Advanced Dental Smiles
473 York Road
Warminster, PA 18974

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PATIENT INFORMATION

Patient's Name: (Last) _____(First)_____ (MI) _____

Address: (Street/Apt.) _____(City) _____(St)_____(Zip)_____

SS#: _____Birth Date:_____Gender: _____Marital Status: ( ) Minor ( ) Single

Phone No: (H)_____(C)_____ ( ) Divorced ( )Married ( ) Widowed

(W): _____ Student?_____ ( ) Full-time ( ) Part-time

Spouse/Parent's Name: _____Email: _____

Are any of your family members our patients? (Yes/No)_____If Yes, Who?_____

How did you hear about us (Please Be Specific)?_____

Previous Dentist's Name and Phone No.: _____

Last Dental Visit (Date):_____

PRIMARY DENTAL INSURANCE

Name of Insurance Co.:_____ Phone No.:_____

Subscriber's Name: _____Date of birth _____Relationship:_____

Employer's Name: _____Group No: _____SS No/ID No.:_____

SECONDARY DENTAL INSURANCE

Name of Insurance Co.:_____ Phone No.:_____

Subscriber's Name: _____Date of birth _____Relationship:_____

Employer's Name: _____ Group No.: _____SS No./ID No.:_____

HEALTH HISTORY

Correct answers to the following questions will allow your dentist to treat you on a more individual basis, providing the care appropriate for your particular needs.

Physician's Name:_____Phone No.:_____

YES	NO	
_____	_____	Are you having any pain or discomfort at this time?
_____	_____	Have you ever had a full mouth x-rays taken of your teeth? If yes, when? _____
_____	_____	Have you ever had treatments for your gums?
_____	_____	Do your gums hurt or bleed when you brush?
_____	_____	Do your teeth hurt when you chew?
_____	_____	Have you ever had orthodontic treatment or worn braces?
_____	_____	Have you ever been aware of a bad odor or taste in your mouth?
_____	_____	Are your teeth sensitive to hot, cold or sweet?
_____	_____	Do you clench or grind your teeth during day or night?
_____	_____	Do you ever wake up from sleep due to shortness of breath
_____	_____	Are you on a special diet?
_____	_____	Do you use a tobacco products? What and how much _____
_____	_____	Do you use alcoholic beverages? How much_____How often_____
_____	_____	Have you been a patient in the hospital during past two years? For what _____

_____ _____ Have you been under the care of a medical doctor during last past years? For what _____

FOR WOMEN ONLY

_____ _____ Are you now or think you may be pregnant?
_____ _____ Are you nursing?
_____ _____ Are you presently taking birth control pills?

Are you taking any other medicine, drug or pills?

If yes, please list _____

Are you allergic or have your reacted adversely to any of the following medications?

_____ Aspirin	_____ Erythromycin	_____ Percodan	_____ Sulfa
_____ Codeine	_____ Local Anesthetic	_____ Penicillin	_____ Tetracycline
_____ Darvon	_____ Scopolamine	_____ Valium	
_____ Demerol	_____ Nitrous Oxide	_____ Sleeping Pills	

_____ Other, list _____

Check any of the following you have had or have at present:

_____ AIDS (HIV)	_____ Diabetes	_____ Nervousness
_____ Arthritis	_____ Emphysema	_____ Pacemaker
_____ Asthma	_____ Epilepsy or Seizures	_____ Pain in Jaw Joints
_____ Angina Pectoris	_____ Fainting or Dizzy Spells	_____ Psychiatric Treatment
_____ Artificial Heart Valve	_____ Fever Blisters	_____ Rheumatic Fever
_____ Anemia	_____ Glaucoma	_____ Rheumatism
_____ Artificial Joints	_____ Heart Disease or Attack	_____ Radiation Treatment
_____ Allergies or Hives	_____ High Blood Pressure	_____ Scarlet Fever
_____ Bruise Easily	_____ Heart Murmur	_____ Sinus Trouble
_____ Blood Transfusion	_____ Heart Surgery	_____ Sickle Cell Disease
_____ Cancer or Tumors	_____ Hay Fever	_____ Stroke
_____ Congenital Heart Lesions	_____ Hepatitis A	_____ Thyroid Disease
_____ Cold Sores	_____ Hepatitis B	_____ Tuberculosis (TB)
_____ Cough	_____ Hemophilia	_____ Ulcer
_____ Cortisone Medicine	_____ Herpes	_____ Venereal Disease
_____ Cosmetic Surgery	_____ Kidney Trouble	_____ Yellow Jaundice
_____ Drug Addiction	_____ Liver Disease	_____

List any other condition not listed above:_____

AUTHORIZATION AND RELEASE

I certify that I have read and understand the above information to the best of my knowledge. I have answered the above questions accurately. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examinations rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill of services. I agr ee to be responsible for payments for all services rendered on my behalf or my dependents.

X_____Date: _____ __

SIGNATURE OF PATIENT, PARENT OR GUARDIAN

DENTAL OFFICE INFORMED CONSENT

It is important to us that you, our patient, understand the treatment we are recommending and any invasive procedures we may, with your agreement, perform. We want to involve you in all decisions concerning invasive procedures you may need. We take informed consent very seriously in our office. Therefore, we only want you to sign this form when you understand that there is a risk associated with dental procedures, and all your questions have been answered.

