## **AFFORDABLE DENTURES & IMPLANTS**°

Last Name:	First Name:
Middle Initial: Preferred Name:	
Gender: □ Male □ Female □ Other	Marital Status: □ Married □ Divorced □Single □ Widowed
Date Of Birth:/	Social Security:
Address:	City, State, Zip:
E-Mail:	Home Phone:
Cell Phone:	Work Phone:
Employer:	
How did you first hear about us (check one)?: □ Fr	iend/Family □ TV □ Drive-By □ Newspaper/Mail □ Internet
□ Billboard □ Phonebook □ Other	
If a friend or family member referred you, whom ma	y we thank?
Emergency Contact Information	
Emergency Contact:	Contact Phone:
General purpose of your visit:	
Please Continue This Form Only If You Have I	nsurance
PRIMARY INSURANCE INFORMATION	
Insurance Company:	
Policy Holder Name:	Social Security:
Policy Holder's DOB://	Policy Holder's Employer:
Relationship to Patient:   Self   Spouse   Child	□ Other
CECONDARY INCLIDANCE INFORMATION	
SECONDARY INSURANCE INFORMATION	
Insurance Company:	
Policy Holder Name:	Social Security:
Policy Holder's DOB://	Policy Holder's Employer:
Relationship to Patient:   Self   Spouse   Child	□ Other

## Medical History

			u had, any o								DV =
AIDS/HIV Positiv Alzheirmers			Cortisone Medicati		□Yes □ No					o Radiation Treatment	□Yes □
Anaphylaxis			Drug Addiction	-	□Yes □ No			_		o Recent Weight Loss o Renal Dialysis	□Yes □
Anemia			Easily Winded				lood Press	_		o Rheumatic Fever	□Yes □
Angina			Emphysema		□Yes □ No			_		o Rheumatism	□Yes □
Arthritis/Gout		□Yes □ No	Epilepsy or Seizure		□Yes □ No		holesterol			o Scarlet Fever	□Yes □
Artificial Heart \			Excessive Bleeding		□Yes □ No					o Shingles	□Yes □
Artificial Joint			Excessive Thirst		□Yes □ No		lycemia		⊒Yes □ N	o Sickle Cell Disease	□Yes □
Asthma		□Yes □ No	Fainting Spells/Diz	ziness	□Yes □ No		ar Heartbe	_		o Sinus Trouble	□Yes □
		Frequent Coughs		□Yes □ No	Kidney Problems		C	⊒Yes □ N	o Stomach/Intestinal Diseas	e □Yes □	
Blood Transfusio	on	□Yes □ No	Frequent Diarrhea		□Yes □ No	Leuken	nia	C	⊒Yes □ N	o Stroke	□Yes □
Breathing Probl	ems	□Yes □ No	Frequent Headach	es	□Yes □ No	Liver D	isease		⊒Yes 🗅 N	o Swelling of Limbs	□Yes □
Bruise Easily		□Yes □ No	Genital Herpes		□Yes □ No	Low Blo	ood Pressu	re [	⊒Yes 🗖 N	o Thyroid Disease	□Yes □
Cancer		□Yes □ No	Glaucoma		□Yes □ No	Lung D	isease	C	⊒Yes 🗖 N	o Tonsillitis	□Yes □
Chemotherapy		□Yes □ No	Hay Fever		□Yes □ No	Mitral \	Valve Prolo	pse 🛭	⊒Yes 🗖 N	o Tuberculosis	□Yes □
Chest Pains		□Yes □ No	Heart Attack/Failur	re	□Yes □ No	Osteop	orosis		⊒Yes □ N	o Tumors/Growths	□Yes □
Cold Sores/Feve			Heart Murmur		□Yes □ No		•	_		o Ulcers	□Yes □
Congenital Hea	rt Disorder		Heart Pacemaker		□Yes □ No		yroid Dised	_		o Venereal Disease	□Yes □
Convulsions		□Yes □ No	Heart Trouble/Dise	ease	□Yes □ No	Psychic	atric Care		⊒Yes 🗖 N	o Yellow Jaundice	□Yes □
Dental Hi											
Dry Mouth					No Orth			_		Sensitive Teeth	□Yes □
Grinding Teeth	□Yes □ No	Loose Teet	h or Broke Fillings	□Yes □	⊒ No  Mou	th Breath	ing	□Ye:	s 🗖 No	Sores or growth in your mout	າ  □Yes 🏻
re you allergio	J	0 ,	rying to get Pregna	ant 🗆	If Yes Plea Nursing Codeine	_		tracep	ptives	□ NONE	
are you allergions Aspirin Metals: Gold,	c to any of t	he followin	rying to get Pregnag?  □ Penicillin □ Latex	ant 🗆	Nursing Codeine Gulfa Drugs	_ ⊒Taking	Oral Con  Acrylic Local A	nesthe	etics	□ Other	
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Date:\_\_\_\_

