ADVANCED DENTAL ARTS

CANCELLATION POLICY

24 HOURS NOTICE IS REQUIRED FOR ALL CANCELLATIONS! A $30 BROKEN APPOINTMENT FEE WILL BE CHARGED TO ALL ACCOUNTS WITH LESS THAN 24 HOURS NOTICE AND FOR ALL NO SHOWS!

OFFICE PAYMENT POLICY

The following is an outline of our office payment policies. Please acquaint yourself with them and then sign below to acknowledge your understanding and acceptance of them.

FEES

Please feel free to discuss our fees with us at any time. Before any dental treatment begins, the patient and/or responsible party will receive a consultation regarding treatment plan and cost. We attempt to keep our fees at a fair level that reflects the quality of care provided in our office. Prompt payment will enable us to keep our fees lower for everyone; therefore, **payment is due at the time services are rendered**. For procedures that take multiple appointments to complete, payment may be split up over the number of appointments required, however **full payment must be remitted before delivery of final restoration or appliance.**

We accept cash, check (returned check fee $20), Visa, MasterCard, and American Express.

INSURANCE

As a courtesy to our patients with insurance, we will file your insurance claim for you. We are currently in network with MetLife and Delta Dental. Please remember that the contract is between you and your insurance company, and **your total balance in our office is always your responsibility**. We have no way to guarantee the actual terms of your insurance policy. The insurance payment may not cover the fee charged in office. Disputes regarding reimbursement or the amount of reimbursement are between you and your insurance carrier.

PAST DUE ACCOUNTS

Account aging begins the day your charges are incurred. Accounts that are ninety days past due will be turned over to a third party collection agency. This action will cause an additional fee of 45% of your unpaid balance to be added to your account. We dislike doing this and will do so only if all other efforts to collect your unpaid balance have failed. Once an account is turned over to collections, we will ask you to seek the services of another dentist and will no longer take responsibility for your family's dental care.

By signing below, I understand the above policy:

_____ _____

Signature Date

4705 NORTHSIDE DRIVE, SUITE 100
MACON, GA 31210

I, _____, consent to be a patient at the above named office and agree to a radiographic and clinical examination. **I also understand and consent to the following:**

1. During the course of treatment, I may undergo procedures in all phases of dentistry including periodontics (gum treatment and surgery), oral surgery, endodontics (root canals), fixed and removable prosthodontics (crowns, bridges, and dentures), implant dentistry, restorative dentistry, temporomandibular disorder treatment, sleep apnea treatment, oral pathology, pediatric dentistry, and radiography.

2. I will provide a thorough and complete medical history, supply a full list of my medications with dosages, and consent to my dentist communicating with my other medical practitioners to inquire about any aspect of my health history.

3. No guarantees can be made about treatment outcomes, restoration longevity, or prognoses. I understand that any branch of medicine, including dentistry, can involve unanticipated results.

4. I will pay in full any cost of treatment or insurance copayments according to the office's financial policy. I understand that even if an insurance pre-estimate is given or a procedure has been preapproved, I am responsible for *any* costs that my insurance does not cover.

5. My treatment plan may change at any time and I will do my best to approach my dental care with optimism and open communication with my dentist, hygienist, and dental office staff.

6. I am welcome to ask questions about any aspects of my dental care and will request information if I am confused or need more information. I am responsible for clarifying any aspects of my treatment that I am unsure about.

_____ _____

Patient or Guardian Name Date

_____ _____

Witness Date

ADVANCED DENTAL ARTS

First Name: _____ Last Name: _____ Middle Initial: _____

Patient Is: ☐ Policy Holder ☐ Responsible Party ☐ Student Preferred Name: _____

Patient Information

Address: _____

City: _____ State/Zip : _____ / _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cell Phone: _____

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birthdate: ___/___/_____ Age: ____ Soc. Sec. #: _____ Drivers Lic: _____

E-Mail: _____

Emergency Contact: _____ *Emergency Contact Number:* _____

Responsible Party (*Primary Policy Holder*)

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____

City: _____ State/Zip : _____ / _____ Relationship to Patient: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cell Phone: _____

Birthdate: ____/____/_____ Soc. Sec. #: _____ Drivers Lic: _____

Primary Insurance Information (*Policy Holder*)

Name of Insured: _____

Insured Soc. Sec.: _____

Employer: _____

Address: _____

City, State, Zip: _____

Policy # or SSN #: _____

Relationship to Insured: Self Spouse Child Other

Insured Birth Date: _____

Insurance Company: _____

Address: _____

City, State, Zip: _____

Group #: _____

How Did You Hear About Us?

