Welcome to Our Practice

Angie S. Rhodes DDS, PA

FAMILY AND COSMETIC DENTISTRY

200 Patrick Lane
Chocowinity NC 27817
(252) 974-2300
drangierhodes.com

PATIENT INFORMATION

Date _____ Name by which you prefer to be called _____

Patient's Name _____
Last First Middle

Street Address _____
Street City State Zip

Billing Address _____
Street City State Zip

☐ Male ☐ Female ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Other

Age _____ Birthdate _____ Social Security # _____

Home Phone _____ E-mail Address _____

Are you a full time student? ☐Yes ☐No If yes, school name _____

Work Phone _____ Employer _____ Occupation _____

Spouse's Name _____ Spouse's Birthdate _____
Last First Middle

Spouse's Employer _____ Spouse's Work Phone _____

Purpose of today's visit _____ How long since your last cleaning and exam? _____

What would you change about your smile? _____

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

INSURANCE INFORMATION

Do you have dental insurance? ☐Yes ☐No Do you have secondary coverage? ☐Yes ☐ No

PRIMARY

Insured's Name _____ Insured's Social Security # _____

Insured's Employer _____ Employer Phone _____

Insurance Company _____ Insurance Phone _____

Insurance Co. Address _____
Street City State Zip

Group # _____ Subscriber ID# (BCBS only) _____

PARENT OR LEGAL GUARDIAN INFORMATION

Name _____ Marital Status _____
Last First Middle

Mailing Address _____
Street City State Zip

Home Phone _____ Work Phone _____ Employer _____

Social Security# _____ Birthdate _____ Relationship to patient _____

EMERGENCY INFORMATION

Name of nearest relative not living with you _____

Complete Address _____

Phone _____

HEALTH INFORMATION

Yes	No	
☐	☐	Are you under a physician's care now? Why? _____
☐	☐	Are you taking any pills, drugs or medication? If so, list: _____
☐	☐	Are you allergic to any drugs or local anesthetics or had unusual reaction? List: _____
☐	☐	Are you allergic to any metals, jewelry or latex?
☐	☐	Do you have headaches? Migraine tension or TMJ (Circle)
		Explain: _____
☐	☐	Are you pregnant? How many weeks? _____
		Have you ever had any of the following?
☐	☐	Abnormal Heart Condition
☐	☐	Mitral Valve Prolapse
☐	☐	Abnormal blood pressure
☐	☐	Abnormal bleeding
☐	☐	Rheumatic Fever
☐	☐	Joint Replacement
☐	☐	Kidney Disease, Renal Failure or Kidney Transplant
☐	☐	Diabetes
☐	☐	Tuberculosis When? _____ Treatment? _____
☐	☐	Hepatitis When? _____ Treatment? _____
☐	☐	Sexually Transmitted Disease (STD)
☐	☐	HIV or AIDS
☐	☐	Radiation Treatment When? _____ Why? _____
☐	☐	Allergies or Asthma
☐	☐	Is there any information about your health we should know?
		Explain: _____
		Physician's Name: _____ Phone _____

Patient Name _____

X _____ Date _____
Signed (patient or parent if minor)
I understand that as a service to me Dr, Angie Rhodes and staff will assist me in processing my insurance claims. However, I am completely responsible for all fees in their entirety.

X _____ Date _____
Signed (patient or parent if minor)
I authorize the use of my radiographs and/or photographs for use in seminars or publications of Angie S. Rhodes DDS, PA.

X _____ Date _____
Signed (patient or parent of minor)

ONLY if you have insurance: SIGNATURE ON FILE

So you don't have to sign an insurance form at each dental visit, Angie S. Rhodes, DDS, PA will maintain this "signature on file" for you
AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize any Provider, Insurer or other Organization to release any information regarding the dental history, treatment, or benefits payable for this claim of the Plan Administrator or its authorized agent for the purpose of determining benefits payable.

X _____
Signed (patient or parent if minor)
AUTHORIZATION TO PAY BENEFITS TO BELOW NAMED DENTIST: I hereby authorize payment directly to Angie S. Rhodes, DDS, PA for services rendered.

X _____ Date _____
Signed (subscriber or patient or parent if minor)

The highest compliment our patients can give us is the referral of their friends and family. Thank you for your trust.