Charles T. Bobo D.M.D., PLLC
223 West Third Street
Oakboro, NC 28129
Telephone: 704-485-2400
Fax: 704-485-3307

Patient Information

Name: _____ Preferred Name: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Mobile #: _____ Work #: _____ Home #: _____

Email: _____

Occupation: _____

Sex: M / F Birth Date: ____ /____ /_____ SS#: _____

Family Status (circle): Single Married Divorced Child Spouse's Name: _____

How did you first hear about our office? (circle one):

Another Patient	Another Dental Office	Phone Book	Online Search
Facebook	Walk In	Sign – Drive by	Insurance Website
Other: _____			

Whom may we thank for referring you to our practice?_____

Contact Information

What is the best way to communicate with you? Home Phone / Mobile Phone / Text / Email

In the event of an emergency, whom should we contact? Name: _____

Relationship: _____ Mobile #: _____ Work #: _____ Home #: _____

Insurance Information

Name of Insured: _____ Relationship to patient: _____

Insured Birth Date: ____ /____ /_____

Insurance Plan Name: _____

Group #: _____ ID #: _____

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PATIENT NAME _____ BIRTH DATE _____

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	
Do you need to pre-medicate?	Yes	No	If yes, please explain: _____

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.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

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Authorization for Release of Information – Compound Release

Name of Patient _____ **Date of Birth** _____

Oakboro Family Dentistry is authorized to release protected health information about the above named patient in the following manner and to persons listed.

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	☐ Appointment Reminders
☐ Spouse (provide name and phone number) _____	☐ Financial ☐ Medical
☐ Parent (provide name and phone number) _____	☐ Financial ☐ Medical
☐ Email communication-Provide email address* _____ *In order for email communication to occur, please accept the disclosure below:	☐ Financial ☐ X Rays ☐ Treatment Plans ☐ Appointment reminders ☐ Breach notification
☐ For **email communication** I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to move forward to allow email communications to occur.	

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- 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 have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

The information is released at the patient's request and this authorization will remain in effect until revoked by the patient.

_____Date _____

Signature of Patient or Personal Representative

*Description of Personal Representative's Authority (attach necessary documentation)

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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 _____

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Communication Agreement

A wide variety of means for communication exists and continues to broaden and develop. By signing this Authorization, I agree that this office, and any third party used for treatment, billing, collection and other services, may use any means of communication with me. Thus, I understand and agree that any phone numbers and email addresses provided by myself to this office and to any of our service providers, now and in the future, may be used as a means to contact me, and that this office and our service providers may leave messages for me manually and by using automated systems such as by artificial or prerecorded voice. Specifically, if I provide a cellular phone number or place a cellular phone call to physician or any of our service providers, I consent and agree to accept collection calls and other communications to my cellular phone from this office and from any of our service providers. For any landline and cellular phone calls this office or any service providers place to me, I consent and agree that those calls may be automatically dialed and that this office and our service providers may use recorded messages. I also agree that this office and any service providers may contact me by sending text messages and emails to any phone number or email address I provide to this office or service providers, and I consent to receive such text messages and emails which may identify the name of this office or service provider sending the communication, and which may disclose the nature of the communication.

Patient Name:_____

Signature of Patient/Guarantor

_____Date_____

We will be providing reminders to our patients regarding upcoming appointments via Email and Text messaging. Please provide the following:

Email:_____

Cell Phone number:_____

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Written Financial Policy

Thank you for entrusting Dr. Charles Bobo and Oakboro Family Dentistry for your dental care. 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.

Payment Options:

You can choose from:

-Cash, Check, Visa, or Mastercard

-NO INTEREST* Payment Plans from CareCredit

- Allow you to pay overtime with NO INTEREST*
- Convenient, low monthly payment plans* also available
- No annual fees or pre-payment penalties

For patients with dental insurance we are happy to work with your carrier to maximize your benefits. However; if we do not receive payment from your insurance carrier within 6 months, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier. Your dental insurance is filed as a courtesy and your dental contract is between you, your employer, and your dental insurance.

For most dental treatment we can provide an estimate of what your benefits may cover. This is just an estimate and any remaining balance not paid by your insurance will be the patient's responsibility.

Some dental treatment (Crowns, bridges, implants, veneers, orthodontics, dentures, partials, etc.) require partial payments (a minimum of ½ of the total treatment fee) prior to the beginning of treatment to cover laboratory fees incurred at the initial preparation. Payment in full is required when treatment is completed. Since the length of treatment varies, payment arrangements are discussed for services such as dentures, partials, or any extensive restorations when treatment is scheduled.

Patients who miss 2 or more appointments in a calendar year without a proper 48 hour notice may be subject to a "No Show" fee or dismissal from the practice.

If you have any questions, please do not hesitate to ask. We are here to provide the dentistry you deserve.

Patient, Parent or Guardian Signature:_____

Patient Name (Please Print):_____

Date: _____

*If paid within the promotional period. Otherwise, interest assessed from purchase date. Minimum monthly payments required.

*Subject to credit approval.