ADVANCED dental care
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NEW PATIENT INFORMATION

Today's Date	Any immediate family members who are patients at this office?				
Last Name	First Name	MI	Preferred Name	Sex M F	Marital Status M S
Date of Birth	Age	SSN	DL #	State	
Address	City	State	Zip		
Email	Home Phone	Mobile Phone			
Employer	Occupation	Work Phone			

EMERGENCY CONTACT INFORMATION

Name	Relation	Home #	Cell #
Nearest Adult Relative	Relation	Home #	Cell #

REFERRAL INFORMATION

Whom can we thank for referring you?
Family Member_____
Coworker_____
Friend_____
Doctor _____

Or did you find us on your own?
___ Our website ____ Lumineers
___ Yellow Pages ___ Facebook, etc
____ Insurance Company ___ Location
____ Letter in Mail
____ Other: _____

Send appointment reminders via:
___Text Message
___Email
___Mail
___Other:_____

PERSON RESPONSIBLE FOR THIS ACCOUNT

☐ Check if same as above	Name	Phone	Date of Birth	SSN
Address	City	State	Zip	
Relationship to patient	Marital Status M S	Email Address		

DENTAL INSURANCE

PRIMARY INSURANCE		SECONDARY INSURNACE	
Policy Holder Name	Date of Birth	Policy Holder Name	Date of Birth
Address, City, State, Zip		Address, City, State, Zip	
Email Address	Phone Number	Email Address	Phone Number
Employer	Work Phone	Employer	Work Phone
PRIMARY Ins Name	ID #	SECONDARY Ins Name	ID #
Address, City, State, Zip		Address, City, State, Zip	
Insurance Phone Number	Group #	Insurance Phone Number	Group #

What is the reason for your visit today? _____

Date of Last Dental Visit: _____

Do you prefer Nitrous Oxide (laughing gas) during your dental procedure? _____

Are you interested in sedation dentistry? ☐ Yes ☐ No

- **Why did you leave your previous dentist?** _____
- **Are you interested in whitening your teeth?** _____
- **If you could change your smile what would you do?** _____

HEALTH QUESTIONNAIRE

Today's Date	**Patient Name**	**Birth Date**

Name of person completing the form (if different from patient) **and relation to patient:**

Please answer the following questions to the best of your ability, realizing that true and accurate answers are important to the delivery of quality of care. <u>All information you provide will be kept confidential.</u>

***** PLEASE ANSWER BY CIRCLING Yes (Y) or No (N) FOR EACH INDIVIDUAL QUESTION*****

1.	Are you in good health?	Y	N
2.	Has there been any change in your health in the last year?	Y	N
3.	Date of last check up by physician ___/___/___	Y	N
4.	Are you currently under a physician's care?	Y	N
	If so, what for?		
	Treating physician's Name Phone Number		
5.	Have you had any serious illness, operations, or hospitalizations?	Y	N
	If so describe and give approximate dates:		
6.	Have you ever had intravenous sedation or general anesthesia?	Y	N
	Were there adverse effects?	Y	N
7.	Do you generally tolerate dental treatment well?	Y	N
8	**DO YOU HAVE <u>OR</u> HAVE YOU EVER HAD**		

a.	Heart disease that was detected at birth?	Y	N	k.	Arthritis? (which Joints?)	Y	N
b.	Rheumatic Fever or Rheumatic Heart Disease? *(Please circle)*	Y	N	l.	Stomach ulcers or Intestinal problems?	Y	N
c.	Cardiovascular Disease? *<u>Please circle</u>* (chest pain, heart trouble, heart attack, high blood pressure, stroke, pacemaker, etc.)	Y	N	m	Any disease, drug or transplant operation that has depressed your immune system?	Y	N
d.	Lung Disease? *<u>Please circle</u>* (asthma, emphysema, chronic cough, bronchitis, pneumonia, TB, Shortness of breath)	Y	N	n.	Noises in Jaw joint, pain near ear when chewing, do you grind/clench your teeth?	Y	N
e.	Neurologic Disorders? (*Please circle)* (seizure, epilepsy, fainting, dizziness, nervous disorder)	Y	N	o.	Implants/artificial joints anywhere in your body? (Heart valve, hip, knee)	Y	N
f.	Blood Disease? (bleeding disorder, anemia, blood transfusion, do you bruise easily)	Y	N	p.	Radiation? (X-ray treatment for cancer) in head and neck region	Y	N
g.	Liver Disease? (jaundice, hepatitis)	Y	N	q.	Frequent or recurring mouth sores?	Y	N
h.	Kidney Disease?	Y	N	r.	Sinus or Nasal problems?	Y	N
i.	Diabetes?	Y	N	s.	Glaucoma?	Y	N
j.	Thyroid Disease? (hypothyroidism, tumor)	Y	N	t.	Recurrent infections of any kind?	Y	N

