ADVANCED
DENTISTRY
— Beyond Total Body Wellness —

Patient Name _____ Address w/Zip_____

Employer_____ Work Phone # _____

Home Phone # _____ Cell Phone # _____

Email _____ SSN _____

Primary Physician's Name_____ Physician Phone# _____

Marital Status_____ Date of Birth_____

Emergency Contact_____ Contact Phone #_____

Place a mark on "yes" or "no" to

AIDS/HIV	❑Yes	❑No	Heart Murmur	❑Yes	❑No	Tuberculosis	❑Yes	❑No
ANEMIA	❑Yes	❑No	Heart Problems	❑Yes	❑No	Tumor or growth on		
Arthritis, Rheumatism	❑Yes	❑No	Hepatitis Type _____	❑Yes	❑No	Head/Neck	❑Yes	❑No
Artificial Heart Valves	❑Yes	❑No	High Blood Pressure	❑Yes	❑No	Ulcer	❑Yes	❑No
Artificial Joints	❑Yes	❑No	Kidney Disease	❑Yes	❑No	Sleep Apnea	❑Yes	❑No
Asthma	❑Yes	❑No	Liver Disease	❑Yes	❑No			
Bleeding abnormally,	❑Yes	❑No	Mitral Valve Prolapse	❑Yes	❑No	Headaches	❑Yes	❑No
with extractions or surgery			Nervous Problems	❑Yes	❑No	Jaw Pain	❑Yes	❑No
Blood Disease	❑Yes	❑No	Pacemaker	❑Yes	❑No	Jaw Popping	❑Yes	❑No
Cancer	❑Yes	❑No	Psychiatric Care	❑Yes	❑No	Limited Opening	❑Yes	❑No
Chemotherapy	❑Yes	❑No	Radiation Treatment	❑Yes	❑No	Congested Ears	❑Yes	❑No
Circulatory Problems	❑Yes	❑No	Rheumatic Fever	❑Yes	❑No	Dizziness	❑Yes	❑No
Cortisone Treatments	❑Yes	❑No	Scarlet Fever	❑Yes	❑No	Ringing Ears	❑Yes	❑No
Cough, persistent	❑Yes	❑No	Sinus Trouble	❑Yes	❑No	Posture Problems	❑Yes	❑No
Diabetes	❑Yes	❑No	Stroke	❑Yes	❑No	Clenching	❑Yes	❑No
Epilepsy	❑Yes	❑No	Swollen Feet or Ankles	❑Yes	❑No	Grinding	❑Yes	❑No
Fainting or dizziness	❑Yes	❑No	Swollen Neck Glands	❑Yes	❑No	Facial Pain	❑Yes	❑No
Glaucoma	❑Yes	❑No	Thyroid Problems	❑Yes	❑No	Neck Ache	❑Yes	❑No
Heart Lesions	❑Yes	❑No	Tonsillitis	❑Yes	❑No	Bell's palsy	❑Yes	❑No

List any medications you are currently taking: Please include any blood thinning medications or aspirin?

_____

_____

Are you allergic to any medications or other substances?

_____

_____

Circle if you have seen: an Orthodontist -had your bite adjusted- had any bite related treatment - TMJ Joint Surgery

Have you taken or currently taking medications for osteoporosis known as bisphosphonates for example Fosamax, Actonel, or Boniva?

____yes ____no List Medication _____

Circle if you have seen any of the following healthcare professionals: ENT, Neurologist, Chiropractor, or Massage Therapist.

Do you snore, use a CPAP or have had a sleep study?

_____yes _____no

Have you ever had radiation to the head and/or neck?

_____ yes _____ no

Do you use tobacco products? _____yes _____no

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Signature: _____ Date: _____

Patient's Employment Information

Employer Name: _____ Occupation: _____

Address: _____

_____

Insurance Information

Primary

Name of *Insured*: _____ is insured a patient? ☐ Yes ☐ No
(Last / First / MI)

Insured's Birth Date: _____ Social Security #: _____ Group #: _____

Insured's Address: _____
(Street / City / State / Zip Code)

Insured's Employer Name: _____

Address: _____
(Street / City / State / Zip Code)

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Additional Insurance

Name of Insured: _____ is insured a patient? ☐ Yes ☐ No
(Last / First / MI)

Insured's Birth Date: _____ Social Secruity #: _____ Group #: _____

Insured's Address: _____
(Street / City / State / Zip Code)

Insured's Employer Name: _____

Address: _____
(Street / City / State / Zip Code)

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed. A minimum charge will be made for failed or cancelled appointment without prior notification of 48 hours. This fee covers only a portion of the overhead such as salaries, electric, heat, etc., which still has to be paid whether you are present or not. Once an appointment is made, please remember this time has been reserved for you.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

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

_____

Please print your name here

_____

Signature

_____

Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement.
- ☐ We weren't able to communicate with the patient.
- ☐ Other *(Please provide specific details)*

_____

_____

_____

_____ _____

Employee signature *Date*