DENTAL MEDICAL AND HISTORY UPDATE

To ensure the highest quality of healthcare, we ask that you complete this patient update form.

Patient Name: _____ Date of Birth: _____

CONTACT INFORMATION

Phone Number (Home): _____ Cell: _____

Address: _____

PREFERED METHOD OF CONTACT (Select all that apply. Any changes to contact information, update below).

☐ Phone call ☐ Email ☐ Text message

Email address: _____

Any changes in insurance? YES ☐ NO ☐
EXPLAIN: _____

Any change in health since last dental visit? YES ☐ NO ☐
EXPLAIN: _____

Any surgeries or hospitalizations since last dental visit? YES ☐ NO ☐
EXPLAIN: _____

Are you being treated for any medical condition at present? YES ☐ NO ☐
EXPLAIN: _____

Any new family history of cancer or other serious health issues? YES ☐ NO ☐
EXPLAIN: _____

Are you taking blood thinners or diagnosed with a bleeding disorder? YES ☐ NO ☐
EXPLAIN: _____

Are you a diabetic? YES ☐ NO ☐
EXPLAIN: _____

Are you taking any medications or supplements (prescription and/or non-prescription)? YES ☐ NO ☐
EXPLAIN: _____

Have you discovered you are allergic to medications, foods, or latex? YES ☐ NO ☐
EXPLAIN: _____

Females only: Are you pregnant? YES ☐ NO ☐

I Certify that I have read, and I understand the questions above. I acknowledge that my questions, if any, about the inquiries above have been answered to my satisfaction. I will not hold my doctor, affiliated entities, or any other member of his/her staff, responsible for any errors or omissions that I have made in the completion of this form.

_____ _____
Patient Signature Date

_____ _____
DDS/Hygiene Signature Date

PATIENT CODE OF CONDUCT

We are committed to ensuring a safe and comfortable environment. By working together in mutual respect and cooperation, we can achieve the best outcomes for your care.

This Code of Conduct outlines the behaviors expected of all patients in our office and informs you of the potential consequences of noncompliance.

Behavioral Expectations

- I will address any concerns with the doctor or staff members calmly and respectfully.
- I will refrain from any form of verbal or physical abuse, harassment, aggression, violence, or any behavior that causes disruption or intimidation.
- I will respect other patients' rights, safety, and privacy.
- I will not take photos or share images from inside the office on social media, as this may violate another patient's privacy.
- I will not use any AI-Enabled Device: Any device capable of collecting, transmitting, or processing data using artificial intelligence or cloud-based services. Examples include but are not limited to:
    - Meta AI glasses (e.g., Ray-Ban Meta)
    - Smartwatches with voice or AI features
    - Virtual assistants (e.g., Siri, Alexa, Google Assistant)
    - Wearables or mobile devices with real-time transcription, recording, or translation features

Consequences of Non-Compliance

If I fail to comply with this Code of Conduct, appropriate measures will be taken to ensure the safety and comfort of other patients and staff. This may include notifying law enforcement and, if necessary, my dismissal from the practice.

I agree to follow the above conditions during my visit to **Inspire Dentistry of the Carolinas** By signing below, I confirm that I understand and accept these terms.

_____ _____

Patient Name Date

_____

Signature

INSPIRE

Office Policies

Patient Details

First Name | Last Name | Date of Birth

Policy

OFFICE HOURS
Our office is open Tuesday through Thursday from 9:00 AM to 5:00 PM. We are also open on select Mondays and Fridays from 9:00 AM to 5:00 PM.

CANCELLATION AND MISSED APPOINTMENT POLICY
To provide quality care and respect the time of all patients, we require a minimum of 24 hours' notice for appointment cancellations or rescheduling.

- Cancellations made less than 24 hours in advance, or failure to attend a scheduled appointment (no-show), will result in a cancellation fee.
- Repeated cancellations or no-shows without proper notice may result in dismissal from Inspire Dentistry of the Carolinas.

Cancellation Fees:

- Appointments up to 1 hour: $50
- Appointments between 1–2 hours: $100
- Appointments 2 hours or more: $150+
- ◦ *For appointments 2 hours or longer, 50% of the estimated copay is required at the time of scheduling.*

PAYMENT POLICY
All co-pays and patient-responsible balances are due at the time of service.

