WELCOME TO HANDCRAFTED DENTISTRY

4208 S. Alston Ave, Durham, NC 27713
info@handcrafteddentistry.com
919-544-5620

NAME: _____ **SEX:** ☐ **M** ☐ **F**

NAME YOU PREFER TO BE CALLED: _____ **DATE OF BIRTH:** __/__/____

HOME ADDRESS: _____

_____ **ZIP CODE:** _____

HOME TELEPHONE: _____ **CELL PHONE:** _____

SSN: _____ **EMAIL ADDRESS:** _____

EMERGENCY CONTACT: _____ **PHONE NUMBER:** _____

EMPLOYER: _____ **OCCUPATION:** _____

NAME OF SPOUSE/PARENT: _____ **PARTY RESPONSIBLE FOR PAYMENT:** _____

INSURANCE CO. NAME: _____ **SUBSCRIBER ID#:** _____

WHO MAY WE THANK FOR REFERRING YOU? _____

YOUR HOBBIES, INTERESTS, PETS, ETC. _____

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MEDICAL AND DENTAL HISTORY

GENERAL HEALTH: ☐ **EXCELLENT** ☐ **GOOD** ☐ **FAIR** ☐ **POOR**

PHYSICIAN'S NAME: _____ **PHONE #:** _____

WHAT IS THEIR SPECIALTY? _____

YEAR OF LAST PHYSICAL: _____

LIST ALL MEDICINES & DOSAGES YOU ARE TAKING NOW (can also bring or email list)

_____

_____

DO YOU HAVE ALLERGIES TO: ☐ **PENICILLIN** ☐ **CODEINE** ☐ **DENTAL ANESTHETIC**
☐ **LATEX** ☐ **OTHER:** _____

DO YOU TAKE MEDICINE OR INJECTIONS FOR OSTEOPOROSIS?
(Fosamax, Romosozumab, other?) _____

WOMEN: PREGNANT? _____ **IF YES, HOW MANY WEEKS?** _____ **NURSING?** _____

HAVE YOU BEEN TOLD BY ANYONE THAT YOU NEED TO BE PREMEDICATED BEFORE DENTAL TREATMENT? _____ **IF YES, WHY?** _____

PLEASE CHECK (YES OR NO) IF YOU HAVE HAD ANY OF THESE CONDITIONS:

	YES	NO		YES	NO
HEART TROUBLE/MURMUR	☐ YES	☐ NO	FAINTING SPELLS	☐ YES	☐ NO
MITRAL VALVE PROLAPSE	☐ YES	☐ NO	RHEUMATIC FEVER	☐ YES	☐ NO
HIGH / LOW BLOOD PRESSURE	☐ YES	☐ NO	JOINT REPLACEMENT	☐ YES	☐ NO
PACEMAKER / CHEST PAIN	☐ YES	☐ NO	HERPES/COLD SORES	☐ YES	☐ NO
ANEMIA / ABNORMAL BLEEDING	☐ YES	☐ NO	GONORRHEA/SYPHILIS	☐ YES	☐ NO
DIABETES type I / II	☐ YES	☐ NO	LIVER/KIDNEY TROUBLE	☐ YES	☐ NO
POSITIVE TUBERCULOSIS TEST	☐ YES	☐ NO	STROKE	☐ YES	☐ NO
ASTHMA OR HAY FEVER	☐ YES	☐ NO	EPILEPSY/SEIZURES	☐ YES	☐ NO
HEPATITIS/JAUNDICE	☐ YES	☐ NO	GI ISSUES	☐ YES	☐ NO
ARTHRITIS	☐ YES	☐ NO	AIDS/ HIV INFECTION	☐ YES	☐ NO
GLAUCOMA	☐ YES	☐ NO	THYROID PROBLEMS	☐ YES	☐ NO
SINUS PROBLEMS	☐ YES	☐ NO	CANCER TX/ RADIATION	☐ YES	☐ NO
SHORTNESS OF BREATH	☐ YES	☐ NO	REFLUX/ULCERS	☐ YES	☐ NO
SLEEP APNEA/DISORDER	☐ YES	☐ NO	OTHER _____ _____		

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IT IS NATURAL TO HAVE SOME ANXIETY ABOUT DENTAL TREATMENT. IS THERE ANYTHING WE CAN DO OR NOT DO TO MAKE YOUR VISITS MORE PLEASANT? _____

HAS THERE BEEN ANY RECOMMENDED DENTAL CARE THAT YOU HAVE YET TO COMPLETE?

