

New Patient Information – General Information

Date of birth: SS#: Email: SS#: Email: Sames / Ages of siblings: Sames	First Middle Street Address: City, State, Zip: General Dentist: Doctor Name Who referred you to our office?: Date of birth: SS#: Embloyer (or School if student): Signature of Patient (Parent if minor): Note: a credit report may be run to determine possible financing options Medical History List any medications presently being taken: Are you currently under the care of a physician? yes no If yes, please explain: List any known allergies: Have you ever had a blood transfusion? yes no If so, most recent?: Have you ever had any of the following? (Please circle if yes) Have you ever had any the following? (Please circle if yes) Have you ever had any the following? (Ple		
First Middle Last treet Address: City, State, Zip: Seneral Dentist: Doctor Name Street Address & City Who referred you to our office?: Date of birth: SS#: Email: Samily members being seen by office?: Some #: Work #: Cell #: Simployer (or School if student): Singulature of Patient (Parent if minor): Wote: a credit report may be run to determine possible financing options Medical History Sist any medications presently being taken: Are you currently under the care of a physician? yes no If yes, please explain: Sist any known allergies: Have you ever had a blood transfusion? yes no If so, most recent?: Have you ever had any of the following? (Please circle if yes) High blood pressure Anemia Kidney Trouble Glaucoma Doublood pressure Anemia Strobe Blood disease Glaucoma Doublood pressure Anemia Liver Trouble Mailignancy Stroke Blood disease Glaucoma Doublood pressure Stroke Blood disease Glaucoma Doublood pressure Anemia Liver Trouble Mailignancy Hepatitis Lung Disease Thy roid Disease Flyroid Disease Thyroid Disease Flyroid Disease F	First Middle Street Address:		
Street Address & City Who referred you to our office?: Doctor Name	Doctor Name Who referred you to our office?: Date of birth: SS#: Date of birth: Date of Patient of Patient of SS#: Date of Dirth: Date of SS#: Date of S	Last	
Doctor Name Street Address & City	Doctor Name Who referred you to our office?: Date of birth: SS#: End of birth: SS#: Family members being seen by office?: Family members being seen by office? Family members being seen by off		
Doctor Name Street Address & City Who referred you to our office?: Date of birth: SS#: Email: Date of birth: Date of birth: SS#: Email: Date of birth: SS#: Email: Date of birth: SS#: Email: Date of birth: Date o	Doctor Name Who referred you to our office?:		
Doctor Name Street Address & City Who referred you to our office?: Date of birth: SS#: Email: Date of birth: Date of birth: SS#: Email: Date of birth: SS#: Email: Date of birth: Date o	Doctor Name Who referred you to our office?:		
Names / Ages of siblings:	Date of birth: SS#: En Names / Ages of siblings:		
Names / Ages of siblings:	Names / Ages of siblings:		
And we would be a seen by office?: Work #:	Family members being seen by office?:	nail:	
Home #:	Home #:	·	
Home #:	Home #:		
Medical History Medical Hi	Note: a credit report may be run to determine possible financing options Medical History		
Medical History Medical Hi	Note: a credit report may be run to determine possible financing options Medical History		
