Jason A. Banks, DDS, PA ● 103 Tanglewood Parkway - Suite K ● Elizabeth City, NC 27909
Phone (252) 331-2304 ● Fax (252) 331-2758

Welcome *– Thank you for selecting our dental office. To help us meet all of your health care needs, please complete this form as accurately as possible. Thank you!*

1) Patient Information

This appointment is for ☐ Yourself ☐ Your Child

Patient Name: _____ Preferred Name:_____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other_____

Date of Birth: _____ Social Security #: _____

Address: _____ City: _____ State: ____ Zip: _____

Home Phone: _____ Work Phone: _____
Cell Phone: _____ Email: _____

In the event of an emergency, who should we contact:
Name: _____ Relationship: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____

Previous Dentist: _____ Previous Dentist Phone: _____
Current Physician: _____ Current Physician Phone: _____

2) Dental Insurance Information

Primary Dental Coverage ☐ Yes ☐ No

Subscriber Name: _____ Relation: _____
Subscriber Social Security #: _____ Subscriber Date of Birth: _____
Subscriber Employer: _____
Insurance Carrier: _____
Insurance Carrier Address: _____
Insurance Carrier Phone: _____ Group #: _____

3) Dental History

Why have you come to the dentist today? _____
Do you require antibiotics before dental treatment?..... Yes____ No____
Are you currently in pain?..... Yes____ No____
Do your gums ever bleed?..... .Yes____ No____
Have you ever had difficulties associated with any previous dental work?..... .Yes____ No____
Do you or have you ever experienced pain in your jaw joint (TMJ / TMD)?..... Yes____ No____
Have your tonsils of adenoids been removed?..... Yes____ No____
Are your teeth sensitive to heat, cold, or anything else?..... Yes____ No____
Do you floss on a regular basis?.....Yes____ No____
Do you use tobacco?.....Yes____ No____
Do you use controlled substances?.....Yes____ No____
Are you wearing contact lenses?.....Yes____ No____
Do you currently have a denture or partial plate?..... Yes____ No____

4) Medical History

Allergies (Please check all that apply)

☐ Aspirin	☐ Latex
☐ Codeine	☐ Metals
☐ Dental Anesthetics	☐ Other
☐ Erythro	☐ Penicillin
☐ Hay Fever	☐ Sulfur

If Female, Please Answer

Are you taking birth control pills? _____
Are you pregnant? _____
If so, # of weeks? _____
Are you nursing? _____

Medical Conditions (Please check all that apply)

☐ Allergies	☐ Glaucoma	☐ Pacemaker
☐ Anemia	☐ Head Injuries	☐ Pregnancy
☐ Arthritis	☐ Heart Attack	☐ Radiation Treatment
☐ Artificial Joints:_____	☐ Heart Disease	☐ Respiratory Problems
☐ Asthma	☐ Heart Murmur	☐ Rheumatic Fever
☐ Blood Disease	☐ Hepatitis	☐ Rheumatism
☐ Cancer	☐ High Blood Pressure	☐ Sinus Problems
☐ Cholesterol	☐ HIV	☐ Stomach Problems
☐ COPD	☐ Jaundice	☐ Stroke – date(s): _____
☐ Diabetes	☐ Kidney Disease	☐ Tuberculosis
☐ Dizziness	☐ Liver Disease	☐ Tumors
☐ Epilepsy	☐ Mental Disorders	☐ Ulcers
☐ Excessive Bleeding	☐ Nervous Disorders	☐ Venereal Disease
☐ Fainting	☐ Other_____	

Please list your current medications: _____

_____

_____

IMPORTANT QUESTIONS

■ Have you ever taken Zometa or Aredia for any of the following: Multiple Myeloma, Lung or Breast Cancer, or Paget's Disease of the bone? These are IV drugs given to stop the spread of aggressive cancers to bone.

☐ Yes ☐ No If Yes, please list date(s) taken:_____

■ Have you ever taken Fosamax, Actonel, Boniva or Arsever for osteoporosis? ☐ Yes ☐ No

If Yes, please list date(s) taken: _____

5) Acknowledgment and Authorization

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____ Date:_____ Relationship to Patient: _____

Signature of Patient, Parent, or Guardian

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ACKNOWLEDGMENT OR RECEIPT OF NOTICE OF PRIVACY PRACTICE

* You May Refuse to Sign this Acknowledgment *

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

□ Individual refused to sign
□ Communication barriers prohibited obtaining the acknowledgment
□ An emergency situation prevented us from obtaining acknowledgment
□ Other (Please Specify)