H. A. NICHOLSON III, D.D.S., P.A.

1631 DOCTORS CIRCLE • WILMINGTON, NC 28401 • TELEPHONE (910) 762-4459

PATIENT INFORMATION

DATE _____

Primary reason for this dental appointment: ❑ Routine Check-Up ❑ Emergency ❑ Consultation

NAME _____ ❑ MARRIED ❑ SINGLE ❑ MINOR ❑ MALE ❑ FEMALE
LAST FIRST M

MAILING ADDRESS _____
STREET APT. # CITY STATE ZIP

STREET ADDRESS _____ _____
(if different than above) STREET APT. # CITY STATE ZIP

BIRTHDATE _____ TELEPHONE _____
MO DAY YR HOME WORK

EMPLOYER (OR SCHOOL) _____ GRADE _____ SS# _____

DENTAL INSURANCE CO. _____ GROUP NO._____

Has any member of your family ever been treated in our office? ❑ Yes ❑ No

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

FAMILY INFORMATION

SPOUSE OR PARENT

Name_____ Address_____
LAST FIRST M STREET CITY STATE ZIP

Birthdate _____Telephone _____SS# _____
HOME WORK

Employer _____

Dental Insurance Co. _____Group No. _____

PERSON TO CONTACT OUTSIDE OF IMMEDIATE FAMILY IN CASE OF EMERGENCY

Name_____ Telephone _____
LAST FIRST M

Address _____
STREET CITY STATE ZIP

DENTAL HISTORY

Do you have a specific dental problem? Describe _____

When was your last dental visit? _____

Name of previous dentist (optional) _____

MEDICAL HISTORY

Medical doctor's name _____

Are you under a doctor's care now? Why? _____

Have you been hospitalized or received a blood transfusion? _____ When? _____

Are you taking any prescriptions or other medications? What? _____

Are you allergic to any medications or substances? _____
(Penicillin, Codeine, Latex Rubber, Etc.)

Are you pregnant? _____

-- MEDICAL HISTORY CONTINUED ON BACK --

PATIENT NAME _____ **DATE** _____
(FULL NAME) LAST FIRST MIDDLE

MEDICAL HISTORY CONTINUED

Please CIRCLE if you have had any of the following:

Heart Trouble	Shortness of Breath	Hay Fever	Thyroid Disease	Hypoglycemia
High Blood Pressure	Swelling of Feet/Ankles/Hands	Sinus Trouble	Parathyroid Disease	Psychiatric Care
Low Blood Pressure	Fainting or Dizziness	Emphysema	X-ray or Cobalt Tmt.	Drug Addiction
Heart Murmur	Stroke	Frequent Cough	Chemotherapy/Radiation	Blood Transfusion
Rheumatic Fever	Diabetes	Lung Disease	Arthritis/Gout	Hemophilia
Congenital Heart Lesion	Excessive Thirst	Tuberculosis	Rheumatism	AIDS (HIV)
Artificial Heart Valve	Artificial Joints/Hips	Liver Disease	Pain in Jaw Joints	Venereal Disease
Heart Pacemaker	Kidney Trouble	Hepatitis A (infec.)	Cortisone Medicine	Cold Sores
Heart Surgery	Ulcers	Hepatitis B (serum)	Glaucoma	Fever Blisters
Blood Disease	Allergies	Yellow Jaundice	Epilepsy or Seizures	Herpes
Anemia	Scarlet Fever	Recent Weight Loss	Nervousness	Bruise Easily
Chest Pain	Asthma	Cancer	Alzheimer's Disease	Sickle Cell Anemia

Have you ever had any other serious illness not circled above?_____ YES NO

Please describe in detail _____

Do you wish to talk to the doctor privately about any problem? _____ YES NO

PAYMENT POLICY

To help our patients meet their dental needs and to help keep costs down, our dental office adheres to the following payment policies:

- ❑ If you do not have dental insurance, you are required to pay your balance in full at the time services are rendered. (We accept cash, checks, Mastercard, Visa and Discover.)
- ❑ If you have dental insurance, it is required that you pay 1/2 of your uninsured balance as well as your deductible on the day of service for any major dental work. The remainder of the balance is due by the day that the treatment is completed.

*We file insurance as a courtesy to our patients and will do everything possible to collect payment through your insurance provider; however, if your insurance provider has not paid your balance within 60 days, it is your responsibility to pay the balance in full. This includes workman's compensation claims.

Delinquent accounts are handled through small claims court.

FINANCE CHARGE

If you do not pay the entire balance within 60 days of service date, the **FINANCE CHARGE** will be a monthly periodic rate of **1.5%**, which is an **ANNUAL PERCENTAGE** rate of **18%**. This charge, along with any collection costs and reasonable attorney fees incurred to effect collection on this account will be added to your monthly balance.

AUTHORIZATION

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history are correct to the best of my knowledge.

SIGNATURE OF RESPONSIBLE PARTY

X _____ Date _____

❑ Adult Patient ❑ Father (or Husband) ❑ Mother (or wife) ❑ Guardian

Reviewed by: Doctor _____ Date _____ B.P. _____

MEDICAL UPDATES

I have read my MEDICAL HISTORY dated _____ and confirm that it adequately states past and present conditions.

DATE	EXCEPTIONS	PATIENT'S SIGNATURE	B.P.	REVIEWED BY
_____	_____	❑ None_____	_____ DR.	_____
_____	_____	❑ None_____	_____ DR.	_____
_____	_____	❑ None_____	_____ DR.	_____
_____	_____	❑ None_____	_____ DR.	_____
_____	_____	❑ None_____	_____ DR.	_____
_____	_____	❑ None_____	_____ DR.	_____