assist you in obtaining and maintaining the highest level of personal dental health and patient relations. We want you to have a healthy, beautiful smile you desire and deserve!

Appointments

Our appointments are scheduled to respect your time. We reserve a specific time for your care and we make every effort to see you at that appointed time. We appreciate your promptness and consideration in not changing your scheduled time. However, if you do need to change an appointment, a **48 hour notice is required**. If a 48 hour notice is not given, we reserve the right to charge **\$35 per hour**, for the missed appointment.

Payment Options

For your convenience, we accept cash, credit cards, and Care Credit (ask us about this wonderful 3rd party financing plan!). For any treatment that exceeds \$1,000 we extend a Courtesy Saving of 5% when all fees are paid at the beginning of treatment. Our office will not send out a statement unless a balance is due. All balances incur 1.5% interest **per month** if a payment is overdue. Returned checks are subject to a \$25 returned check fee.

Dental Insurance

We are pleased to assist you in obtaining the maximum benefit from your dental insurance plan. Once your plan coverage has been verified, we will accept assignment of payment from your insurance company. Majority of dental insurances only aid patients with the cost of health care, it is never meant to pay 100% coverage of all services that you may want or need, which means you will be responsible for your deductible and the portion your plan will not cover. Payment of your portion is expected at the time you are in our office for dental care. As a courtesy, we are happy to file your insurance with direct payment to our office, however, **our patients are responsible for the entire account balance not covered by insurance.**

We appreciate you as a patient and thank you kindly for you cooperation.

I have read and understand the important information and accept my responsibilities as a patient in this office.

Signature (Patient or Legal Guardian)

Date

Kari H. Langley, DMD, PA
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704-583-0966

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name _____ Date of Birth _____

Patient Address _____

I have received a copy of the Notice of Privacy Practices for the practice of Kari H. Langley, DMD, PA

Signature of Patient or Guardian

Date

Authorization for Release of Information
To Family and/or Friends

Kari H. Langley, DMD is authorized to release protected health information about the patient named above to the entities named below.

Entity to Receive Information. Initial each that is subject to this authorization.

_____ Give information to spouse

_____ Give information to the following persons _____

Description of information to be released. Initial each that is subject to this authorization.

_____ Financial Information

_____ Family Billing Information

_____ Information results from tests or x-rays

_____ Medical information as follows _____

_____ Other _____

Rights of Patient

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to Kari H. Langley, DMD, PA.

I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that 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 understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing this authorization.

This authorization shall be enforced and effective until revoked by the patient or representative signing the authorization.

Signature of Patient or Guardian

Date