Medical History List any medications presently being taken: Are you currently under the care of a physician? yes no If yes, please explain: List any known allergies: Have you ever had a blood transfusion? yes no If so, most recent?: Have you ever had a blood transfusion? yes no If so, in what month?: Have you ever had any of the following? (Please circle if yes) High blood pressure Anemia Kidney Trouble Epilepsy Low blood pressure Stroke Blood disease Glaucoma Clotting problems Ulcers Sinus Trouble Malignancy Heart disease Arthritis Lung Disease Thyroid Diseadiation therapy Hepatitis Bowel Disease Thyroid Diseadiation therapy Hepatitis Bowel Disease Thyroid Diseadiation therapy Hepatitis Bowel Disease Tityl Venereal disease Diabetes Psychiatric Treatment Other: Wittral Valve Prolapse HIV Rheumatism	Medical History List any medications presently being taken: Are you currently under the care of a physician? yes no If yes, please explain: List any known allergies: Have you ever had a blood transfusion? yes no If so, most recent?: WOMEN: Are you pregnant? yes no If so, in what month?: Have you ever had any of the following? (Please circle if yes) High blood pressure Anemia Kidney Transfusion Stroke Blood dise Low blood pressure Stroke Blood dise Clotting problems Ulcers Sinus Trous Rheumatic fever Asthma Liver Trous Heart disease Arthritis Lung Dise Radiation therapy Hepatitis Bowel Dise Venereal disease Diabetes Psychiatri Mitral Valve Prolapse HIV Rheumatic Rheumatic Rheumatic Rheumatic Mitral Valve Prolapse HIV Rheumatic Mitral Valve Prolapse Rheumatic Mitral Valve Prolapse Rheumatic Mitral Valve Prolapse HIV Rheumatic Mitral Valve Prolapse Rheumatic Mitral Valve Prolapse HIV Rheumatic Mitral Valve Prolapse H		
Medical History Are you currently under the care of a physician? yes no If yes, please explain: List any known allergies: Have you ever had a blood transfusion? yes no If so, most recent?: WOMEN: Are you pregnant? yes no If so, in what month?: Have you ever had any of the following? (Please circle if yes) High blood pressure Anemia Kidney Trouble Epilepsy Low blood pressure Stroke Blood disease Glaucoma Clotting problems Ulcers Sinus Trouble Malignancy Rheumatic fever Asthma Liver Trouble Tuberculosis Heart disease Arthritis Lung Disease Thyroid Diseard Clotting problems Hepatitis Bowel Disease TMJ Venereal disease Diabetes Psychiatric Treatment Other: Witral Valve Prolapse HIV Rheumatism	Medical History List any medications presently being taken: Are you currently under the care of a physician? yes no If yes, please explain: List any known allergies: Have you ever had a blood transfusion? yes no If so, most recent?: WOMEN: Are you pregnant? yes no If so, in what month?: Have you ever had any of the following? (Please circle if yes) High blood pressure Anemia Kidney Trace Blood disection of the problems Ulcers Sinus Troce Clotting problems Ulcers Sinus Troce Rheumatic fever Asthma Liver Troce Heart disease Arthritis Lung Disection therapy Hepatitis Bowel Disection of the problems Proposition of the problems Rediation therapy Hepatitis Bowel Disection of the problems Proposition of the problems Rheumatic fever Rediation therapy Hepatitis Bowel Disection of the problems Proposition of the problems Rheumatic fever Repaired to the problems Rediation therapy Hepatitis Rowel Disection of the problems Rheumatic fever Rheumatic fever Repaired to the problems Rheumatic fever Repaired to the problems Rheumatic fever Rheumatic fever Repaired to the problems Rheumatic fever Rheumatic fever Repaired to the problems Rheumatic fever Rheumat		
Are you currently under the care of a physician? yes no If yes, please explain:	Are you currently under the care of a physician? yes no If yes, please explain: Are you currently under the care of a physician? yes no If yes, please explain:		