☐ Another Patient _____

☐ Drove By ☐ Yellow Pages ☐ Google

☐ Our Website ☐ Advertisement ☐ Insurance

☐ Other _____

Previous Dentist: _____

Medical Doctor: _____

Please List any Dental Concerns: _____

_____

_____

Medical History

Patient Name _____ Birth Date_____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Circle One

Are you under a physician's care now?	Yes	No	If yes, please explain: _____
Have you ever been hospitalized or had a major operation?	Yes	No	If yes, please explain: _____
Have you ever had a serious head or neck injury?	Yes	No	If yes, please explain: _____
Are you taking any medications, pills, or drugs?	Yes	No	If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux?	Yes	No	If yes, please explain: _____
Are you on a special diet?	Yes	No	If yes, please explain: _____
Do you use tobacco?	Yes	No	
Do you use controlled substances?	Yes	No	

Women: Are you:
Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa Drugs

☐ Other If yes, please explain: _____

_____

Please list all medications you are currently taking along with the dosage: _____

_____

_____

_____

Do you have, or have you had, any of the following? ***(Check all that apply)***

- ☐ Aids/Hiv Positive
- ☐ Alzheimer's Disease
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis/Gout
- ☐ Artificial Joint
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Breathing Problem
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Chest Pains
- ☐ Cold Sores/Fever Blisters
- ☐ Congenital Heart Disorder
- ☐ Convulsions
- ☐ Cortisone Medicine
- ☐ Diabetes
- ☐ Drug Addiction
- ☐ Easily Winded
- ☐ Emphysema
- ☐ Epilepsy or Seizures
- ☐ Excessive Bleeding
- ☐ Excessive Thirst
- ☐ Fainting Spells/Dizziness
- ☐ Frequent Cough
- ☐ Frequent Headaches
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Heart Attack/Failure
- ☐ Heart Murmur
- ☐ Heart Pacemaker
- ☐ Heart Trouble/Disease
- ☐ Hemophilia
- ☐ Hepatitis A
- ☐ Hepatitis B or C
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hives or Rash
- ☐ Hypoglycemia
- ☐ Irregular Heartbeat
- ☐ Kidney Problems
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lung Disease
- ☐ Mitral Valve Prolapse
- ☐ Osteoporosis
- ☐ Pain in Jaw Joints
- ☐ Parathyroid Disease
- ☐ Psychiatric Care
- ☐ Radiation Treatments
- ☐ Recent Weight Loss
- ☐ Renal Dialysis
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Scarlet Fever
- ☐ Sickle Cell Disease
- ☐ Sinus Trouble
- ☐ Stomach/Intestinal Disease
- ☐ Stroke
- ☐ Swelling of Limbs
- ☐ Thyroid Disease
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumors or Growths
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Yellow Jaundice

Dental History

Date of Last Cleaning:_____ Reason for this visit: _____

- Have you ever had any complications following dental treatment? Yes No
  If yes, please explain: _____
- Do your gums bleed? Yes No
- Are you concerned about your breath? Yes No
- Do you have any sores or lumps in or near your mouth? Yes No If yes,
  where_____

Do you have or have you ever had any of the following? ***(Check all that apply)***

- ☐ Soreness when chewing
- ☐ Difficulty in opening or closing your mouth
- ☐ Clenching or grinding your teeth
- ☐ Gag easily
- ☐ Frequent headaches
- ☐ Pain in jaw joints
- ☐ Periodontal treatment

Do you prefer to save your teeth? Yes No

How often do you brush? _____ Floss? _____

Are you interested in aesthetic dental work to improve your smile? Yes No

Are you interested and/or considering dental implants? Yes No / Do you wear a denture? Yes No

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We accept cash, check (returned check fee $20), Visa, MasterCard, and American Express.

INSURANCE ASSIGNMENT AND RELEASE

As a courtesy to our patients with insurance, we will file your insurance claim for you. I understand that the assignment of my insurance benefits will be sent directly to Advanced Dental Arts for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Advanced Dental Arts may use my health care information and may disclose such information to secure my insurance reimbursement.

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By signing below, I understand the above policy:

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ **Date** _____

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 _____ **Date** _____