

**Tyler B. Rae, D.M.D**

Name: \_\_\_\_\_ Birthday: \_\_\_\_\_

SSN: \_\_\_\_\_ Phone: (H) \_\_\_\_\_ (C) \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Email Address: \_\_\_\_\_

Employer: \_\_\_\_\_

**Responsible Party ( only if under age 18)**

Name: \_\_\_\_\_ Birthday: \_\_\_\_\_

SSN: \_\_\_\_\_ Phone: (H) \_\_\_\_\_ (C) \_\_\_\_\_

Mailing Address: \_\_\_\_\_

**Do you have Dental Insurance? \_\_\_\_\_ (if yes, please show your insurance card to the front desk)**

**We will gladly assist you with your dental insurance plan. Most plans cover only a portion of the fee, therefore as a courtesy we will file your insurance for you but ask that you pay any copays or non-covered services at your scheduled appointment. If your insurance has not paid within 60 days, you will be billed for the unpaid balance and payment in full will be expected. We accept all major credit cards, cash, personal checks, money order or Care Credit.**

**We want to provide the best possible care for all patients and reserve a specific time just for you and make every effort to see you as scheduled. We appreciate your promptness and consideration in not changing your appointment. However, if you need to change your appointment, we require a 24 hour notice. We do require you to confirm your appointment in advance via email, text or phone call. If you do not cancel within 24 hours a fee of \$35 will be charged to you.**

**I understand that my insurance is an agreement between the insurance company and me, therefore I am ultimately responsible for all fees incurred for dental treatment regardless of payment or denial from my insurance. I also authorize insurance payment directly to Carolina Dental Alliance. I authorize the release of necessary information to my insurance company to determine liability for payment and to obtain reimbursement for any claims. If this account is assigned to an attorney or collection agency, I agree to be responsible for any and all collection fees of 25% as well as any court cost incurred.**

Signature \_\_\_\_\_

Date \_\_\_\_\_

**Consent:**

I authorize Rae Family Dentistry to take x-rays, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of my dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be dictated. I also understand the use of anesthetic agents embodies a certain risk. I have read, understand and agree to all terms and conditions above.

**Authorization To Release Information:**

By law, without your authorization, we are unable to communicate with your spouse, adult children, caregivers or parents if you are over 18.

We will need your permission to communicate with your family or caregivers in the following circumstances:

1. Making Appointments
2. Confirming Appointments
3. Discussing Treatment needed or performed
4. Account or Financial information

Please indicate the following persons and relationship of whom we may release information to:

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

We will communicate with you via text, email or phone. Please let us know if you wish not to have any of these available.

A copy of Notice of Privacy Practices is available upon request.

Printed Name: \_\_\_\_\_

Date: \_\_\_\_\_

Patient/Legal Guardian Signature: \_\_\_\_\_

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.

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?

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: \_\_\_\_\_