ANSLEY MIDTOWN DENTAL

GENERAL AND COSMETIC DENTISTRY

Name: _____ Go By: _____

Last First Middle

Address: _____

Phone Numbers: h. _____ o. _____ c. _____

Birthdate: _____ Gender: _____ SS#: _____ DL#: _____

Email: _____ Marital Status: _____

Spouse/Partner's Name (optional): _____ May we discuss your treatment with them? Y N

Place of Employment: _____ Position: _____

If a Student, name of School: _____

How did you find out about us? _____

Emergency Contact Name: _____ Phone #: _____

Dental Insurance Information

Who is the Policy Holder? (circle) Self Husband Wife Partner Mother Father Other

If the Policy Holder is <u>not</u> yourself, please provide us with the policy holder's:

Name: _____

Their Employer/Company policy is through: _____

Their Birthdate: _____ Their SS#: _____

Their Address: _____ Phone #: _____

Dental Insurance Company name: _____ Phone #: _____

Group #: _____ ID#: _____

Claims Mailing Address: _____

Appointment Change or Cancellation Policy

We request 48 hour notice but require 24 hour notice for any change to your scheduled appointment. We attempt to confirm each appointment, however, once you have reserved an appointment time you are responsible for that time, regardless of our contact or non-contact. **Our broken appointment fee is $25 for each 15 minutes of time reserved.** For example, if an hour appointment is cancelled with less than 24 hour notice, the broken appointment fee will be $100.

Please initial that you understand the Appointment Change or Cancellation Policy: _____

Your Financial Responsibility and Other Policies

For patients **who are not utilizing** dental benefits, payment is due in full at the time of service. For patients **who are utilizing** dental benefits, your estimated out-of-pocket portion is due at the time of service. This includes, but is not limited to, co-pays and deductibles.

If you have dental benefits, we will help estimate the coverage that you have available and file your claim as a courtesy. Professional care is provided to you, our patient, and not to an insurance company. Thus, the insurance company is responsible to the patient and the patient is responsible to the doctor.

It is your responsibility to understand your own dental coverage. You are the only one who has complete access to your policy information, so we strongly recommend that you know your benefit and policy information ensuring that you are aware of what services are and are not covered. If your insurance company does not produce payment within 60 days of the date of service, the balance will become patient responsibility. If an account holds a balance past 90 days from the date of service, the account will be subject to Collections or subject to 1.5% monthly interest (18% annually (APR)). The patient is responsible for all Collection Agency fees and attorney fees. We accept Visa, MasterCard, Discover, American Express, Care Credit, cash, personal checks, and cashier's checks. If you are paying by personal check, please understand that there is a returned check fee of $30.00.

I hereby authorize payments made by the group insurance benefits directly to the dental office, otherwise payable to me. I understand that I am ultimately responsible for all cost 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. I have updated my dental/medical histories and they are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payers (insurance) for the purposes of collecting payment for services and/or also to other health professionals as necessary for my treatment.

I realize that the responsible adult (parent or guardian) must remain in the office while a minor is being treated.

Please initial that you understand Your Financial Responsibility and Other Policies: _____

Notice of Privacy Practices

Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the use and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this form. We encourage you to read it carefully and completely before signing this acknowledgement. We reserve the right to change our privacy practices as described in our Notice. If changes are made to our Notice, we will issue a revised Notice. Those changes may apply to any of your protected health information that we maintain. To obtain a current Notice, contact our office anytime.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

Signature: _____ Date: _____

Consent for Use and Disclosure of Health Information

Purpose of giving Consent: By signing below, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations, as described more fully in our Notice of Privacy practices. You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this consent.

Signature: _____ Date: _____

Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to our office. Please understand that revocation of the Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke Consent.