Are you currently under the care of a physician? yes no If yes, please explain:	Are you currently under the care of a physician? yes no If yes, please explain: List any known allergies: Have you ever had a blood transfusion? yes no If so, most recent?: WOMEN: Are you pregnant? yes no If so, in what month?: Have you ever had any of the following? (Please circle if yes) High blood pressure Anemia Kidney Trough Stroke Blood dise Clotting problems Ulcers Sinus Trough Stroke Sinus Trough Stroke Liver Trough Heart disease Arthritis Lung Dise Radiation therapy Hepatitis Bowel Dise Radiation therapy Hepatitis Bowel Dise Radiation therapy Hepatitis Bowel Dise Received For the care of the care		
Are you currently under the care of a physician? yes no If yes, please explain:	Are you currently under the care of a physician? yes no If yes, please explain: List any known allergies: Have you ever had a blood transfusion? yes no If so, most recent?: WOMEN: Are you pregnant? yes no If so, in what month?: Have you ever had any of the following? (Please circle if yes) High blood pressure Anemia Kidney Trough Stroke Blood dise Clotting problems Ulcers Sinus Trough Stroke Sinus Trough Stroke Liver Trou		
List any known allergies: Have you ever had a blood transfusion? yes no If so, most recent?: WOMEN: Are you pregnant? yes no If so, in what month?: Have you ever had any of the following? (Please circle if yes) High blood pressure Anemia Kidney Trouble Epilepsy Low blood pressure Stroke Blood disease Glaucoma Clotting problems Ulcers Sinus Trouble Malignancy Rheumatic fever Asthma Liver Trouble Tuberculosis Heart disease Arthritis Lung Disease Thyroid Disease Radiation therapy Hepatitis Bowel Disease TMJ Venereal disease Diabetes Psychiatric Treatment Other:	List any known allergies: Have you ever had a blood transfusion? yes no If so, most recent?: WOMEN: Are you pregnant? yes no If so, in what month?: Have you ever had any of the following? (Please circle if yes) High blood pressure		
Have you ever had a blood transfusion? yes	Have you ever had a blood transfusion? yes no If so, most recent?:		
Have you ever had a blood transfusion? yes	Have you ever had a blood transfusion? yes no If so, most recent?:		
MOMEN: Are you pregnant? yes no If so, in what month?: Have you ever had any of the following? (Please circle if yes) High blood pressure	MOMEN: Are you pregnant? yes no If so, in what month?: Have you ever had any of the following? (Please circle if yes) High blood pressure		
MOMEN: Are you pregnant? yes no If so, in what month?: Have you ever had any of the following? (Please circle if yes) High blood pressure	MOMEN: Are you pregnant? yes no If so, in what month?: Have you ever had any of the following? (Please circle if yes) High blood pressure		
Have you ever had any of the following? (Please circle if yes) High blood pressure Anemia Kidney Trouble Epilepsy Low blood pressure Stroke Blood disease Glaucoma Clotting problems Ulcers Sinus Trouble Malignancy Rheumatic fever Asthma Liver Trouble Tuberculosis Heart disease Arthritis Lung Disease Thyroid Disease Radiation therapy Hepatitis Bowel Disease TMJ Venereal disease Diabetes Psychiatric Treatment Other: Mitral Valve Prolapse HIV Rheumatism	Have you ever had any of the following? (Please circle if yes) High blood pressure Anemia Kidney Tro Low blood pressure Stroke Blood dise Clotting problems Ulcers Sinus Tro Rheumatic fever Asthma Liver Trou Heart disease Arthritis Lung Dise Radiation therapy Hepatitis Bowel Dis Venereal disease Diabetes Psychiatri Mitral Valve Prolapse HIV Rheumati		
