Langley DENTAL CARE
Cosmetic & Family Dentistry

PATIENT INFORMATION FORM
PLEASE FILL OUT COMPLETELY

Name: First _____MI ____Last: _____Preferred name: _____

Date of Birth: ____/____/_____ Gender: M / F Marital Status: M / D / S / Sep SSN: _____-_____-_____

Home address: Street: _____

City: _____State: _____ Zip Code: _____

Telephone: Home: _____-_____-_____ Work: _____-_____-_____ Cell: _____-_____-_____

Email: _____ **Preferred contact**: home □ work □ cell □ email □

Employer: _____ Phone_____

Employment address:_____

Responsible Party: Myself □ Other: _____ Relation to Patient: _____

Emergency Contact: _____ Phone (H) _____ (W) _____ (C) _____

Spouse Name: _____ Children's names: _____

How did you hear about our office? Social Media ☐ Drove by ☐ Internet ☐ Patient Referral ☐

Who can we thank? _____ Other: _____

Dental Insurance Yes □ No □

Dental Insurance Carrier: _____

Policy Holder: _____

WE REQUIRE A COPY OF YOUR INSURANCE CARD AND DRIVERS LICENSE

As a courtesy, we will gladly file your insurance with your insurance company.
However, all charges are the responsibility of the patient or guardian.

I certify that the information on this form is correct. I am responsible for any balance on this account, even if I have dental coverage. I authorize Kari H. Langley D.M.D., P.A. to release my information to my insurance company.

signature: _____ Date: _____

8814 Rachel Freeman Way, Suite 104, Charlotte, NC 28278
Phone 704.583.0966 ▪ Fax 704.583.0520

Langley DENTAL CARE
Cosmetic & Family Dentistry

IMPORTANT INFORMATION FOR OUR PATIENTS

Part of our mission at Kari H. Langley Family Dentistry is to provide you with quality, state-of-the-art dental care. It is our goal to assist you in obtaining and maintaining the highest level of personal dental health and patient relations. We want you to have a healthy, beautiful smile you desire and deserve!

Appointments

Our appointments are scheduled to respect your time. We reserve a specific time for your care and we make every effort to see you at that appointed time. We appreciate your promptness and consideration in not changing your scheduled time. However, if you do need to change an appointment, a **48 hour notice is required**. If a 48 hour notice is not given, we reserve the right to charge **$35 per hour**, for any missed, cancelled or broken appointment.

Payment Options

For your convenience, we accept cash, credit cards, and Care Credit (ask us about this wonderful 3rd party financing plan!). Our office will not send out a statement unless a balance is due. All balances incur 1.33% interest **per month** if a payment is overdue. Returned checks or payments are subject to a $35 returned check fee.

Ask us about our in-house payment options for your dental needs!

Dental Insurance

We are pleased to assist you in obtaining the maximum benefit from your dental insurance plan. We **estimate** benefits and we accept assignment of payment from your insurance company. Dental insurances aid patients with the cost. Payment of your portion in full is expected at the time you are in our office for dental care. As a courtesy, we are happy to file your insurance with direct payment to our office; however, **patients are responsible for the entire account balance not paid by your insurance company.**

We appreciate you as a patient and thank you kindly for your cooperation.

I have read and understand the important information and accept my responsibilities as a patient in this office.

_____ _____

Signature (Patient or Legal Guardian) Date

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Langley Dental Care

Patient Medical History

Date 3/19/2019

Patient Name: Birth Date: Date 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	
Are you on a special diet?	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-Fen or Redux?	Yes No	If yes	
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes No	If yes	
Do you drink alcohol? if so how many per week?	Yes No	If yes	
Have you traveled outside of the US in the last year?	Yes No	If yes	
Do you have a history of drug or alcohol abuse?	Yes No	If yes	
Do you use tobacco?	Yes No	If yes	

Women: Are you...

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

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic

☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other?	Yes No	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	Cortisone Medicine	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 Bifida	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						

Any medical conditions or serious illness not listed above? 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:_____

KARI H. LANGLEY, DMD
Authorization for Release of Information – Compound Release

Name of Patient _____ Date of Birth _____

Kari H. Langley, DMD is authorized to release protected health information about the above named patient in the following manner and to identify persons.

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 ☐ Other_____
☐ Other person (s) (provide name and phone number)	☐ Financial ☐ Treatment
☐ Email communication-Provide email address* _____ *For email communication to occur, please accept the disclosure below:	☐ Financial ☐ Treatment ☐ Appointment reminders ☐ Breach notification ☐ Specialists
☐ Text communication – Provide number * _____ *For text communication to occur, accept the disclosure below:	☐ Appointment reminder ☐ Other: _____
☐ 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.	
☐ Photo of patient received by patient or legal guardian ☐ Photo taken by staff (Example: pre/post procedure) ☐ Other	☐ May be posted in office ☐ May be posted on website ☐ Other_____

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.

_____Date _____

Signature of Patient or Personal Representative

Revised Oct 2014

KARI H. LANGLEY, DMD

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 _____