

Employment Information

The following is for: the patient the person responsible for payment, Name: _____ Relationship _____

Employer Name: _____ Occupation: _____

Address: _____

The following is for: the patient's spouse the person responsible for payment, Name: _____ Relationship _____

Employer Name: _____ Occupation: _____

Address: _____

Street

City

State

Zip Code

Phone

Dental Insurance Information

Primary Insurance _____ Subscriber ID _____

Name of Primary Insured: _____ DOB: _____ Group # _____

Secondary Insurance: _____ Subscriber ID: _____

Name of Secondary Insured: _____ DOB: _____ Group # _____

Dental History

Do you have any current dental problems? Yes No If yes, please explain: _____

Yes No 1. Is this your first dental visit? If no, date of last complete dental examination. _____

Yes No 2. Are your teeth sensitive?

Yes No 3. Do your gums bleed or hurt?

Yes No 4. Have you noticed any loose teeth or change in your bite?

Yes No 5. Have you noticed any mouth odors or bad tastes?

Yes No 6. Does food tend to become caught between your teeth?

Yes No 7. Do you clench or grind your teeth?

Yes No 8. Have you ever had Orthodontic treatment?

Yes No 9. Have you ever seen a Periodontist?

Yes No 10. Has your bite ever been adjusted?

Yes No 11. Do you have clicking or popping in your jaw?

Yes No 12. Do you have difficulty opening or closing your mouth?

Yes No 13. Have you ever been told you have a TMJ problem?

Yes No 14. Do you get frequent headaches?

Yes No 15. Would you like to keep your teeth all your life?

Yes No 16. Have you ever had any complications following dental treatment? If yes, please explain _____

Yes No 17. Do you feel nervous about having dental treatment? If yes, what is your biggest concern? _____

Yes No 18. Have you ever had an upsetting dental experience? If yes, please describe _____

Yes No 19. Are you happy with the appearance of your teeth? If no, what would you like to change? _____

Consent for Services

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs and other diagnostic appropriate by doctor to make a thorough diagnosis.
2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies a certain risks. I understand that I can ask for a complete recital on any possible complication.
4. I agree to be responsible for payment of all services on my behalf or my dependants. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1 ½ % late charge (18% APR) may be added to my account.
5. I hereby give Dr. Pominville the absolute right and permission to use my photographs/slides for educational or promotional purposes. The undersigned completely and forever releases any right to present future compensation in connection with the use of said photographs/slides.

_____ Date: _____ Relationship to Patient: _____

Signature of patient, parent or guardian

ADVANCED DENTAL CARE
Dr. Sam Pominville
7626 N. State Street
Lowville, NY 13367
Phone: 315-376-3121
Fax: 315-376-8635

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, acknowledge that I have received a copy of Advanced Dental Care's notice of Privacy Practices. This Notice describes how Advanced Dental Care may use and disclose my protected dental information, certain restrictions on the use and disclosure of my dental information, and rights I may have regarding my protected dental information.

SIGNATURE (Patient or Parent/Guardian if Minor) RELATIONSHIP TO PATIENT DATE

I, _____, permit Advanced Dental Care to disclose my protected dental information to any of the following people listed below. I understand that this request will not expire until I revoke it in writing. If this patient is a minor, the following individuals may accompany my child to appointments in my absence.

Name of Individuals	Relationship
1. _____	_____
2. _____	_____
3. _____	_____

SIGNATURE (Patient or Parent/Guardian if Minor) RELATIONSHIP TO PATIENT DATE

Patient Authorization Update

AUTHORIZATION TO PAY BENEFITS TO DENTIST

I hereby authorize payments directly to the dentist of the dental benefits, if any, otherwise payable to me for his/her services as described, realizing I am responsible to pay non-covered services.

SIGNATURE (Patient or Parent/Guardian if Minor) RELATIONSHIP TO PATIENT DATE

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize the dentist to release any information acquired in the course of my treatment necessary to process insurance claims. I also authorize the release of any information to my current insurance company or third party contractor upon their request.

SIGNATURE (Patient or Parent/Guardian if Minor) RELATIONSHIP TO PATIENT DATE