ADVANCED DENTAL ARTS

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

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 their treatment plan and its 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, checks (returned check fee $30), Visa, MasterCard, and American Express.

INSURANCE

As a courtesy to our patients with insurance, we will file your insurance claim for you. Please remember that the contract is between you and your insurance company, and **your total balance in our office is always your responsibility. It is also your responsibility to know the coverage benefits of your insurance policy.** We are happy to estimate your benefits, but we have no way to guarantee the actual terms of your insurance policy. The insurance payment may not cover the fee charges in the 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. 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.

CANCELLATION POLICY

Please provide at least 24-hour notice for cancellations and rescheduling. To ensure timely care and minimize wait times, our office requires confirmation for all scheduled appointments. If we do not receive confirmation from you within 24 hours of your appointment, it is our policy to cancel the appointment and offer the time slot to another patient.

_____ _____

Signature Date

ADVANCED DENTAL ARTS

CONSENT FOR TREATMENT

I consent to the dental procedures deemed necessary or advisable by the dentist for diagnosis and treatment. During 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. I understand that I may ask questions about any aspects of my dental care. I understand that no guarantee can be made regarding treatment results, restoration longevity, or prognoses and that any branch of medicine, including dentistry, can involve unanticipated results.

_____ _____

Signature Date

HIPAA PRIVACY STATEMENT

We are required by law to maintain the privacy of your health information and to provide you with this notice of our legal duties and privacy practices. We use your health information for treatment, to obtain payment for treatment, and for administrative purposes. We will not use or disclose your information without your written authorization, except as described in this notice or as required by law.

A full copy of our Privacy Policy is available upon request.

I acknowledge I have received or been offered a copy of the Notice of Privacy Practices.

☐ Yes

_____ _____

Signature Date

AUTHORIZATION TO RELEASE INFORMATION

I authorize Advanced Dental Arts to release any medical or dental information necessary to process my insurance claims or to communicate with other healthcare providers involved in my care. I understand this authorization may be revoked in writing at any time, except to the extent that action has already been taken.

I authorize the release of my dental information as outlined above.

_____ _____

Signature Date

For Office Use Only:

☐ Individual refused to sign HIPAA Privacy Statement. Reason: _____

ADVANCED DENTAL ARTS

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

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

Patient Information

Address: _____

City: _____ State/Zip : _____ / _____

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

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 (*Only if Patient is a Minor*)

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 DOB: _____

Insured Soc. Sec.: _____

Employer: _____

Relationship to Insured: Self Spouse Child Other

Insurance Company: _____

Address: _____

City, State, Zip: _____

Group #: _____

How Did You Hear About Us?

☐ Another Patient _____

☐ Drove By ☐ Yelp ☐ Google ☐ Facebook

☐ 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 dental treatment 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: _____
Do you take, or have you taken, bisphosphonates?	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)***

Allergy Problems
- ☐ Asthma
- ☐ Hay Fever
- ☐ Sinus Trouble

Blood Problems
- ☐ Anemia
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Bruise Easily
- ☐ Excessive Bleeding
- ☐ Hemophilia
- ☐ Sickle Cell Disease

Bone or Joint Problems
- ☐ Arthritis
- ☐ Artificial Joint
- ☐ Osteoporosis

Cancer Problems
- ☐ Chemotherapy
- ☐ Leukemia
- ☐ Radiation Treatments
- ☐ Tumors or Growths

Heart Problems
- ☐ Angina or Chest Pain
- ☐ Congenital Heart Disorder
- ☐ Heart Attack or Failure
- ☐ Heart Murmur
- ☐ Heart Pacemaker
- ☐ Heart Trouble/Disease
- ☐ High Blood Pressure
- ☐ Irregular Heartbeat
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Rheumatic Fever

Liver or Kidney Problems
- ☐ Cirrhosis
- ☐ Hepatitis A
- ☐ Hepatitis B or C
- ☐ Kidney Failure
- ☐ Liver Disease
- ☐ PKD
- ☐ Renal Dialysis
- ☐ Yellow Jaundice

Lung Problems
- ☐ Breathing Problem
- ☐ Easily Winded
- ☐ Emphysema
- ☐ Frequent Cough
- ☐ Lung Disease
- ☐ Tuberculosis

Other Problems
- ☐ Recent Weight Gain or Loss
- ☐ Ulcers
- ☐ AIDS or HIV Positive
- ☐ Alzheimer's Disease
- ☐ Anaphylaxis
- ☐ Cold Sores or Fever Blisters
- ☐ Convulsions
- ☐ Cortisone Medicine
- ☐ Diabetes
- ☐ Drug Addiction
- ☐ Epilepsy or Seizures
- ☐ Excessive Thirst
- ☐ Fainting Spells/Dizziness
- ☐ Frequent Headaches
- ☐ Glaucoma
- ☐ Gout
- ☐ Herpes
- ☐ High Cholesterol
- ☐ Hives or Rash
- ☐ Hypoglycemia
- ☐ Parathyroid Disease
- ☐ Psychiatric Care
- ☐ Rheumatism
- ☐ Scarlet Fever
- ☐ Stomach/Intestinal Disease
- ☐ Stroke
- ☐ Swelling of Limbs
- ☐ Thyroid Disease
- ☐ Tonsillitis
- ☐ Venereal Disease

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 any planned surgeries or treatments? ☐ Yes ☐ No

If yes, please explain: _____

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

AUTHORIZATION FOR RELEASE OF DENTAL INFORMATION

PATIENT NAME _____ **DATE OF BIRTH _____/_____/_____**

I, the undersigned, authorize Advanced Dental Arts to release my dental and medical information to the following person(s). This includes appointment details, diagnoses, treatment plans, billing information, and any other information related to my dental care.

NAME	RELATIONSHIP	PHONE NUMBER

PATIENT ACKNOWLEDGEMENT AND SIGNATURE

I understand that I may revoke this authorization at any time in writing. Revocation does not apply to information already disclosed under this authorization. Information disclosed may be subject to re-disclosure and may no longer be protected under HIPAA.

PATIENT SIGNATURE _____ **DATE _____**

IF SIGNED BY A REPRESENTATIVE, PLEASE SPECIFY AUTHORITY: PARENT/GUARIAN POWER OF ATTORNEY OTHER:_____

To the best of my knowledge, the questions on these forms 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 _____