6135 Hwy 16 South – PO Box 1005 – Denver, NC 28037
(704) 483-4159 Phone – (704) 483-6669 Fax
Email: office@collinsfamilydentistrync.com
Website: collinsfamilydentistrync.com

Welcome to our practice.

We think that you'll find us a little different in small but important ways. We strive to make everyone feel comfortable and welcomed in our office. It is our goal to provide you with the best oral health care possible. We strive to do this by offering the most current technology available while providing a friendly, caring atmosphere. Perhaps you are new to our area or maybe a past experience has left you with apprehension when it comes to dental care. Dental technology has come a long way from what you might remember. Welcome to comfortable dentistry.

First we'll involve you during the course of your treatment. Dental health is a team effort with one collective goal—nurturing your teeth, mouth and gums to simply be the best they can be. We are beginning to take a stronger approach to treating your overall health, as the mouth is not separate from the body. In doing so, we are screening all patients for potential sleep apnea risk. Sleep breathing disorders are detrimental to oral health as well as overall health. It is important that we can guide you to a possible diagnosis and conservative therapy.

X-rays are critical to the practice of dentistry. In our practice we do believe the judicious use of x-rays is in our patients' best interest. X-rays are not just business-as-usual. We use them to properly and accurately diagnose any unseen problems that may exist but cannot be detected with a visual exam alone.

Let us know when you are having radiation treatments for medical issues or have current x-rays at a previous office that we can request.

If you have any questions about your treatment or any other concerns, we always take the time to discuss these concerns with you.

Please visit our website to meet our staff before your first appointment.

Welcome!

**Patient Information** **Today's Date:** ________________

First Name: ______________________ Last Name: ______________ Middle Initial ____ Preferred name: ____________

Address: (Mailing) __________________________ City ____________________ State ________ Zip ____________

Sex: __M or __F Age: ______ Marital Status: (circle) Married Single Divorced Separated Widowed

Date of Birth: ______________________________ SS# __________________________________

Phone: (Home) ________________ (Work) ________________________ (Cell) __________________________

Preferred Contact Number is: ___Home ___Cell ___Work **Do you wish to receive text messages to confirm appointments? ___yes ____no**

Employer: ______________________ Address: __________________________________ Phone: ______________

**Do you wish to receive email appointment reminders? ___yes ____no Email address:** ____________________________

**Emergency Contact or Nearest Relative: Name:** ______________________ **Phone:** ____________________________

**Do you have current xrays at your previous dentist we can request? ___yes ___no. If yes ask for record release form.**

**If patient is a minor (under 18):** Who is accompanying child today? __________________________ Relation to Patient: ____________

**Mother/Stepmother Information (To be completed if patient is under 18)**

First Name: ________________________ Last Name: __________________________ Middle Initial: ________

Address: __________________________________ City/State: ____________________ Zip: ____________

Phone: (Home) ____________________ (Cell) ____________________ (Work) ____________________

Date of Birth: ____________________ SS# ___________________________

Employer: ______________________________ Address of Employer: ______________________________

**Father/Stepfather Information (To be completed if patient is under 18)**

First Name: ________________________ Last Name: __________________________ Middle Initial: ________

Address: __________________________________ City/State: ____________________ Zip: ____________

Phone: (Home) ____________________ (Cell) ____________________ (Work) ____________________

Date of Birth: ____________________ SS# ___________________________

Employer: ______________________________ Address of Employer: ______________________________

**Primary Dental Insurance**

Name of Insured/Policy Holder: First __________________________ Last __________________________ MI ________
(This is Employee of company or Individual Policy Owner)

Date of Birth: ________________ SS# __________________ Relation to Patient (Circle one): Self Spouse Child Other

Name of Employer: ______________________________ Employer Address: ______________________________

Insurance Company: ____________________ Address: __________________ City/State/Zip ____________________

Insurance Phone#: __________________ Group/Policy#: __________________ Member ID#: ____________________

**Secondary Dental Insurance (If applicable)**

Name of Insured/Policy Holder: First __________________________ Last __________________________ MI ________
(This is Employee of company or Individual Policy Owner)

Date of Birth: ________________ SS# __________________ Relation to Patient (Circle one): Self Spouse Child Other

