CENTER FOR ADVANCED DENTISTRY
We Make Anthem Smile

WELCOME

Name:_____Home Phone:_____

Address:_____City:_____State: _____Zip:_____

Social Security Number:_____Birth date:_____

Check Appropriate Marital Status: __Minor __Single __Married __Other

Spouse or Parent's Name: _____Telephone Number: _____

If patient is a student, Name of School/College?_____State:_____

Whom may we thank for referring you today?_____

INSURANCE INFORMATION

Name of Insured: _____Relation to Patient:_____

Birthday of Insured:_____Social Security Number: _____Date of Employment:_____

Employer: _____Work Phone: _____

Employer Address:_____City: _____State:_____Zip: _____

Insurance Company:_____Membership/Subscriber ID: _____

Group Number: _____Address:_____City/State: _____Zip:_____

INTERNET AUTHORIZATION

If you would like to receive emails about upcoming appointments and promotions, please provide us with your email below:

Email address: _____

ACKNOWLEDGEMENT OF RECEPIT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I,_____, have received a copy of this office's notice of Privacy Practice.

Patient or Responsible Parties Name

_____ _____

Signature Date

Medical History

Medical Physicians Name:_____ Telephone Number: _____

Have you been under the care of a physician/hospital in the last 2 years?_____ For?_____

Please list any major surgeries or illnesses you've had in the last 2 years:_____

_____

Women: Are you pregnant or nursing? __Yes or __No Are you taking any hormones or birth control? __ Yes or __ No

Do you currently smoke (vape/marijuana/tobacco products) or use straight tobacco products? __Yes or __ No If so, for how long?_____

Have you ever been told by a doctor that you need to take medication prior to dental treatment? __ Yes __ No

Are you now or have you taken any prescription medications during the year? __ Yes or __No

If yes, please list them: (Please list recent INR/A1C readings if necessary):_____

_____

Are you allergic or sensitive to any drugs or medications? __ Yes __ No If yes, please list: _____

Please check Yes or No for the following:

Yes	No		Yes	No		Yes	No	
____	/ ____	**Abnormal Blood Pressure**	____	/ ____	**Diabetes**	____	/ ____	**Organ Transplant**
____	/ ____	**Allergies**	____	/ ____	**Epilepsy**	____	/ ____	**Polio**
____	/ ____	**Anemia**	____	/ ____	**Fainting**	____	/ ____	**Prolonged bleeding**
____	/ ____	**Angina**	____	/ ____	**Glaucoma**	____	/ ____	**Prolonged Cough**
____	/ ____	**Arthritis**	____	/ ____	**Heart Disease**	____	/ ____	**Psychiatric Treatment**
____	/ ____	**Artificial Heart Valve/Pacemaker**	____	/ ____	**Heart Murmur**	____	/ ____	**Radiation Treatment**
____	/ ____	**Artificial Joints**	____	/ ____	**Hepatitis**	____	/ ____	**Sickle Cell Anemia**
____	/ ____	**Asthma**	____	/ ____	**HIV**	____	/ ____	**Stroke**
____	/ ____	**Cancer**	____	/ ____	**Jaundice**	____	/ ____	**Thyroid Disease**
____	/ ____	**Chemical Dependency**	____	/ ____	**Kidney Disease**	____	/ ____	**Tuberculosis**
____	/ ____	**Chemotherapy**	____	/ ____	**Latex Allergy**	____	/ ____	**Ulcers or Sores**
____	/ ____	**Congenital Heart Lesions**	____	/ ____	**Liver Disease**	____	/ ____	**Venereal Disease**

Other/Autoimmune Diseases: _____

I have read the above questions and the answers I have given are true and to the best of my knowledge, I am indicating my consent for routine dental procedures such as X-rays, cleanings, fillings, crowns and local anesthesia, as needed by signing below.

Provider review:

Date: Initials:

_____ _____

Signature Date

_____ _____

Dentists Signature of Review Date

_____ _____

Printed name: Date of birth

DENTAL HISTORY

Reason for Today's Visit: _____

Date of Last Dental Visit: _____ Date of Last X-rays: _____

How do you feel about the condition of your teeth? _____

How do you feel about the color of your teeth? _____

If you could change anything about your smile, what would it be and how important is it to you? _____

_____

Do you have any chipped or cracked teeth? _____

Have you ever had orthodontic treatment? __Yes or __No If so, when? _____

If not, are you interest in orthodontic treatment? __Yes or __No

Have you ever been told you have periodontal disease? __Yes or __No

If yes, when was your last deep cleaning and at which office was it done? _____

Do you have a family history of periodontal disease? __Yes or __No If yes, please circle one of the following: **maternal** or **paternal**.

