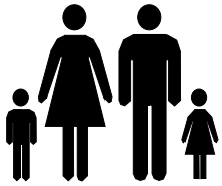
ADVANCED FAMILY DENTISTRY



PATIENT INFORMATION TODAYS DATE_____

NAME_____ SOC.SEC. #_____-_____-_____

ADDRESS_____

CITY_____STATE_____ZIP_____HOME PHONE_____

SEX____AGE_____BIRTHDATE_____-___-_____MARITAL STATUS_____

PATIENT EMPLOYED BY_____OCCUPATION_____

BUSINESS ADDRESS_____

BUS.PHONE_____CELL PHONE_____

IN CASE OF EMERGENCY WHO SHOULD WE CONTACT? _____

WHOM SHOULD WE THANK FOR REFFERING YOU TO OUR PRACTICE?
_____

PRIMARY INSURANCE

PERSON RESPONSIBLE FOR ACCOUNT_____

RELATION TO PATIENT_____BIRTHDATE____-___-____SS#____-___-_____

ADDRESS (IF DIFFERENT FROM PATIENTS) _____ _____

CITY_____STATE_____ZIP_____PHONE_____

PERSON RESPONSIBLE EMPLOYED BY_____OCCUPATION_____

BUSINESS ADDRESS_____BUS.PHONE_____

INSURANCE COMPANY_____GROUP #_____

NAME OF OTHER DEPENDENTS COVERED UNDER THIS PLAN_____
_____

DENTAL HISTORY

REASON FOR TODAY'S VISIT_____

FORMER DENTIST_____ADDRESS_____

DATE OF LAST DENTAL CARE_____REASON_____

PAST MAJOR DENTAL TREATMENT (SURGERY, BRACES, ETC) _____

HOW OFTEN DO YOU BRUSH? _____FLOSS_____

WHAT DID YOU LIKE MOST ABOUT ANY FORMER DENTAL OFFICE? _____

WHAT DID YOU LIKE LEAST ABOUT GOING TO THE DENTIST? _____

CHECK IF YOU HAVE HAD PROBLEMS WITH ANY OF THE FOLLOWING:

__BAD BREATH	__ GRINDING TEETH	__ SENSITIVE TO HOT OR COLD
__BLEEDING GUMS	__ BROKEN FILLINGS	__ SENSITIVE WHEN BITING
__SORE JAW	__ SORES IN MOUTH	__ SENSITIVE TO SWEETS

MEDICAL HISTORY

PHYSICIAN'S NAME_____ADDRESS_____

HAVE YOU HAD ANY SERIOUS ILLNESSES OR OPERATIONS? _____

DO YOU HAVE ANY MEDICAL CONDITIONS WE SHOULD KNOW ABOUT? _____

PLEASE CHECK IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING:

__ AIDS	__DIABETES	__LIVER DISEASE
__ANEMIA	__EPILEPSY	__MITRAL VALVE PROLAPSE
__ARTHRITIS, RHEUMATISM	__FAINTING	__PACEMAKER
__ARTIFICIAL HEART VALVES	__HEADACHES (MIGRANES)	__RADIATION TREATMENT
__ARTIFICIAL JOINTS	__HEART MURMUR	__RESPIRATORY DISEASE
__ASTHMA	__HEART PROBLEMS	__RHEUMATIC FEVER
__BLOOD DISEASE	__HEMOPHILIA	__SHORTNESS OF BREATH
__CANCER	__HEPATITIS (TYPE____)	__STROKE
__CHEMICAL DEPENDENCY	__HIGH BLOOD PRESSURE	__THYROID PROBLEMS
__CHEMOTHERAPY	__HIV POSITIVE	__TOBACCO HABIT
__CIRCULATORY PROBLEMS	__JAW PAIN	__TUBERCULOSIS
__CORTISONE TREATREMENTS	__KIDNEY DISEASE	__VENEREAL DISEASE

(WOMEN) ARE YOU PREGNANT? _____ NURSING? _____ TAKING BIRTH CONTROL PILLS? _____

MEDICATIONS (PLEASE LIST) _____

DRUG ALLERGIES_____

AUTHORIZATION

I AUTHORIZE MY INSURANCE COMPANY TO PAY TO THE DENTIST OR DENTAL GROUP ALL INSURANCE BENEFITS OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL INSURANCE SUBMISSIONS. I AUTHORIZE THE DENTIST TO RELEASE ALL INFORMATION NECESSARY TO SECRUE THE PAYMENT OF BENEFITS. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE.

I UNDERSTAND PAYMENT IS DUE AT TIME OF TREATMENT UNLESS PRIOR ARRANGEMENTS HAVE BEEN APPROVED.

SIGNATURE_____DATE_____

ADVANCED FAMILY DENTISTRY

OFFICE HOURS

We are open Monday - Thursday from 8:00 a.m. to 5:00 p.m. and Friday 7:00 a.m. to 2:00 p.m. with the exception of being closed for lunch from 1:00 - 2:00 p.m. Monday - Thursday.

INSURANCE

As a courtesy to our patients, we accept and can file most insurance claims for you. Insurance benefits are only estimates and the patient is ultimately responsible for any remaining balance.

ALTERNATIVE BENEFITS

Our doctors recommend treatment in the best interest of our patients. Many insurance companies have alternative benefits clauses that may affect your benefits and ultimately the final cost of your treatment plan. This is only an estimate of you benefits.

PAYMENT FOR SERVICES

Payment is expected at time of service unless other arrangements are made in advance. We accept cash, checks, all major credit cards and dental insurance. You are responsible for any charges that your insurance does not cover. If your insurance company does not pay us within 60 days, you will be responsible for the remaining balance. Accounts over 90 days overdue will be turned over to a collection agency. There is a $25 fee charged for all returned checks. In office financing - We use a PAC plan. We set up with your checking account an automatic monthly withdrawal over a 3-month period for treatment that costs over $1000.00. We require a 30% down payment; the balance is drafted from your checking account automatically on the date of each of month selected. For patients who wish to pay for treatment over an extended period of time, we offer a payment plan that is administered by an independent company.

BROKEN APPOINTMENTS AND LATE ARRIVALS

We require 24 hours notice if you need to change your appointment. You will be charged a $50 missed/broken appointment fee for all missed and or broken appointments. Broken appointments are those that have been cancelled with less than 24 hours notice. This fee is to cover expense of setting up the treatment room, sterilizing the instruments and having the staff idle when they could be treating another patient. To ensure that AFD is able to give our patients the greatest care possible in the timeliest manner, we reserve the right to cancel or reschedule any patient who is over 15 minutes late to their appointment.

DIVORCE DECREES

This office is NOT a party to your divorce decree. The legal guardian who accompanies the minor at the visit is responsible for payment.

INITIAL EXAMINATION

We require x-rays for your first examination. If you have current x-rays within the past year you will be responsible for obtaining your x-rays from your previous dentist, otherwise x-rays will be taken at that time.

INFECTION CONTROL

Our office meets all required federal and state infection control standards. All instruments are heat sterilized which kills TB spores, hepatitis, and the AIDS virus. Our dental unit water supply is self-contained, virtually eliminating the possibility of contaminated water lines.

This office policy is subject to change without notification.

I HAVE READ AND UNDERSTAND THESE SERVICES AND POLICIES

Signature _____ Date _____

Print Patient's Name _____