High blood pressure Anemia Kidney Trouble Epilepsy Low blood pressure Stroke Blood disease Glaucoma Clotting problems Ulcers Sinus Trouble Malignancy Rheumatic fever Asthma Liver Trouble Tuberculosis Heart disease Arthritis Lung Disease Thyroid Disease Radiation therapy Hepatitis Bowel Disease TMJ Venereal disease Diabetes Psychiatric Treatment Other: Mitral Valve Prolapse HIV Rheumatism	High blood pressure Anemia Kidney Tro Low blood pressure Stroke Blood disc Clotting problems Ulcers Sinus Tro Rheumatic fever Asthma Liver Tro Heart disease Arthritis Lung Dise Radiation therapy Hepatitis Bowel Dis Venereal disease Diabetes Psychiatri Mitral Valve Prolapse HIV Rheumati		
Low blood pressure Stroke Blood disease Glaucoma Clotting problems Ulcers Sinus Trouble Malignancy Rheumatic fever Asthma Liver Trouble Tuberculosis Heart disease Arthritis Lung Disease Thyroid Disease Radiation therapy Hepatitis Bowel Disease TMJ Venereal disease Diabetes Psychiatric Treatment Other: Mitral Valve Prolapse HIV Rheumatism	Low blood pressure Stroke Blood disections problems Ulcers Sinus Trous Rheumatic fever Asthma Liver Trous Heart disease Arthritis Lung Disect Radiation therapy Hepatitis Bowel Disect Venereal disease Diabetes Psychiatri Mitral Valve Prolapse HIV Rheumatic Recommendations of the problems of the problem		
Clotting problems Ulcers Sinus Trouble Malignancy Liver Trouble Tuberculosis Heart disease Arthritis Lung Disease Thyroid Disease Radiation therapy Hepatitis Bowel Disease TMJ Venereal disease Diabetes HIV Rheumatism Mitral Valve Prolapse	Clotting problems Ulcers Sinus Trou Rheumatic fever Asthma Liver Trou Heart disease Arthritis Lung Dise Radiation therapy Hepatitis Bowel Dis Venereal disease Diabetes Psychiatri Mitral Valve Prolapse HIV Rheumati	ouble Epilepsy	
Rheumatic fever Asthma Liver Trouble Tuberculosis Heart disease Arthritis Lung Disease Thyroid Disease Radiation therapy Hepatitis Bowel Disease TMJ Venereal disease Diabetes Psychiatric Treatment Other: Mitral Valve Prolapse HIV Rheumatism	Rheumatic fever Asthma Liver Trou Heart disease Arthritis Lung Dise Radiation therapy Hepatitis Bowel Dis Venereal disease Diabetes Psychiatri Mitral Valve Prolapse HIV Rheumati	ease Glaucoma	
Heart disease Arthritis Lung Disease Thyroid Disease Ardiation therapy Hepatitis Bowel Disease TMJ Venereal disease Diabetes Psychiatric Treatment Other: Mitral Valve Prolapse HIV Rheumatism	Heart disease Arthritis Lung Dise Radiation therapy Hepatitis Bowel Dis Venereal disease Diabetes Psychiatri Mitral Valve Prolapse HIV Rheumati	ıble Malignancy	
Radiation therapy Hepatitis Bowel Disease TMJ Venereal disease Diabetes Psychiatric Treatment Other: Mitral Valve Prolapse HIV Rheumatism	Radiation therapy Hepatitis Bowel Dis Venereal disease Diabetes Psychiatri Mitral Valve Prolapse HIV Rheumati	ble Tuberculosis	
Venereal disease Diabetes Psychiatric Treatment Other: Mitral Valve Prolapse HIV Rheumatism	Venereal disease Diabetes Psychiatri Mitral Valve Prolapse HIV Rheumati	ase Thyroid Disease	j
Mitral Valve Prolapse HIV Rheumatism	Mitral Valve Prolapse HIV Rheumati	ease TMJ	
		c Treatment Other:	
Reason for today's appointment:		sm	_
	Reason for today's appointment:		
Do you have any fears or apprehensions based on past dental experiences? ☐ yes ☐ no ☐ If yes, explain:		If yes, explain:	