9.	**ARE YOU CURRENTLY TAKING OR USING ANY OF THE FOLLOWING**							
	a.	Antibiotics?	Y	N	h.	Stomach or GI medication? (antacids, etc)	Y	N
	b.	Anticoagulants (blood thinners)?	Y	N	i.	Cholesterol reducing drugs?	Y	N
	c.	Aspirin, ibuprofen, NSAIDS or anti-inflammatory drugs, narcotics, opioids, or other pain relievers? *(Please circle)*	Y	N	j.	Marijuana, cocaine, or other "recreational drugs?	Y	N
	d.	Vitamins, Natural remedies (gingko biloba ephedra, ginseng)?	Y	N	k.	Weight reduction pills or diet aids (Over- the- counter or "natural" products?	Y	N
	e.	High Blood pressure or heart medication?	Y	N	l.	Antihistamines, decongestants?	Y	N
	f.	Steroids?	Y	N	m.	Thyroid medications?	Y	N
	g.	Tranquilizers, antidepressants?	Y	N	n.	Any other regular medications, pills, supplements or drugs?	Y	N
10.	**PLEASE LIST ALL CURRENT MEDICATIONS HERE**_____ _____ _____							
11.	**ARE YOU ALLERGIC TO OR HAD A BAD REACTION FROM:**							
	a.	Local Anesthetic (Novacain-like drugs)	Y	N	e.	Aspirin, ibuprofen, NSAIDS, other pain meds	Y	N
	b.	Penicillin, Amoxicillin, Cephalosporin	Y	N	f.	Codeine or other narcotics or opioids	Y	N
	c.	Other antibiotics	Y	N	g.	Latex	Y	N
	d.	Barbiturates, sedatives	Y	N	h.	Other Allergic reactions? _____	Y	N
12.	Do you use alcohol? How much per day?						Y	N
13.	Do you smoke? What product and how many per day? _____ For how long? _____						Y	N
14.	Do you use spit tobacco? For how long? _____						Y	N
15.	Are you, or have you been, in a drug or alcohol recovery program?						Y	N
16.	Do you have any other disease, condition, or problem not listed above that you think the doctor should know about? _____						Y	N
17.	Do you wish to talk to the doctor privately about anything?						Y	N
18.	**WOMEN**							
	a.	Are you taking birth control pills?	Y	N	c.	Are you breast feeding?	Y	N
	b.	Are you pregnant?	Y	N	d.	Are you taking hormonal replacement medication or therapies?	Y	N
	c.	Are you trying to become pregnant or <u>any chance</u> you might be pregnant?	Y	N				

I understand the importance of a truthful health history and realize that incomplete information may have an adverse effect on my treatment. To the best of my knowledge, the information above is a complete and accurate.

____/____/____ _____ _____

Date **Patient/Guarantor (Print)** **Patient/Guarantor (Signature)**

FINANCIAL POLICY

This is an agreement between Advanced Dental Care, LLC, as creditor, and the Patient/Debtor named on this form. In this agreement the words "you," "your," and "yours" mean the Patient/Debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we," "us," and "our" refer to Advanced Dental Care, LLC. By executing this agreement, you are agreeing to pay for all services that are received.

We are a fee-for-service practice. Payment is due at the time of service.