Name of Employer: ______________________________ Employer Address: ______________________________

Insurance Company: ____________________ Address: __________________ City/State/Zip ____________________

Insurance Phone#: __________________ Group/Policy#: __________________ Member ID#: ____________________

**Medicaid**

Name as printed on card: ________________________________ Recipient ID# ____________________

Date of Birth of Recipient: Recipient SS#

# Eaglesoft Medical History

Patient Name: Birth Date: Date Created:

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.

| Question | Answer | |
|---|---|---|
| Are you under a physician's care now? | ◯ Yes ◯ No | If yes |
| Have you ever been hospitalized or had a major operation? | ◯ Yes ◯ No | If yes |
| Have you ever had a serious head or neck injury? | ◯ Yes ◯ No | If yes |
| Are you taking any medications, pills, or drugs? | ◯ Yes ◯ No | If yes |
| Do you take, or have you taken, Phen-Fen or Redux? | ◯ Yes ◯ No | If yes |
| Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? | ◯ Yes ◯ No | If yes |
| Are you on a special diet? | ◯ Yes ◯ No | |
| Do you use tobacco? | ◯ Yes ◯ No | |
| Do you use controlled substances? | ◯ Yes ◯ No | If yes |

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 ☐ Sulfa Drugs ☐ Local Anesthetics

Other? ☐ If yes

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

| Condition | Answer | Condition | Answer | Condition | Answer | Condition | Answer |
|---|---|---|---|---|---|---|---|
| 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 Problems | ◯ 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 If yes

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:

X_______________________________________ Date:__________

**Written Financial Policy and Privacy Policy**

Thank you for choosing Ashley M. Collins, DDS, PA. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

**INSURANCE:**

Insurance is an **agreement between you and your insurance company**. You are responsible for knowing your policy information, terms, and benefits including exclusions and waiting periods. You are responsible for any co-insurance, deductibles, or non-covered services not paid by your insurance. Any information regarding benefits that we receive from your insurance company is NOT a guarantee of payment. Payment of claims is determined once the claim is received at your insurance office. As a courtesy to you, we will gladly file your dental insurance.

We work with most insurance plans, however, we are not in network with all plans. At the time of your visit, we may ask you to pay an ESTIMATED portion that insurance may not cover. Keep in mind that we will do our best to estimate this portion, however, if there is a balance due after insurance pays, you are responsible to pay our practice that balance. You will receive a statement from our office indicating what your insurance has paid. Any balance remaining is due upon receipt.

You will always be responsible for all charges incurred. If we do not receive payment from your insurance carrier within 90 days, the claim will be closed and you will be responsible for payment of any unpaid treatment fees. You will then be responsible for collecting payment from your insurance company.

By signing below you authorize Ashley M. Collins, DDS, PA to file your dental insurance and release payment to this office.

**PAYMENT OPTIONS:**

We accept the following forms of payment: Cash, Check, Visa, MasterCard, American Express, Discover, & NO INTEREST[1] Payment Plans[2] from CareCredit

Please note: Ashley M. Collins, DDS, PA requires payment prior to the beginning of your treatment. If you choose to discontinue care before treatment is complete, you will receive a refund less the cost of care received.

For plans requiring multiple appointments, alternative payment arrangements may be provided.

**Ashley M. Collins, DDS, PA charges $20 for returned checks.**

**PRIVACY POLICY**

It is our goal to keep your information private and will do so as required by law. You are entitled to a copy of our Privacy Policy. If you would like a copy of our Privacy Policy please ask someone in the front office.

**Please list any persons that you wish to have access to your medical records & account information, including treatment & billing questions:**

Name:____________________ Relationship:__________ Name:____________________ Relationship:__________

Records Release: There are times that we may need to send your records to a specialist or to a Dentist/Doctor of your choice or an insurance company. By signing below you give permission for such release.

By signing below, you attest that you have been made aware of the financial policies and privacy policies of Ashley M. Collins, DDS, PA and also give permission to release your records when necessary.

________________________________________

**Signature - Patient, Parent or Guardian** **Date**

________________________________________

**Patient Name (Please Print)**

**[1]If paid within the promotional period. Otherwise, interest assessed from purchase date. Minimum monthly payment required.**
**[2]Subject to credit approval**

Revised: 11/18/19