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: _____

Physical Address: _____ City, State, Zip: _____

Mailing Address: _____ City, State, Zip: _____

E-Mail: _____ Home Phone: _____

Cell Phone: _____ Work Phone: _____

Employer: _____

Preferred Pharmacy: _____ Address:_____

Preferred Pharmacy Phone: _____

How did you first hear about us (check one)?: □ Friend/Family □ TV □ Drive-By □ Newspaper/Mail □ Internet

□ Billboard □ Phonebook □ Other_____

If a friend or family member referred you, whom may we thank? _____

Emergency Contact Information

Emergency Contact: _____ Contact Phone: _____

General purpose of your visit: _____

Please Continue This Form Only If You Have Insurance

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 _____

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

Do you have, or have you had, any of the following?

AIDS/HIV Positive	☐ Yes ☐ No	Cortisone Medicine	☐ Yes ☐ No	Hemophilia	☐ Yes ☐ No	Radiation Treatments	☐ Yes ☐ No
Alzheimer's Disease	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Hepatitis A or B	☐ Yes ☐ No	Recent Weight Loss	☐ Yes ☐ No
Anaphylaxis	☐ Yes ☐ No	Drug Addiction	☐ Yes ☐ No	Hepatitis C	☐ Yes ☐ No	Renal Dialysis	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Easily Winded	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Angina	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Rheumatism	☐ Yes ☐ No
Arthritis/Gout	☐ Yes ☐ No	Epilepsy or Seizures	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Artificial Heart Valve	☐ Yes ☐ No	Excessive Bleeding	☐ Yes ☐ No	Hives or Rash	☐ Yes ☐ No	Shingles	☐ Yes ☐ No
Artificial Joint	☐ Yes ☐ No	Excessive Thirst	☐ Yes ☐ No	Hypoglycemia	☐ Yes ☐ No	Sickle Cell Disease	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Fainting Spells/Dizziness	☐ Yes ☐ No	Irregular Heartbeat	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No
Blood Disease	☐ Yes ☐ No	Frequent Cough	☐ Yes ☐ No	Kidney Problems	☐ Yes ☐ No	Stomach/Intestinal Disease	☐ Yes ☐ No
Blood Transfusion	☐ Yes ☐ No	Frequent Diarrhea	☐ Yes ☐ No	Leukemia	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Breathing Problems	☐ Yes ☐ No	Frequent Headaches	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Swelling of Limbs	☐ Yes ☐ No
Bruise Easily	☐ Yes ☐ No	Genital Herpes	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No	Thyroid Disease	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Lung Disease	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Chemotherapy	☐ Yes ☐ No	Hay Fever	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Chest Pains	☐ Yes ☐ No	Heart Attack/Failure	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No	Tumors/Growths	☐ Yes ☐ No
Cold Sores/Fever Blisters	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Pain in Jaw Joints	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Congenital Heart Disorder	☐ Yes ☐ No	Heart Pacemaker	☐ Yes ☐ No	Parathyroid Disease	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
Convulsions	☐ Yes ☐ No	Heart Trouble/Disease	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No	Yellow Jaundice	☐ Yes ☐ No

Have you ever had an illness not listed above? ☐ Yes ☐ No If yes, please explain: _____

Women: Are you? ☐ Pregnant/Trying to get pregnant ☐ Nursing ☐ Taking oral contraceptives

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic	☐ None
☐ Metals: Gold, Titanium, Mercury	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics	☐ Other _____

Although dental professionals primarily treat the area in and around your mouth, your mouth is a part of your entire body of course. Therefore, health problems that you may have, or substances that you may be ingesting are very likely to have an important interrelationship with the dental services you will receive. Thank you for answering the following questions.

Please answer the following questions? Use the back of this form if needed.

1. Are you under a physician's care now and/or do you have sleep apnea or snoring?	☐ Yes ☐ No	If yes, please explain: _____
2. Have you ever been hospitalized or had a major operation?	☐ Yes ☐ No	If yes, please explain: _____
3. Have you ever had a problem with tooth extractions of any kind?	☐ Yes ☐ No	If yes, please explain: _____
4. Have you ever had a serious head/neck injury or head/neck radiation?	☐ Yes ☐ No	If yes, please explain: _____
5. Are you taking any medications, health supplements or controlled substances?	☐ Yes ☐ No	If yes, please explain: _____
6. Have you ever taken or are you currently taking Phen-Fen or Redux? (prescribed for weight loss usually)	☐ Yes ☐ No	If yes, please explain: _____
7. Have you ever taken or are you currently taking Fosamax, Boniva, Actonel, Reclast, Zometa, Prolia or any other medications called bisphosphonates? (prescribed for osteoporosis usually)	☐ Yes ☐ No	If yes, please explain: _____
8. Have you ever taken or are you currently taking blood thinners including but not limited to aspirin, Coumadin or Plavix?	☐ Yes ☐ No	If yes, please explain: _____
9. Have you ever taken or are you currently taking Selective Serotonin Re-Uptake Inhibitors (SSRIs) for depression or otherwise?	☐ Yes ☐ No	If yes, please explain: _____
10. Do you use tobacco in any form (smoking/e-vape, chew, pouches, etc.)?	☐ Yes ☐ No	If yes, please explain: _____
11. Do you have diabetes or are you on any special diet of any kind?	☐ Yes ☐ No	If yes, please explain: _____
12. Do you currently wear a full or partial denture? If you answered yes, please tell us how old it is.	☐ Yes ☐ No	If yes, please explain: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian: X _____ **Date:**_____/_____/_____

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 what my insurance will bear. I agree to pay $_____ out of my own pocket since my insurance will only cover $ _____ 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.

_____ _____

Signature of Patient or Patient's Legal Guardian Date of Signature

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 of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PROTECTED HEALTH INFORMATION DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER 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 Consents: _____

_____

We will address you by your first name unless you specify otherwise. If you prefer to be summoned from the reception area by a different name please indicate here:

□ Other _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:

(This includes spouses, friends, relatives and any 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 confirm my appointments, advise of special services, treatment and billing information.

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As Privacy Officer, I attempted to obtain the patient'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