CREDIT CARD PROCESSING FEE
A 3% processing fee will be applied to all credit and debit card transactions.

To avoid this fee, we also accept **cash** and **personal checks**.
Please note:

- If a check is returned for insufficient funds or any other reason, a **3% returned check fee** will be charged to your account.
- After a returned check, **checks will no longer be accepted** as a payment method for your account.

INSURANCE FILING
As a courtesy, we will submit insurance claims on your behalf and make every effort to ensure they are processed accurately. However, insurance benefits are not guaranteed, and all benefit estimates are subject to final determination by your insurance provider.

You are responsible for any balance not covered by your insurance plan.

Common Insurance Denial: Alternate Benefit Clause
Some insurance plans apply an "alternate benefit" clause, which may downgrade coverage for certain procedures. For example, a tooth-colored (resin) filling may be downgraded to a silver (amalgam) filling, or a porcelain crown may be downgraded to a metal crown. When this occurs, you are responsible for the difference in cost.

Please note: We do not offer amalgam (silver) fillings at Inspire Dentistry of the Carolinas.

INSURANCE ASSIGNMENT AND FINANCIAL AGREEMENT
I authorize and request that my insurance company remit payment directly to Inspire Dentistry of the Carolinas for services rendered. I understand that my insurance provider may not cover the full cost of treatment. I agree to be financially responsible for any remaining balance for services provided to me or my dependents.

E-Signature (draw, upload or type)

Date:

Relationship to Patient

◯ Self ◯ Spouse ◯ Parent

INSPIRE

Friends Family Authorization for Release of Information

Patient Details

First Name | Last Name | Date of Birth

Authorization

Select all appropriate ways to contact you as a patient.

☐ Voice Mail ☐ Text Communication ☐ Email

SMS Consent Disclosure No mobile information will be shared with third parties/affiliates for marketing or promotional purposes. All categories above exclude text messaging originator opt-in data and consent; this information will not be shared with any third parties. By checking this box, I consent to receive SMS text messages from Inspire Dentistry of the Carolinas regarding appointments, treatment information, billing notifications, office updates, and occasional promotional messages. Message frequency may vary. Message and data rates may apply. Reply STOP to opt out at any time. Reply HELP for assistance. Consent is not a condition of treatment. View our Privacy Policy and SMS Terms of Service for additional information.

☐ Yes, I consent to receive SMS messages from Inspire Dentistry of the Carolinas.

Inspire Dentistry of the Carolinas is authorized to release protected health information about the above named patient in the following manner and to identified persons below.

Entity to Receive Information and Description of information to be released

Name | Relationship | Phone Number

Check which information below can be released to the above named person(s):

☐ Financial ☐ Treatment ☐ Appointment reminders

For e-mail communication to occur, accept the disclosure below

☐ For email and/or text 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 receive email and/or text communication as selected.

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 This authorization will remain in effect until revoked by the patient.

E-Signature (draw, upload or type)

_____

Date:

Inspire Dentistry of the Carolinas

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 _____

OralID®

Shine Light. Change Lives.

Consent Form – Oral Cancer Screening

Our office strives to bring its patients state-of-the-art technology to provide you with the latest advancements in oral health. We have recently introduced the OralID screening device into our office. The OralID examination will aid in visualization of oral mucosal abnormalities, such as cancer and pre-cancer. The procedure is quick, painless and no rinses or dyes are used.

Similar to other cancers, early detection of oral cancer is critical. If oral cancer is detected in its later stages, which typically only occurs during a conventional oral cancer exam, the chances of survival are dramatically reduced.

Who is at Risk?

- Age - 17+ years
- Tobacco Use
- Alcohol Use
- HPV infection
- Previous history of cancer

If you have any questions about risk factors, please feel free to talk to our hygiene staff. We recommend all of our patients be screened with the OralID.

Our office charges $35 per screening with the OralID. We will attempt to bill your insurance, but you will be responsible for any unpaid amount or denial by your insurance company.

☐ Yes, I request that your staff perform an examination with the OralID. I accept financial responsibility for this examination.

Signature _____ Name _____ Date _____

☐ No, I prefer to not have this examination at this visit.

Signature _____ Name _____ Date _____