Kari H. Langley, DMD

FAMILY DENTISTRY

PATIENT INFORMATION FORM

PLEASE FILL OUT COMPLETELY

Name: First _____MI ____Last: _____Preferred name:_____
Date of Birth: ____/____/_____ Gender: M / F Marital Status: M / D / S / Sep SSN:_____-_____-_____

Home address: Street: _____

City: _____State:_____ Zip Code: _____

Telephone: Home: _____-_____-_____ Work: _____-_____-_____ Cell: _____-_____-_____

Email: _____ **Preferred contact:** home □ work □ cell □ email □

Employer: _____ Phone_____

Employment address:_____

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

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

Spouse Name: _____ Children's names: _____

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 INSURANCE CARD AND DRIVERS LICENSE

Dental Insurance Company:
Address:
Policy #: Group#
Name of Insured (Policy Holder):
Patient's Relation to Insured: Self □ Spouse □ Child □
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.

As a courtesy, we will gladly file your insurance with your insurance company.
However, all charges are the responsibility of the patient or guardian.

I certify that the information on this form is correct. I am responsible for any balance on this account, even if I have dental coverage. I authorize Kari H. Langley D.M.D., P.A. may release my information to my insurance company

Patient's or Guardian Signature _____ Date: _____

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

Kari H. Langley, DMD
FAMILY DENTISTRY

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 any missed, cancelled or broken appointment.

Payment Options

For your convenience, we accept cash, credit cards, and Care Credit (ask us about this wonderful 3rd party financing plan!). 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. **Cash Reward**: For any treatment that exceeds $1,000 we extend a Courtesy Saving of 5% when all fees are paid by cash at the beginning of treatment.

Dental Insurance

We are pleased to assist you in obtaining the maximum benefit from your dental insurance plan. We estimate benefits and we accept assignment of payment from your insurance company. Dental insurances aid patients with the cost. Payment of your portion in full 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, **patients are responsible for the entire account balance not paid by your insurance company.**

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

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

Kari H. Langley, DMD

FAMILY DENTISTRY

TIME 8:11 AM | Kari H. Langley, DMD, PA | DATE 6/26/2013

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? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

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?

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

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.

Kari H. Langley, DMD
FAMILY DENTISTRY

Friends & Family Form(Release)

Name of Patient _____ Date of Birth _____

_____ is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Entity to Receive Information. Check each person/entity that you approve to receive information.	**Description of information to be released.** Check each that can be given to person/entity on the left in the same section.
❑ Voice Mail ❑ Email	❑ **Appointment Reminders** ❑ **X-Rays, Appointment Reminders, Treatment Plans, Insurance Benefits**
❑ Spouse (provide name & phone number) _____	❑ **Financial** ❑ **Treatment Plans** ❑ **Appointment Reminders**
❑ Parent (provide name & phone number) _____	❑ **Financial** ❑ **Treatment Plans**
❑ Other (Ex: Grand-Parent, Step- Parent, Nanny) _____	❑ **Financial** ❑ **Treatment Plans**

Patient Information

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. 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 shall be in effect until revoked by the patient.

Date _____

Signature of Patient or Personal Representative_____

Revised January 2010