MEDICAL HISTORY

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, please explain: _____

Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____

Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____

Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____

Are you on a special diet? ◯ Yes ◯ No

Do you use tobacco? ◯ Yes ◯ No

Do you use controlled substances? ◯ Yes ◯ No

Women: Are you

Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs

☐ Other If yes, please explain: _____

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 Problem ◯ 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 above? ◯ Yes ◯ No _____

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 _____ DATE _____

SECTION 3

Dental History (Patient To Fill Out Completely)

Primary reason for this dental appointment: ☐ Examination ☐ Emergency ☐ Consultation

Date of your last dental visit_____ For what?_____

	Yes	No
Date of your last dental cleaning _____		
Do you have a specific dental problem? Describe_____	☐	☐
What kind of dental procedures have you had done in the past?_____	☐	☐
Do you have any sensitive teeth?_____	☐	☐
Have you ever had a toothache or a fractured tooth? _____	☐	☐
Have you ever had periodontal problems?_____	☐	☐
Do you like your smile? Why? _____	☐	☐
Does food catch between your teeth or do you have areas that are difficult to floss? _____	☐	☐
Does loss of teeth tend to run in your family?_____	☐	☐
Do you ever have clicking, popping or discomfort in the jaw joint? Do you brux or grind? _____	☐	☐
Have you ever had Orthodontics (Braces)? _____	☐	☐
Have your past experiences in a dental office always been positive? _____	☐	☐
Do you smoke or chew tobacco? Any sores or growths in your mouth? Describe_____	☐	☐
Name of previous dentist (Optional)_____	☐	☐
Why did you leave your last dentist? _____	☐	☐
Have you noticed spots or stains on your teeth that concern you? _____	☐	☐
Anything else that concerns you about the appearance of your teeth? _____	☐	☐

If you could change anything about your smile, what would you change?_____

_____

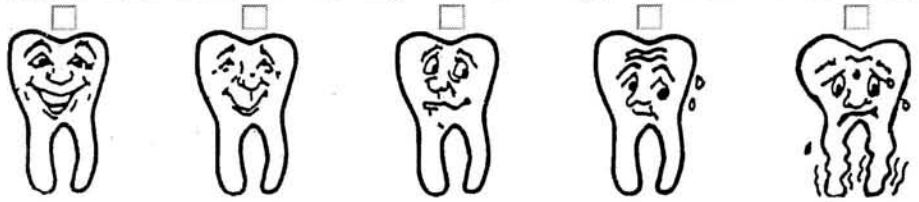
Do you have a denture or partial denture? ☐ No ☐ Yes How old are they?_____How do you like them? _____

_____

Have you ever required Nitrous Oxide (Laughing Gas) or sedatives for your dental treatment? _____ ☐ ☐

Check Your Level of Bravery: Don't Worry, We Cater To Cowards

☐ ☐ ☐ ☐ ☐



SECTION 4

Initial Clinical Exam (I.C.E.)

Date:_____ Patient Name:_____

Blood Pressure: _____ : _____

Stains:	☐No	☐Lt	☐Mod	☐Hvy	TMJ:	☐Asymptomatic	☐Symptoms:				
Calculus:	☐No	☐Lt	☐Mod	☐Hvy	Homecare: Brushing: ____ x/day			Floss: _____ x/week			
Plaque:	☐No	☐Lt	☐Mod	☐Hvy	Perio Diag:	☐Normal	☐Gingivitis	☐Early Perio	☐Mod Perio	☐Adv Perio	☐Maint
Bleeding:	☐No	☐Lt	☐Mod	☐Hvy	Instructions:	☐Brush	☐Floss	☐Perio Aid	☐Other:_____		
					Ortho: Occlusal Type:		☐CLI	☐CLII	☐CL III		

Soft Tissue Screening

Cancer Exam: ☐Normal ☐Lesion: Describe _____

See dental history for smoking history

	Normal	*Abnormal*	
Lips	☐	☐	_____
Mucosa	☐	☐	_____
Palate	☐	☐	_____
Tongue	☐	☐	_____
Floor	☐	☐	_____
Glands	☐	☐	_____
Pharynx	☐	☐	_____

Upper Right	Upper Anterior	Upper Left
Lower Right	Lower Anterior	Lower Left

Maximum Pocket Depth Per Sextant in mm

Recall: _____Months Doctor's Signature: Reviewed by: _____