Signature of Patient, Parent, or Guardian: X\_\_\_\_\_

## **Financial Understanding Agreement** Patient's Printed Name Thank you for choosing our office. We appreciate you. We want to delight you with our service. Part of our service must deal with communicating your financial responsibilities. That is the purpose of this form. **PAYMENT AND INSURANCE IN GENERAL** Professional services are rendered on a cash or cash equivalent basis only and payment is due in full at the time services are rendered. Debit and most credit cards are accepted. With approved credit, patients may be eligible for third-party financing which entitles patients to a revolving charge account upon approval of the application. We file most major insurance forms with the understanding that you, the Patient, assign your rights to the insurance benefits to us in full but we require that patients pay their estimated amount towards the total cost at the start of treatment. Please remember that all professional services are rendered to the patient and not to the insurance company. The patient is ultimately responsible for the total charges regardless of insurance filing or insurance company involvement. **CERTAIN INSURANCE PATIENTS** I understand that I may elect to purchase a denture(s) or other enhanced category of dental services that is priced above out of my own pocket since my insurance will only cover \$ what my insurance will bear. I agree to pay \$ of my denture(s) or other enhanced category of dental services. I want the enhanced value (warranty/tooth upgrade) associated with the enhanced offering and I am willing to pay out of my pocket for it. Patient Initials HALF (1/2) DOWN PAYMENT, IF APPLICABLE I, the Patient, understand that if the services rendered to me consist of partial dentures or crowns / bridges (and full dentures too in certain longer term scenarios) then I will be required to pay half (1/2) of the total unit price for each item at the time of impression. For example, if I am scheduled to get a seven hundred dollar (\$700.00) crown, I will pay three hundred and fifty dollars (\$350.00) at the time an impression is taken in my mouth. From that impression, my actual crown will be made. The same policy applies for the other services listed above. The half (1/2) payment serves to help cover some of the costs of the impression taking and the crown or other dental prosthetic creation time (labor), materials, and overhead. This amount is what I will pay at the impression taking time regardless of any insurance coverage I have. Should I fail to return for the placement of the crown or other item (e.g. partial denture, bridge or full denture), then I realize and agree that the half (1/2) payment shall serve as a payment in full for the costs mentioned in the paragraph above and that I shall have no claim to the return of that money. If my return for the final crown or other item seating is delayed by me, I understand that the fit might not be adequate any longer as structures in my mouth can shift over time. In such a case, I might have to pay for new impressions to be made or for a new dental appliance to be made or both. In that case, I will have to pay half (1/2) of the total price again for each new item at the time of impression. If I return as scheduled, I will receive my crown or other item(s) and I shall at that time owe the other half (1/2) payment whether by cash, credit card, check (if allowed), third-party financing (if pre-approved or insurance). **BAD CHECK FEE AND NO SHOW** At the office's sole discretion, the office may assess a bad check fee of twenty-five dollars (\$25.00) for any check that is returned for insufficient fund (NSF) or for stop payment or which is returned unpaid for any other reason. The office may assess a no show fee of fifty dollars (\$50.00) for any appointment that is scheduled but missed by a patient for reasons other than the office's closure for weather.

Date of Signature

Signature of Patient or Patient's Legal Guardian

## HIPAA OMNIBUS RULE PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.

Date:	
The undersigned acknowledges receipt of a copy A copy of this signed, dated document shall be as	of the currently effective Notice of Privacy Practices for this healthcare facility. effective as the original.
	CTED HEALTH INFORMATION DOCUMENT RELEASE SHOULD I REQUEST THER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.
Please print name of Patient	Signature of Patient or Patient's Legal Guardian
Legal Representative / Guardian	Relationship of Legal Representative / Guardian
Your comments regarding Acknowledgements or 0	Consents:
We will address you by your first name unless you ent name please indicate here:	u specify otherwise. If you prefer to be summoned from the reception area by a differ-
□ Other	-
PLEASE LIST ANY OTHER PARTIES WHO CAN HA	AVE ACCESS TO YOUR HEALTH INFORMATION:
	care takers who can have access to this patient's records):
Name:	Relationship:
Name:	Relationship:
I authorize this office to contact me in order to co	onfirm my appointments, advise of special services, treatment and billing informa-
services to promote your improved health. This of	form, you acknowledge and authorize, that this office may recommend products or office may or may not receive third party remuneration from these affiliated companies. you this information with your knowledge and consent.
Office Use Only	
As Privacy Officer, I attempted to obtain the patier	nt's (or representatives) signature on this Acknowledgement but did not because:
□ It was emergency treatment	
□ I could not communicate with the patient	
□ The patient refused to sign	
The patient was unable to sign because:	
Other (please describe)	

Signature of Privacy Officer