

Inspire Dentistry of the Carolinas

We would like to get to know you better!

Patient Name: _____ Date: _____ ☐ Male ☐ Female

Address: _____ City/State: _____ Zip: _____

Cell: _____ Work: _____

Date of Birth: _____ Email : _____

Patient (or Responsible Party) Social Security #: _____

IF CHILD: Parent Name: _____ Work Phone: _____ Parents SS # _____

Parent Employer: _____ Parent Occupation: _____

SELF: Employer: _____ Occupation: _____

SPOUSE: Name: _____

Whom may we thank for referring you in our office:

EMERGENCY:

Person to contact in case of emergency _____ Relationship _____ Phone Number _____

DENTAL HISTORY:

Former Dentist: _____ Last Visit: _____ Date of Last Dental X-rays _____

Reason for today's visit: _____

How often do you brush? _____ Floss? _____ Use Mouthwash? _____

Please check any of the following conditions that apply to you:

- | | | | |
|---|--|---|---|
| ☐ Bad Breath | ☐ Grinding Teeth | ☐ Periodontal (Gum) Disease | ☐ Bleeding Gums |
| ☐ Mouth Sores | ☐ Clicking or Popping Jaw | ☐ Loose Teeth or Broken Fillings | ☐ Sensitivity when Chewing |
| ☐ Sensitivity to Hot | ☐ Sensitivity to Cold | ☐ Food Collects Between Teeth | ☐ Sensitivity when Biting |

	YES	NO	COMMENTS
Are you happy with your Smile?	☐	☐	_____
Have you had Orthodontics (Braces)	☐	☐	_____
Do you think you will eventually need dentures?	☐	☐	_____
Have you ever had a reaction to anesthetic?	☐	☐	_____
Do you avoid brushing part of your mouth?	☐	☐	_____
Do you smoke or use smokeless tobacco?	☐	☐	_____
Have you ever had any teeth removed?	☐	☐	_____

If you could make one change to your teeth what would it be? _____

If it has been more than 1 year since your last dental visit what kept you from going to the dentist? _____

If you could eliminate one part of the dental visit, what would it be? _____

Time 2:30 PM

Charles Anonuevo DDS, PLLC
Eaglesoft Medical History

Date 4/13/2018

Patient Name:

Birth Date:

Data Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	☐ Yes ☐ No	If yes	
Have you ever been hospitalized or had a major operation?	☐ Yes ☐ No	If yes	
Have you ever had a serious head or neck injury?	☐ Yes ☐ No	If yes	
Are you taking any medications, pills, or drugs?	☐ Yes ☐ No	If yes	
Do you take, or have you taken, Phen-Fan or Redux?	☐ Yes ☐ No	If yes	
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	☐ Yes ☐ No	If yes	
Are you on a special diet?	☐ Yes ☐ No		
Do you use tobacco?	☐ Yes ☐ No		

Women: Are you...

☐ Pregnant/Trying to get pregnant?☐ Nursing?☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin
☐ Metal☐ Penicillin
☐ Latex☐ Codeine
☐ Sulfu Drugs☐ Acrylic
☐ Local Anesthetics

Other?

☐

If yes

Do you use controlled substances?

☐ Yes ☐ No

If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive	☐ Yes ☐ No	Corticosteroids	☐ Yes ☐ No	Hemophilia	☐ Yes ☐ No	Radiation Treatments	☐ Yes ☐ No
Alzheimer's Disease	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Hepatitis A	☐ Yes ☐ No	Recent Weight Loss	☐ Yes ☐ No
Anaphylaxis	☐ Yes ☐ No	Drug Addiction	☐ Yes ☐ No	Hepatitis B or C	☐ Yes ☐ No	Renal Dialysis	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Easily Winded	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Angina	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Rheumatism	☐ Yes ☐ No
Arthritis/Gout	☐ Yes ☐ No	Epilepsy or Seizures	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Artificial Heart Valve	☐ Yes ☐ No	Excessive Bleeding	☐ Yes ☐ No	Hives or Rash	☐ Yes ☐ No	Shingles	☐ Yes ☐ No
Artificial Joint	☐ Yes ☐ No	Excessive Thirst	☐ Yes ☐ No	Hypoglycemia	☐ Yes ☐ No	Sickle Cell Disease	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Fainting Spells/Dizziness	☐ Yes ☐ No	Irregular Heartbeat	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No
Blood Disease	☐ Yes ☐ No	Frequent Cough	☐ Yes ☐ No	Kidney Problems	☐ Yes ☐ No	Spina Stiffness	☐ Yes ☐ No
Blood Transfusion	☐ Yes ☐ No	Frequent Diarrhea	☐ Yes ☐ No	Leukemia	☐ Yes ☐ No	Stomach/Intestinal Disease	☐ Yes ☐ No
Breathing Problems	☐ Yes ☐ No	Frequent Headaches	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Bruise Easily	☐ Yes ☐ No	Genital Herpes	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No	Swelling of Limbs	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Lung Disease	☐ Yes ☐ No	Thyroid Disease	☐ Yes ☐ No
Chemotherapy	☐ Yes ☐ No	Hay Fever	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Chest Pains	☐ Yes ☐ No	Heart Attack/Failure	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Cold Sores/Fever Blisters	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Pain in Jaw Joints	☐ Yes ☐ No	Tumors or Growths	☐ Yes ☐ No
Congenital Heart Disorder	☐ Yes ☐ No	Heart Pacemaker	☐ Yes ☐ No	Parathyroid Disease	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Convulsions	☐ Yes ☐ No	Heart Trouble/Disease	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
						Yellow Jaundice	☐ Yes ☐ No

Have you ever had any serious illness not listed ☐ Yes ☐ No If yes

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:

X

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

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:

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

Photography Release

First Name

Last Name

Date of Birth

I the undersigned, do hereby authorize and consent to the use of photographs/x-rays of me taken by [insert dental office name]. I grant them permission to reproduce, print and publish photographs taken of me in a professional publication or in the form of prints, film or slides in connection with articles and lectures dealing with the jaw or dental disorders. I specifically waive any claim for invasion of my personal privacy which might accrue to me on account of the use of such pictures without my express consent in each instance.

I do consent to the use of my photographs or images for marketing materials including website and patient education for Inspire Dentistry of the Carolinas only.

I further understand that if the photographs and/or images are used, my name or similar identifying information will not be used. No full face or comparable photos will be used without your express written authorization. I further acknowledge that my participation is voluntary and that I will not receive any compensation, financial or otherwise, with respect to the taking, use or publication of these photographs for any dental office publications.

I acknowledge and agree that publication of photographs confers no rights of ownership or royalties whatsoever.

Acknowledgment

☐ Yes- I agree to the photography release above.

☐ No- I do not agree to the photography release above.

E-Signature (draw, upload or type)

Date:



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

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 _____
