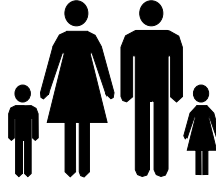


# ADVANCED FAMILY DENTISTRY



## 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:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> BAD BREATH    | <input type="checkbox"/> GRINDING TEETH  | <input type="checkbox"/> SENSITIVE TO HOT OR COLD |
| <input type="checkbox"/> BLEEDING GUMS | <input type="checkbox"/> BROKEN FILLINGS | <input type="checkbox"/> SENSITIVE WHEN BITING    |
| <input type="checkbox"/> SORE JAW      | <input type="checkbox"/> SORES IN MOUTH  | <input type="checkbox"/> 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:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> AIDS                    | <input type="checkbox"/> DIABETES               | <input type="checkbox"/> LIVER DISEASE         |
| <input type="checkbox"/> ANEMIA                  | <input type="checkbox"/> EPILEPSY               | <input type="checkbox"/> MITRAL VALVE PROLAPSE |
| <input type="checkbox"/> ARTHRITIS, RHEUMATISM   | <input type="checkbox"/> FAINTING               | <input type="checkbox"/> PACEMAKER             |
| <input type="checkbox"/> ARTIFICIAL HEART VALVES | <input type="checkbox"/> HEADACHES (MIGRANES)   | <input type="checkbox"/> RADIATION TREATMENT   |
| <input type="checkbox"/> ARTIFICIAL JOINTS       | <input type="checkbox"/> HEART MURMUR           | <input type="checkbox"/> RESPIRATORY DISEASE   |
| <input type="checkbox"/> ASTHMA                  | <input type="checkbox"/> HEART PROBLEMS         | <input type="checkbox"/> RHEUMATIC FEVER       |
| <input type="checkbox"/> BLOOD DISEASE           | <input type="checkbox"/> HEMOPHILIA             | <input type="checkbox"/> SHORTNESS OF BREATH   |
| <input type="checkbox"/> CANCER                  | <input type="checkbox"/> HEPATITIS (TYPE _____) | <input type="checkbox"/> STROKE                |
| <input type="checkbox"/> CHEMICAL DEPENDENCY     | <input type="checkbox"/> HIGH BLOOD PRESSURE    | <input type="checkbox"/> THYROID PROBLEMS      |
| <input type="checkbox"/> CHEMOTHERAPY            | <input type="checkbox"/> HIV POSITIVE           | <input type="checkbox"/> TOBACCO HABIT         |
| <input type="checkbox"/> CIRCULATORY PROBLEMS    | <input type="checkbox"/> JAW PAIN               | <input type="checkbox"/> TUBERCULOSIS          |
| <input type="checkbox"/> CORTISONE TREATMENTS    | <input type="checkbox"/> KIDNEY DISEASE         | <input type="checkbox"/> 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 SECURE 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 \_\_\_\_\_