Dental History

Do you have regular dental care? ☐ Yes ☐ No ☐ Don't Know

When was your last dental visit? _____

For what purpose? _____

When was your last cleaning appt? _____

When were your last dental x-rays taken? _____

Are you happy with the appearance with your teeth? ☐ Yes ☐ No ☐ Don't Know

Do you chew on both sides of your mouth? ☐ Yes ☐ No ☐ Don't Know

Are your teeth unusually sensitive to: ☐ Hot ☐ Cold ☐ Sweets ☐ Biting

Are you difficult to get numb? ☐ Yes ☐ No ☐ Don't Know

Do your gums bleed when you brush? ☐ Yes ☐ No ☐ Don't Know

Have you ever had unusual swelling in your mouth? ☐ Yes ☐ No ☐ Don't Know

Do you have unusual or frequent pain in your: ☐ Teeth ☐ Jaw ☐ Jaw Joints ☐ Ears

Have you ever worn braces? ☐ Yes ☐ No

Have you ever been told you have a gum disease? ☐ Yes ☐ No ☐ Don't Know

Patient/Parent/Guardian Signature _____ Date _____

Medical History Updates

Date: _____ Changes: _____

_____

_____

Signatures: _____

Date: _____ Changes: _____

_____

_____

Signatures: _____

Date: _____ Changes: _____

_____

_____

Signatures: _____

Date: _____ Changes: _____

_____

_____

Signatures: _____

Connor K. Schmidt D.M.D. Suzanne S. Holmes D.D.S. Kate G. Putney D.D.S

Holmes & Putney DDS, PA
2801-B Wooten Boulevard, Building B
Wilson, N.C. 27893

Welcome to our practice! We are thankful that you have chosen us as your dental health provider. We strive to provide quality dental care in a safe and pleasant environment. You, the patient, are our number one concern. If you ever have a question or comment, please feel free to speak with anyone on our staff. We only grow and improve through constructive comments! Below you will find our payment policy. Please read this closely and sign at the bottom of the page. We look forward to working with you

Drs. Holmes, Putney, Schmidt and Staff

- It is your responsibility to give us all needed insurance information – otherwise payment is due when services are rendered.
- We file insurance as a courtesy to our patients. If your insurance does NOT cover procedures as we **ESTIMATE** you are responsible for the balance.
- Your estimated portion is due at the time of service.
- Our **ESTIMATES** do not guarantee what your insurance will pay. The most accurate way to determine what your insurance will pay is with a prior approval of your proposed treatment from your insurance company. At your request, our office will be glad to assist you with this.
- We suggest that you make every effort to stay informed of your annual remaining insurance benefits. We can only be certain of the benefits paid to our office. You are responsible for the accounting of any benefits used at other dental offices or specialists such as the periodontist, oral surgeon, endodontist, etc.
- For any balance left over 60 days, finance charges will accrue at a rate of 1.5% per month or $3.00 per month, whichever is greater.
- Any balance not paid in full in 90 days may be sent to collections.
- We reserve the right to charge $25 for any check returned to us for nonpayment.
- We reserve the right to charge $50 for any appointment missed, without 24 hours notice given.

I have read the payment policy, and I understand and agree to these specifications.

Patient/Parent/Guardian Signature_____

Date_____

SECONDARY INSURANCE POLICY HOLDERS:
We will file your secondary insurance as a courtesy after your primary insurance has paid. You are still expected to pay your estimated responsibility of your primary insurance at the time of service. We will send you a refund after your secondary insurance pays.

Holmes and Putney DDS, PA

Acknowledgement of Receipt
Of Notice of Privacy Practices

Patient Name & Address: _____

_____

_____

I have received a copy of the Notice of Privacy Practices for the above named practice.

_____ _____

Signature Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- ☐ An emergency existed & a signature was not possible at the time.
- ☐ The individual refused to sign.
- ☐ A copy was mailed with a request for a signature by return mail.
- ☐ Unable to communicate with the patient for the following reason:

  _____

- ☐ Other: _____

  _____

Prepared By _____

Signature _____

Date _____