Dental treatment and procedures are not to be taken for granted as being routine or without risk for complications. As with all medical treatment to one's body, including dental treatment, there are no guarantees that the results will be as planned and to each individual's satisfaction. When dealing with the human body there are potentially many variables, some predictable and others are not. Complication rates in dentistry are low but do exist. Even a minor procedure like "filling" can lead to major complications that cannot be foreseen. For example, "Novacaine" injection could lead to allergic reaction, anaphylaxis, facial hemorrhage, swelling, bruising, and even hospitalization or death. Granted these are fairly uncommon occurrences but individuals who are contemplating this should be aware of this prior to consenting. Whenever drilling is involved, even a simple cavity can lead to pulpal (nerve) problems, abscess, fractured tooth, and/or post treatment pain to biting and to temperature extremes (hot and cold). These complaints can be transient or may persist requiring further treatments. The above examples are only samples of possible complications with dental treatment and are not limited to these. In general, complications include but are not limited to pain, swelling, bleeding, infection, and other nerve problems.

I have read, understand and consent to dental treatments. INITIALS:_____DATE:_____

NOTICE OF PRIVACY PRACTICES PATIENT ACKNOWLEDGEMENT

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information. I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice. I understand I can obtain this practice's current Notice of Privacy Practices on request.

Signature: _____Date: _____

Relationship to patient (if signed by a personal representative of patient):_____

PATIENTS WITHOUT INSURANCE COVERAGE

Patients without insurance coverage are required to pay for services as rendered. We accept cash, Visa, MasterCard, American Express and Discover or Debit/ATM cards. We offer an in-house customized Membership Plan. We offer 5% courtesy on the prepayment of *Patient-Doctor discussed treatment* plans. We offer up to 12 months interest free financing plans.

OFFICE POLICY

When you make an appointment we reserve that time for you. We understand that extreme or unavoidable emergencies or circumstances do arise which may require you to cancel your appointment. **We reserve the right to charge for any appointment(s) broken without a 48 hours notice. The charge will be $50.00 for every thirty minutes of appointment time. Checks returned from the bank is subject to $ 35.00 service fee.**

Accounts delinquent more than 60 days from the date of billing are subject to a 1.5% per month (18% annually) finance charge. If your account is sent to our collection agency you will be responsible for collection and court costs along with attorney's fees.

We welcome you to our office and want to provide you with the best dental care possible. If you have any questions regarding our policies and your treatment, please do not hesitate to ask.

I HAVE READ AND UNDERSTAND THE ABOVE DENTAL OFFICE INFORMED CONSENT AND FINANCIAL POLICIES.

Signature: _____ Date: _____

OUR FINANCIAL POLICY

Thank you for choosing us as your dental care provider. We are committed to your dental treatment being successful. We agree in writing with every patient to sign our financial policy, as we have found with our past experience that this policy makes our mutual experience easier and without confusion. This policy is to ensure that all of our patients receive a highest level of quality dental care in a friendly and healthy environment while understanding their financial responsibilities. This policy as well as other health and insurance forms provided must be read, agreed to, and signed prior to any dental treatment.

Cash Patients
Patients with no insurance are expected to pay in cash, check or credit card the day the service is rendered, unless specific arrangements are made in advance.

Insurance Patients
For those patients covered by insurance, we may accept assignment of benefits. This means you must sign the portion of your insurance form that assigns payment to our office. Very few insurance policies cover 100% of the cost of your treatment. In this day and age many cover 50% or less on many services and actually cover nothing on others. Due to this, and the frequent delays in receiving payment from the insurance company, you will be asked to pay your deductible and your portion of your charges the day the service is rendered. We will estimate as closely as possible, your coverage, but until we actually receive the payment from the insurance company, it is just an estimate. Some patients request that we send in a pre-determination to their insurance carriers. We state what treatment you need, and they tell us what they will cover on that treatment plan. Many patients prefer to get service started immediately, and some treatments should be started immediately. In these cases we will ask you to pay for your services in full as they are done, and when the insurance company pays their portion we will reimburse you for what they pay. We will assist you in dealing with the insurance company, but ultimately the responsibility of payment and insurance problems lies with you. If we do accept assignment of benefits from the insurance company, if the insurance company hasn't paid after 45 days, the full balance is expected from you personally.

The above policies apply equally to parents and guardians of minors being treated, and minors cannot be treated without a parent or guardian authorizing treatment and agreeing to financial responsibility. Thank you for reading and understanding our financial policy. If you have any questions or concerns; please feel free to ask them at any time. We wish to be of assistance in any way we can.

Sincerely,

Dr. _____

I HAVE READ AND UNDERSTAND THE ABOVE DENTAL OFFICE INFORMED FINANCIAL POLICIES.

_____ Date: _____

Signature of responsible party

_____

Please print your name

❖ **WE OFFER DENTAL WARRANTY ON CERTAIN DENTAL TREATMENT. PLEASE ASK DOCTORS FOR DETAILS.**