Have you been diagnosed with sleep apnea? __Yes or __No Who gave you your diagnosis? _____

If so, how long ago and when was your last sleep study? _____

Are you currently experiencing excessive sleepiness? __Yes or __No If so, for how long? _____

Do you have history of oral cancer? __ Yes or __ No If yes, when was your diagnosis? _____

Do you have a family history of oral cancer? __Yes or __No

If yes, please select one of the following: maternal or paternal; Relation: _____

Please mark yes or no:

Yes / No If yes please give a brief description:

____/____ Clenching _____

____/____Grinding _____

____/____Bleeding Gums _____

____/____ Jaw pain _____

____/____Bad Breath _____

____/____Clicking/Popping of Jaw _____

____/____Food Collection Areas _____

____/____Hot sensitivity _____

____/____ Cold Sensitivity _____

____/____Sweet Sensitivity _____

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Patient name: _____ Date of Birth: _____

Please note the following items are our office policies. We ask that you **initial next to section** as acknowledgement.

____ **FINANCIAL AGREEMENT:**

Payment in full for all charges is required at time of visit, unless prior arrangements have been made.

____ **INSURANCE FILING:**

You, the patient, are ultimately responsible for payment in full on your account, not the insurance company. We do, however file dental insurance claims as a courtesy to our patients. We can only make *estimates* regarding your insurance benefits based on the information provided by you and your insurance company. In the event your insurance company does not pay as much as expected, the remaining balance is due and payable immediately by you, the patient.

____ **ASSIGNMENT OF INSURANCE BENEFITS:**

I/we hereby assign directly to Dr. Flowers insurance benefits otherwise payable to me/us. I/we hereby authorize the release of any information relating to any claims. I/we understand I/we are financially responsible for charges not paid by this assignment.

____ **DELINQUENT ACCOUNTS:**

All delinquent accounts (30 days or older) are subject to reasonable service charges and/or legal interest rates.

____ **COLLECTION PROCEEDINGS:**

In the event you account is turned over to a collection agency for non-payment or other delinquency, you will be responsible for payment of any collection costs (30%) and/or attorney fees, in addition to the balance owed. Any account turned over to a collection agency forfeits any past special fees and/or discounts. Such as special fees and/or discounts will be reversed, and you will be responsible for payment of regular fee for procedures at the time of service

____ **APPOINTMENTS:**

Please be on time for your appointments. Dr. Flowers, Jessica and Karly try to honor the schedules, but due to the nature of dentistry, there are often unforeseen delays and emergencies. If the timing is critical to your schedule and we are running late, please notify the front desk and you will be rescheduled if that is your choice.

____ **CANCELLATIONS:**

We ask that you call us as soon as possible if you need to cancel an appointment; 24 hours' notice is our policy. This courtesy on your part will enable us to use the appointment slot for someone else and you will avoid being charged $25 for cancelling the appointment.

____ LATE ARRIVALS:

We understand that things happen that can delay you getting to our office on time, however, if you are late for your appointment you should expect to wait. The front office will have to check with Dr. Flowers and/or Jessica/Karly to determine if there is enough time to still see you. Please be aware that you make be asked to reschedule your appointment

____ WALK-INS:

Our office visits are by appointment only. If you walk-in with a dental emergency, we will do our best to get you on the schedule and seen as soon as possible. Please do not assume that you will be seen immediately; set appointments do take precedence.

____ NO-SHOWS:

There will be a $25 charge for every hour that the appointment is scheduled. After the 3rd "no-show" appointment you may be asked to seek dental care elsewhere or be asked for a deposit for future appointments and you may be discharged from our office.

____ FAILED APPOINTMENTS:

We reserve the right to charge a $25 fee for cancellations with less than 24 hours' notice. We also reserve the right to reschedule your appointment in you are more than 15 minutes late

____ OTHER NOTES:

Foul, abusive and threatening language and behavior in the office towards our staff or other patients will not be tolerated and will result in your being discharged from the practice and your insurance will be notified.

I have completely read and understand the contents of this agreement. I agree to comply with all policies.

_____ _____

Patient or Responsible Party Signature Date

_____ _____

Please Print Patient or Responsible Party Relationship