Have you ever seen an Orthodontist before?

□ yes

 \square no

Please complete the following if patient is a minor

♦ Guardian 1 - Name:			☐ Mother ☐ Father ☐ Other:
Street Address:			
Home #:	Work #:		Cell #:
Employer:			
SS #:		Date of birth:	
Email address:			
♦Guardian 2 - Name:			☐ Mother ☐ Father ☐ Other:
Street Address:			
Home #:	Work #:		Cell #:
Employer:			
SS #:		Date of birth:	
Email address:			
Insurance Company Name and Address: Employee/ Subscriber Name and Address:			
Employee/ Subscriber SS#:		Employee/Subscribe	er Birthdate:
Group Number:			
Employer/ Company Name and Address:			
Patient Relationship to Employee (circle): Self	Spou	se Child	Other:
Is patient covered by another plan of benefits?	□ yes □ no	If yes, name and add	dress of carrier:
Group Number:			
Name and address of employer:			
Employee/Subscriber Name:		Employee	/Subscriber SS#:
Employee/Subscriber Birthdate:			
Patient Relationship to Employee (circle): Self	Spou	se Child	Other:
Please sign so that we can release information	to your insurance co	ompany:	

Please sign if you wish your benefits to be paid directly to our office: _

Compound Authorization Form					
Name of patient:		Date of birth: _	Day	/ /	/
The purpose of this authorization is to infort that Carolina Braces is to release the follow	· ·		t inform	nation. The pa	tient has requested
Voice Mail/Answering Machine	Phone number	:			
Appointments		Instructions (Pre/Post Prod	cedure/	Operation)	
Financial		Lab/Test Results		_ Medical	
Email	Email address:				
Appointments		Instructions (Pre/Post Prod	cedure/0	Operation)	
Lab/Test Results		NPP		_Breach Inforr	nation Details
Financial		Medical			
Text Message	Phone number	:			
Appointments		Instructions (Pre/Post Prod	cedure/	Operation)	
Financial		Lab/Test Results		_ Medical	
Spouse	Name:				
Appointments		Instructions (Pre/Post Prod	cedure/	Operation)	
Financial		Lab/Test Results		Medical	
Other	Name:				
Appointments		Instructions (Pre/Post Prod	cedure/	Operation)	
Financial		Lab/Test Results		_ Medical	
Right of the Patient:					
I understand that I have the right to revoke health information to be disclosed as descri		·	_	-	
I understand that a revocation is not effective going forward. I understand that information the recipient and may no longer be protected authorization and that my treatment will not patient.	n used or disclose ed by federal or st	ed as a result of this authori ate law. I understand that I	zation m	nay be subject e right to refu	to re-disclosure by se to sign this
Signature of Patient or Legal Representativ	e		Date		

Carolina Braces

100 Sawmill Rd #200 Raleigh, NC 27615 (919) 676-7846 7780 Brier Creek Pkwy #100 Raleigh, NC 27617 (919) 957-9400

smpatient care @ carolina braces.com

I acknowledge that I have received a copy of this office's Notice of Privacy practices.

patientcarebc@carolinabraces.com

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to patient: We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the notice. You may refuse to sign this acknowledgement of receipt, but we must keep a record of your refusal. If you refuse to sign this acknowledgement of receipt, we are required to treat you and we may still use and/or disclose your health information as HIPAA permits.

rint Name	
ignature	
ate	
FOR OFFICE USE ONLY We have made every effort to obtain written acknowledgement or receipt of our Notic not be obtained because:	e of Privacy from this patient, but it could
 The patient refused to sign Due to an emergency situation it was not possible to obtain acknowledgement We were unable to communicate with the patient Other (provide specific details) 	
Employee Signature Date	

HIPAA Acknowledgement of receipt of the Notice of Privacy Practices

This form does not constitute legal advice and covers only federal, not state law.

AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Information to be Used or Disclosed

Persons Authorized to Use or Disclose Information

The information covered by this authorization includes:

Information listed above will be used or disclosed by

Date

PATIENT'S PHOTO AND PATIENT'S NAME

OFFICE OF DR. ROBERT KENT DDS MS PA

Persons to Whom Information May Be Disclosed

Information described above may be disclosed to:

OFFICE OF DR. ROBERT KENT DDS MS PA WEBSITE

SOCIAL MEDIA OF DR. ROBERT KENT DDS MS

Expiration Date of Authorization

This authorization is effective unless revoked or terminated by the patient or the patient's representative.

Right to Terminate or Revoke Authorization

Signature of Patient Representative and Relationship

You may revoke or terminate this authorization by submitting a written revocation to **DR. ROBERT KENT DDS MS PA**. You should contact the Privacy Compliance Officer to terminate this authorization.

Potential for Re-Disclosure

Information that is disclosed under this authorization may be disclosed again by this person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

Name of Patient	Date

