PATIENT INFORMATION

PATIENT

Name _____ Address _____

City _____ State _____ Zip _____

Home Phone:_____ Work Phone: _____ Cell Phone: _____ Birth Date:_____

Social Security # _____ Sex (M/F)_____ Marital Status _____

Employer _____ Email Address _____

PERSON RESPONSIBLE FOR BILL (IF DIFFERENT THAN PATIENT)

Name _____ Billing Address _____

City _____ State _____ Zip _____

Home Phone:_____ Work Phone:_____ Birth Date:_____

Social Security # _____ Sex (M/F)_____ Marital Status _____

Relationship to Patient_____ Email Address _____

DENTAL INSURANCE COVERAGE (Y/N) _____

NO Skip to "Referred By" below.

YES Provide an insurance card to the desk and answer the following questions.

PERSON PROVIDING INSURANCE (IF DIFFERENT THAN PATIENT)

Name _____ Employer _____

Birth Date _____ Social Security # _____

Relationship to Patient _____ Work Phone _____

MORE THAN ONE DENTAL INSURANCE COVERAGE (Y/N)_____

If **YES** please explain to desk personnel.

REFERRED BY _____

IN CASE OF EMERGENCY NOTIFY _____ **PHONE** _____

All accounts are due and payable when services are rendered and shall be delinquent and bear interest at a rate of 1.5% per month thereafter. Should full payment not be made when due the undersigned agrees to pay all cost of collection, including a reasonable attorney fee not to exceed 33%. The undersigned further waives as to this debt or any renewal thereof all rights of exemption under the laws of Alabama as to real or personal property. The undersigned gives permission to contact employers as well as make inquiries pertaining to this applicant. Further, the undersigned agrees that time for payment may be extended or other indulgence granted by ALABAMA DENTAL ASSOCIATES but that any such action shall not constitute a waiver of any right by the said ALABAMA DENTAL ASSOCIATES.

Signed (By Responsible Party)_____

Today's Date _____

PATIENT MEDICAL HISTORY

PATIENT NAME _____

PHYSICIAN _____ OFFICE PHONE _____ DATE OF LAST EXAM _____

	YES	NO
1. ARE YOU UNDER MEDICAL TREATMENT NOW?	☐	☐
2. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS?	☐	☐
3. ARE YOU TAKING ANY MEDICATION(S) INCLUDING NON-PRESCRIPTION MEDICINE?	☐	☐
IF YES, WHAT MEDICATION(S) ARE YOU TAKING? _____		
4. DO YOU USE TOBACCO?	☐	☐
5. DO YOU USE ALCOHOL, COCAINE OR OTHER DRUGS?	☐	☐
6. ARE YOU WEARING CONTACT LENSES?	☐	☐

7. ARE YOU ALLERGIC TO OR HAVE YOU HAD ANY REACTIONS TO ANY DRUGS? IF YES, PLEASE SPECIFY.

_____

_____

8. WHEN WAS YOUR LAST COMPLETE PHYSICAL? _____

9. WOMEN ONLY:	YES	NO
A) ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT?	☐	☐
B) ARE YOU NURSING?	☐	☐
C) ARE YOU TAKING BIRTH CONTROL PILLS?	☐	☐

10. PLEASE INDICATE WHICH OF THE FOLLOWING APPLIES TO YOU. CHECK ONLY IF ANSWER IS YES.

☐ HIGH BLOOD PRESSURE	☐ HEART DISEASE	☐ CHEST PAINS	☐ KIDNEY DISEASES
☐ HEART ATTACK	☐ CARDIAC PACEMAKER	☐ EASILY WINDED	☐ AIDS OR HIV INFECTION
☐ RHEUMATIC FEVER	☐ HEART MURMUR	☐ STROKE	☐ THYROID PROBLEM
☐ SWOLLEN ANKLES	☐ ANGINA	☐ HAY FEVER / ALLERGIES	☐ HEPATITIS / JAUNDICE
☐ FAINTING / SEIZURES	☐ MITRAL VALVE PROLAPSE	☐ TUBERCULOSIS	☐ SEXUALLY TRANSMITTED DISEASE
☐ ASTHMA	☐ ANEMIA	☐ RADIATION THERAPY	☐ STOMACH TROUBLES / ULCERS
☐ LOW BLOOD PRESSURE	☐ EMPHYSEMA	☐ GLAUCOMA	☐ RESPIRATORY PROBLEMS
☐ EPILEPSY / CONVULSIONS	☐ CANCER	☐ RECENT WEIGHT LOSS	☐ OTHER _____
☐ LEUKEMIA	☐ ARTHRITIS	☐ LIVER DISEASE	_____
☐ DIABETES	☐ JOINT REPLACEMENT OR IMPLANT	☐ HEART TROUBLE	_____

COMMENTS _____

PATIENT DENTAL HISTORY

PLEASE INDICATE WHICH OF THE FOLLOWING APPLIES TO YOU. CHECK ONLY IF ANSWER IS YES.

1. DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING? ☐	8. DO YOU HAVE FREQUENT HEADACHES? ☐
2. ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOODS? ☐	9. DO YOU CLENCH OR GRIND YOUR TEETH? ☐
3. ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS/FOODS? ☐	10. DO YOU BITE YOUR LIPS OR CHEEKS, FREQUENTLY? ☐
4. DO YOU FEEL PAIN TO ANY OF YOUR TEETH? ☐	11. HAVE YOU EVER HAD ANY DIFFICULT EXTRACTIONS IN THE PAST? ☐
5. DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH? ☐	12. HAVE YOU HAD ANY ORTHODONTIC WORK? ☐
6. HAVE YOU HAD ANY HEAD, NECK OR JAW INJURIES? ☐	13. HAVE YOU EVER HAD PROLONGED BLEEDING FOLLOWING EXTRACTIONS? ☐
7. HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING PROBLEMS IN YOUR JAW?	14. HAVE YOU EVER HAD INSTRUCTION ON THE CORRECT METHOD OF BRUSHING YOUR TEETH? ☐
A) CLICKING? ☐	15. HAVE YOU EVER HAD INSTRUCTIONS ON THE CARE OF YOUR GUMS? ☐
B) PAIN (JOINT, EAR, SIDE OF FACE)? ☐	
C) DIFFICULTY IN OPENING OR CLOSING? ☐	
D) DIFFICULTY IN CHEWING? ☐	

I certify that I have read and understand the above information, to the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

X _____ _____

PATIENT, PARENT OR GUARDIAN DATE

PATIENT ACKNOWLEDGEMENT OF PRIVACY PRACTICES CONSENT & RELEASE FORM

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

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 PERSONAL HEALTH INFORMATION DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR/ FACILITYS IN THE FUTURE.

_____

Patient's Name (print)

_____

Signature
(Parent or Guardian signature for minors)

_____

Date

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes stepparents, grandparents and any caretakers who can have access to this patient's records):

Name:_____ Relationship:_____

Name:_____ Relationship:_____

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

CANCELLATION AND NO-SHOW POLICY

Quality care for our patients is our priority. Please take a few minutes to review our no-show policy and sign at the bottom of the form. If you have any questions, please let us know.

Definition of a "No-Show" Appointment

Alabama Dental Associates defines a "No-Show" appointment as any scheduled appointment in which the patient either:

- Does not arrive to the appointment
- Cancels with less than 24 hours' notice
- Arrives more than 10 minutes late and is consequently unable to be seen

How to Avoid Getting a "No-Show"

1. **Confirm** your appointment
2. **Arrive** 5-10 minutes early
3. **Give 24 hours'** notice to cancel an appointment

Appointment Confirmation

Alabama Dental Associates will attempt to contact you two business days before your scheduled appointment to confirm your visit. If we are unable to speak with you and have to leave a message, you will need to contact Alabama Dental Associates by 3:00 pm the business day before the appointment – otherwise the appointment will be canceled and marked as a "no-show".

Always Arrive 5-10 Minutes Early

When you schedule an office visit with us, we expect you to arrive at our practice 5-10 minutes prior to your scheduled visit. This allows time for you and our staff to address any insurance or billing questions and or to complete any necessary paperwork before the scheduled visit.

Give 24 Hours' Notice if You Need to Cancel

When you need to cancel or rebook a scheduled visit, we expect you to contact our office no later than 24 hours before your scheduled visit. This allows us reasonable amount of time to determine the most appropriate way to reschedule your care as well as giving us the opportunity to rebook the now vacant appointment slot with another patient. **There will be a charge of $26 for no-show appointments and appointments cancelled without 24 hours' notice.**

I have read and understood the Alabama Dental Associates "No-Show" Policy as described above.

Patient Signature: _____ **Date:** _____