

AFFORDABLE DENTAL NEW PATIENT FORM

PATIENT DETAILS

Name : _____
Last Name First Name Middle Name Title

Preferred Name : _____ Male Female

Address : _____ City : _____ State : _____ Zip : _____

SSN : _____ Date of Birth : _____

Home Phone : _____ Work Phone : _____

Cell Phone : _____ Email Address : _____

Employer : _____ Occupation : _____

Marital Status : Domestic Partner Single Married Divorced Widowed Separated

How did you hear about our office? _____

NOTE: We will contact you by Email and/or by Phone for appointment confirmation.

INSURANCE - Primary

Subscriber Name : _____ Relationship to Patient : _____ Subscriber DOB: _____

Subscriber SSN / ID : _____ Subscriber Employer : _____

Insurance Co. Name : _____

Insurance Co. Address : _____

Insurance Co. Phone : _____ Group Number : _____

INSURANCE - Secondary

Subscriber Name : _____ Relationship to Patient : _____ Subscriber DOB: _____

Subscriber SSN / ID : _____ Subscriber Employer : _____

Insurance Co. Name : _____

Insurance Co. Address : _____

Insurance Co. Phone : _____ Group Number : _____

ASSIGNMENT & RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Affordable Dental Care all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the Dentist to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature : _____
 Relationship : _____ Date : _____

CONSENT

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

Patient / Guardian Signature : _____

Patient Name : _____ Date of Birth : _____

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?	<input type="radio"/> Yes	<input type="radio"/> No	If Yes, Explain _____
Have you ever been hospitalized or had a major operation?	<input type="radio"/> Yes	<input type="radio"/> No	If Yes, Explain _____
Have you ever had a serious head or neck injury?	<input type="radio"/> Yes	<input type="radio"/> No	If Yes, Explain _____
Are you taking any medications, pills or drugs?	<input type="radio"/> Yes	<input type="radio"/> No	If Yes, Explain _____
Do you take, or have you taken, Phen-Fen or Redux?	<input type="radio"/> Yes	<input type="radio"/> No	
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	<input type="radio"/> Yes	<input type="radio"/> No	
Are you on a special diet?	<input type="radio"/> Yes	<input type="radio"/> No	
Do you use tobacco?	<input type="radio"/> Yes	<input type="radio"/> No	
Do you use controlled substances?	<input type="radio"/> Yes	<input type="radio"/> No	

Women:	Are you Pregnant / Trying to get pregnant?	Taking oral contraceptives?	Nursing?
	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No

Are you allergic to any of the following?

- Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal Latex Sulfa drugs
 Others - If yes, please explain _____

Do you have, or have you had, any of the following?