For your convenience we offer the following methods of payment.

Preference of payment: Cash/Check
Credit Card: Visa MasterCard American Express Discover CareCredit

Missed Appointment: I/We agree to the Missed Appointment Policy, which states that a $50 fee will be assessed if Advanced Dental Care is not notified within 48 hours before cancelling appointment.
Insured Patients: Insured patients are expected to pay their deductible and the percentage co-insurance payment at the time of service. Because this is an insurance requirement, we cannot bill you for these.

Payments: Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid 15 days from the date statement was issued.

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account, the finance charge, if any, and any payments or credits applied to your account during the month.

Finance Charges: In the event of default in payments, a service charge of 1.5% per month (18% annual rate) on the unpaid balance will be assessed.

Charges to Account: We shall have the right to cancel your privilege to make charges against your account at any time. Future visits would then need to be paid at the time of service.

Collection Charges: I/We agree to pay all attorneys, court costs, filling fees, and all collection costs. Additionally, up to 50% of the amount owing may be assessed on any collection agency retained to pursue the matter. Minimum monthly finance charge is $5.00. A $25 charge will be assessed on any returned checks or declined credit cards on prearranged payment plans.

Divorce: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Transferring of Records: You will need to request in writing, and pay a reasonable copying fee, if applicable (currently $25) if you want to have copies of your records sent to another doctor or organization. You authorize us to include all relevant information, including your payment history. If you are requesting your records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information, including your payment history.

Patient Initials:_____ Date:_____

INSURANCE RELEASE

I understand and agree that dental insurance policies are an arrangement between the insurance carrier and myself. I understand it is my primary responsibility to determine if the dentists at Advanced Dental Care are contracted with my specific plan and what those plan benefits and limitations are. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I understand that **Advanced Dental Care is a third party submitting dental claims for myself and only provides estimates as to my insurance co-payment.** I clearly understand and agree that all services rendered are charged directly to me and that I am personally responsible for the payment. I also assume responsibility to inform Advanced Dental Care of benefits that may have been paid to another office during the plan year so that yearly maximums can be determined. I hereby authorize release of any information, including diagnosis and records of any treatments or examination rendered, charges billed, payments made, and interest charges assessed, etc. to my insurance company or companies or any other agency necessary for the collection of this account. I authorize the dentist or his designees to release financially identifiable information and treatment descriptions and information, either electronically, by facsimile, or paper form to my insurance carrier or any related entities that require such information to be submitted. This release is solely for the purpose of facilitating the billing and reimbursement directly to the doctor of insurance benefits under which I am entitled. This authorization is considered to be effective for present and all future insurance claims and supersedes all prior arrangements signed.

INFORMED CONSENT & CONSENT TO PROCEED

I authorize Dr. Bennett and /or his associates or assistants as he may designate, to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide) analgesic, therapeutic, and/or pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments.

I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to bruising, hematoma, cardiac stimulation, temporary or rarely permanent numbness, and muscle soreness. I understand that occasionally needles break and may require surgical retrieval.

I understand that as part of dental treatment, including preventative procedures such as cleaning and basic dentistry, including fillings of all types, teeth may remain sensitive or even possible quite painful, both during and upon completion of treatment. Gums and surrounding tissues may also be sensitive or painful during and/or after treatments. After lengthy appointments, jaw muscles may also be sore or tender. Although rare, it is also possible for the tongue, cheek or other oral tissue to be inadvertently abraded or lacerated (cut) during routine dental procedures.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may associated with general preventative and operative treatment procedures in hopes of obtaining the potential desired result, which may or may not be achieved, for my benefit or for the benefit of my minor child or ward. I acknowledge that the nature and purpose of foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

I certify that I have had all of my questions/concerns regarding the above matters and you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

Patient/Guardian (print) _____ **Date** _____

Patient/Guardian (signature) _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

_____

You May Refuse to Sign This Acknowledgement

I have received a copy of the Notice of Privacy Practices from Advanced Dental Care, LLC.

_____
Please Print Name

_____
Signature

_____
Date

(For Office Use Only)

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

_____

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