_____

HOW CAN WE HELP YOU? _____

APPROXIMATE DATE OF LAST DENTAL VISIT: _____

WOULD YOU LIKE FOR US TO REQUEST YOUR PREVIOUS DENTAL RECORDS? ☐ **YES** ☐ **NO**

I BRUSH MY TEETH _____ **TIME(S) PER DAY**

FLOSS _____ **X PER WEEK OR** ☐ **NEVER**

OTHER DENTAL PRODUCTS YOU USE: _____

CHECK ALL THAT APPLY TO YOU:

☐ **X-RAYS TAKEN IN LAST 3 YEARS: IF YES, CHECK ONE OR MORE BELOW**
☐ **BITEWINGS** ☐ **PANORAMIC** ☐ **FULL SERIES** ☐ **I CAN'T REMEMBER**
☐ **ORTHODONTIC TREATMENT (BRACES). AT WHAT AGE?** _____

☐ **DENTURES THAT ARE REMOVABLE. IF YES, CHECK (** ☐ **TOP** ☐ **BOTTOM** ☐ **BOTH)**

☐ **SOME TEETH ARE SENSITIVE. IF YES, CHECK (** ☐ **HOT** ☐ **COLD** ☐ **SWEETS** ☐ **PRESSURE)**

☐ **TOOTHACHE OR PAIN. IF YES, CHECK (** ☐ **TMJ/JAW JOINTS** ☐ **FACE** ☐ **NECK**
☐ **SINUSES)**

☐ **JAW JOINT CLICKS. IF YES, CHECK (** ☐ **ON CHEWING** ☐ **OPENING** ☐ **CLOSING**
☐ **IN MORNING)**

☐ **CLENCH OR GRIND TEETH. IF YES, CHECK (** ☐ **DAY** ☐ **NIGHT)**

☐ **HAVE NIGHTGUARD**

☐ **I RATE MY SMILE (ON A SCALE FROM 1-10 WITH 1 BEING POOR AND 10 BEING GREAT):** _____

☐ **I WOULD LIKE TO CHANGE THE APPEARANCE OF SOME TEETH (please describe below)**
_____

☐ **FOOD CATCHES BETWEEN SOME TEETH.**

☐ **GUMS BLEED ON BRUSHING OR FLOSSING.**

☐ **I HAVE BEEN TOLD I HAVE GUM DISEASE. (Treatment date, if any** _____ **)**

☐ **I HAVE DRY MOUTH. IF YES, CHECK (** ☐ **MODERATE** ☐ **SEVERE)**

IS THERE ANYTHING ELSE YOU WOULD LIKE FOR US TO KNOW?:
_____
_____

I certify that the above information is correct.

PATIENT (OR GUARDIAN) SIGNATURE: _____ **DATE:** _____

THANK YOU!

When you are finished with these forms, please email them to info@handcrafteddentistry.com

Handcrafted Dentistry

4208 S. Alston Ave. Durham, NC 27713

Acknowledgement of receipt of Notice of Privacy Practices and Compound Authorization

By signing below, I acknowledge that I have received a copy of this office's Privacy Practices. You may refuse to sign this acknowledgement.

Patient Name: (Last)_____(First)_____(MI) _____

Address: _____

(City)_____(State)_____(Zip)_____

☐ I have been asked whether I choose to designate other persons/entities to receive my health or dental information. I **do not** choose to designate such persons on the Compound Authorization form.

☐ I give my permission for Caitlin Singleton, DDS, PLLC to release listed information to the entities named below.

☐ **Spouse / Significant Other** (Provide Name): _____

- Financial Billing Information
- Medical / Dental Information

☐ **Parent/ Family Member or Other** (Provide relationship and Name):_____

- Financial Billing Information
- Medical/Dental Information

☐ **Employer / Workers Compensation** (Provide Name):_____

- Information about return to work and/or work restrictions and any absences that result from appointments.

☐ **School/ Preschool / Daycare** (provide name):_____

- Information about absences that result from appointments
- Activity Restrictions

Signature:_____Date: _____

Patient Unable / Unwilling to sign
Witness: _____

Revocation /Amendment

Name / Signature:_____Date: _____

Reason for change: _____

Financial and Cancellation Policy

At Handcrafted Dentistry, your oral health is our priority, and we've done everything we can to ensure you will receive the treatment you need at a price that fits your budget and your lifestyle. We believe that dental insurance shouldn't dictate who your dentist is; we believe that decision should be up to you. Handcrafted Dentistry accepts most major insurance plans as an out-of-network provider. Payment is due at time of service and as a courtesy, our insurance coordinator will file your claims and take care of all of the paperwork for you. If you want to talk details or have questions about your insurance plan, please call the office at (919) 544-5620 and we will be happy to provide you with more information about your specific plan.

We accept cash, check, & major credit cards. Additionally, we offer Care Credit to help patients who need extensive or extended payment options for care.

If you must cancel or rebook your appointment, we respectfully request at least 24 hours' notice. Cancellations or missed appointments without 24 hours' notice will result in a $50 cancellation fee.

Please initial indicating you have read and understand these statements:_____