- | | | | |
|---|---|---|--|
| <input type="radio"/> AIDS / HIV Positive | <input type="radio"/> Cortisone Medicine | <input type="radio"/> Hemophilia | <input type="radio"/> Radiation Treatments |
| <input type="radio"/> Alzheimer's Disease | <input type="radio"/> Diabetes | <input type="radio"/> Hepatitis A | <input type="radio"/> Recent Weight Loss |
| <input type="radio"/> Anaphylaxis | <input type="radio"/> Drug Addiction | <input type="radio"/> Hepatitis B or C | <input type="radio"/> Renal Dialysis |
| <input type="radio"/> Anemia | <input type="radio"/> Easily Winded | <input type="radio"/> Herpes | <input type="radio"/> Rheumatic Fever |
| <input type="radio"/> Angina | <input type="radio"/> Emphysema | <input type="radio"/> High Blood Pressure | <input type="radio"/> Rheumatism |
| <input type="radio"/> Arthritis/Gout | <input type="radio"/> Epilepsy or Seizures | <input type="radio"/> High Cholesterol | <input type="radio"/> Scarlet Fever |
| <input type="radio"/> Artificial Heart Valve | <input type="radio"/> Excessive Bleeding | <input type="radio"/> Hives or Rash | <input type="radio"/> Shingles |
| <input type="radio"/> Artificial Joint | <input type="radio"/> Excessive Thirst | <input type="radio"/> Hypoglycemia | <input type="radio"/> Sickle Cell Disease |
| <input type="radio"/> Asthma | <input type="radio"/> Fainting Spells/Dizziness | <input type="radio"/> Irregular Heartbeat | <input type="radio"/> Sinus Trouble |
| <input type="radio"/> Blood Disease | <input type="radio"/> Frequent Cough | <input type="radio"/> Kidney Problems | <input type="radio"/> Spina Bifida |
| <input type="radio"/> Blood Transfusion | <input type="radio"/> Frequent Diarrhea | <input type="radio"/> Leukemia | <input type="radio"/> Stomach/Intestinal Disease |
| <input type="radio"/> Breathing Problem | <input type="radio"/> Frequent Headaches | <input type="radio"/> Liver Disease | <input type="radio"/> Stroke |
| <input type="radio"/> Bruise Easily | <input type="radio"/> Genital Herpes | <input type="radio"/> Low Blood Pressure | <input type="radio"/> Swelling of Limbs |
| <input type="radio"/> Cancer | <input type="radio"/> Glaucoma | <input type="radio"/> Lung Disease | <input type="radio"/> Thyroid Disease |
| <input type="radio"/> Chemotherapy | <input type="radio"/> Hay Fever | <input type="radio"/> Mitral Valve Prolapse | <input type="radio"/> Tonsilitis |
| <input type="radio"/> Chest Pains | <input type="radio"/> Heart Attack / Failure | <input type="radio"/> Osteoporosis | <input type="radio"/> Tuberculosis |
| <input type="radio"/> Cold Sores / Fever Blisters | <input type="radio"/> Heart Murmur | <input type="radio"/> Pain in Jaw Joints | <input type="radio"/> Tumors or Growths |
| <input type="radio"/> Congenital Heart Disorder | <input type="radio"/> Heart Pacemaker | <input type="radio"/> Parathyroid Disease | <input type="radio"/> Ulcers |
| <input type="radio"/> Convulsions | <input type="radio"/> Heart Trouble / Disease | <input type="radio"/> Psychiatric Care | <input type="radio"/> Veneral Disease |
| | | | <input type="radio"/> Yellow Jaundice |

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: _____

Patient Name : _____ Date of Birth : _____

FINANCIAL AGREEMENT

- For my convenience, this office may release my information to my insurance company and receive payment directly from them.
- I understand that I am responsible for my estimated portion of the treatment fees at the time that treatment is delivered.
- I understand that my dental insurance benefits are one form of payment that I am providing to this dental practice and that payment for the total cost of services delivered to me is ultimately my responsibility. This practice will make efforts to help me secure optimal reimbursement from my insurance plan. However, if the insurance carrier does not pay as expected, I am ultimately responsible for all fees charged.
- I understand that, due to the complexity of dental diagnosis, treatment plans sometimes change. I will be responsible for payment for the care that is actually delivered to me.
- In the case of returned checks or any other reversal of payment methods that I have provided to the practice, my account will be subject to a **\$30** processing fee.
- If I allow my account to become severely delinquent in payments, causing the practice to enlist the assistance of a collections agency, I agree to pay all related fees and court costs.
- Accounts not paid within **90 days** are subject to a **1.5%** monthly finance charge.
- Any unpaid insurance balance is assumed to be patient financial responsibility.

Signature : _____

Date : _____

NOTICE OF PRIVACY POLICIES

I have had full opportunity to read and consider the contents of the Notice of Privacy Practices. I understand that I am giving my permission to your use and disclosure of my protected health information in order to carry out treatment, payment activities and healthcare operations. I also understand that I have the right to revoke permission.

Signature : _____

Date : _____

MISSED APPOINTMENTS

I understand that this practice requires at least **48 hours** advance notice to cancel or reschedule my appointment. I also understand that, in the case that I miss an appointment, providing no or late (failing to inform the office at least **48 hours** in advance) cancellation, my account will be subject to a **\$25** charge.

Signature : _____

Date : _____

CONSENT OF SERVICES

I understand that the information that I have given is correct to the best of my knowledge. I hereby authorize the Dentist or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my dental needs. Upon such diagnosis, I authorize the Dentist to perform all recommended treatment mutually agreed upon and to employ such assistance as required to provide proper care. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications. I agree to be responsible for payment of all services rendered to me or my dependents. I understand payment is due at the time of service.

Signature : _____

Date : _____