CENTER FOR
ADVANCED DENTISTRY
DR. PATEL | DR. CORBETT | DR. LEMONS

PATIENT INFORMATION

LAST NAME: _____ FIRST NAME: _____ MIDDLE: _____

PERFERRED NAME: _____ DOB: _____/_____/_____

SEX: M F MARITAL STATUS: S M D W CHILD

EMAIL ADDRESS: _____ SOCIAL SECURITY: _____-_____-_____

HOME ADDRESS:

HOME PHONE #: _____ CELL PHONE #: _____

NAME OF EMPLOYER: _____ OCCUPATION: _____

WORK PHONE #:_____ DRIVER'S LICENSE #: _____

BEST WAY TO CONFIRM YOUR APPOINTMENT: EMAIL TEXT CALL ALL NONE

EMERGENCY CONTACT NAME: _____ RELATIONSHIP: _____

EMERGENCY CONTACT PHONE #: _____

INSURANCE INFORMATION

POLICY HOLDER NAME: _____ DOB OF POLICY HOLDER: _____/_____/_____

RELATIONSHIP TO PATIENT: _____ INSURANCE CO: _____

EMPLOYER: _____ TOLL FREE #: _____

ID #: _____ GROUP #: _____

WHO CAN WE THANK FOR REFERRING YOU? _____

PATIENT/ GUARDIAN SIGNATURE: _____DATE: _____/_____/_____

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MEDICAL HISTORY

PATIENT'S NAME: _____

HEALTH PROBLEMS THAT YOU HAVE, OR MEDICATION THAT YOU MAYBE TAKING, COULD HAVE AN IMPORTANT INTERRELATIONSHIP WITH THE DENTISTRY THAT YOU WILL BE RECEIVING. THANK YOU FOR ANSWERING THE FOLLOWING QUESTIONS.

ARE YOU CURRENTLY UNDER A CARE OF A PHYSICIAN? ☐ YES ☐ NO DATE OF LAST PHYSICAL: _____/_____/_____

NAME OF PHYSCIAN: _____ PHONE#: _____

ADDRESS: _____

PLEASE LIST ANY MEDICATIONS YOU ARE TAKING NOW:

DO YOU SMOKE OR USE TOBACCO PRODUCTS?	☐ YES	☐ NO	IF YES, HOW MUCH? _____
ARE YOU PREGNANT OR THINK YOU MAY BE?	☐ YES	☐ NO	IF YES, EXPECTED DELIEVERY DATE: _____
ARE YOU NURSING?	☐ YES	☐ NO	
DO YOU HAVE OR USED CONTROLLED SUBSTANCES?	☐ YES	☐ NO	
DO YOU BRUISE EASILY?	☐ YES	☐ NO	
DO YOU TAKE ANYTHING FOR THE TREATMENT OR PREVENTION OF OSTEOPOROSIS? (E.G. FOSAMAX)	☐ YES	☐ NO	IF YES, PLEASE LIST BELOW

MEDICATIONS

1._____ 2. _____ 3. _____ 4. _____ 5. _____

6._____ 7. _____ 8. _____ 9. _____ 10. _____

ARE YOU ALLERGIC OR HAD REACTIONS TO ANY OF THE FOLLOWING?

LOCAL ANESTHETIC (NOVOCAINE)	☐ YES	☐ NO	LATEX/ RUBBER	☐ YES	☐ NO
PENECILLIN	☐ YES	☐ NO	ASPIRIN	☐ YES	☐ NO
SULFA DRUGS	☐ YES	☐ NO	ANY METALS (GOLD, NICKEL, ETC.)	☐ YES	☐ NO
BARBITURATES, SEDATIVES, SLEEPING PILLS	☐ YES	☐ NO	OTHER (PLEASE LIST): _____		

HAVE YOU EVER HAD? (CIRCLE THOSE THAT APPLY)

ABNORMAL BLOOD PRESSURE	☐ HIGH	☐ LOW	NO	HEART MURMUR	☐ YES	☐ NO
AIDS or HIV	☐ YES	☐ NO		HEART SURGERY	☐ YES	☐ NO
ALLERGIES	☐ YES	☐ NO		HEPATITIS	☐ YES	☐ NO
ANEMIA	☐ YES	☐ NO		JAUNDICE	☐ YES	☐ NO
ARTHRITIS	☐ YES	☐ NO		JOINT REPLACEMENT or IMPLANT (PRE-MED)	☐ YES	☐ NO
ASTHMA OR HAY FEVER	☐ YES	☐ NO		KIDNEY TROUBLE	☐ YES	☐ NO
BACK PROBLEMS	☐ YES	☐ NO		LYMPH NODE ENLARGEMENT/ SWOLLEN GLANDS	☐ YES	☐ NO
BLOOD TRANSFUSION	☐ YES	☐ NO		MENTAL HEALTH CARE	☐ YES	☐ NO
CANCER	☐ YES	☐ NO		MITRAL VALVE PROLAPSE	☐ YES	☐ NO
CHEMICAL DEPENDENCY	☐ YES	☐ NO		PACEMAKER	☐ YES	☐ NO
COLD SORES or FEVER BLISTERS	☐ YES	☐ NO		PROLONGED BLEEDING	☐ YES	☐ NO
CONGENITAL HEART LESIONS	☐ YES	☐ NO		RHEUMATIC FEVER	☐ YES	☐ NO
DIABETES	☐ YES	☐ NO		SEXUALLY TRANSMITTED DISEASE	☐ YES	☐ NO
DRASTIC WEIGHT LOST	☐ YES	☐ NO		SINUS TROUBLE	☐ YES	☐ NO
EPILEPSY or SEIZURES	☐ YES	☐ NO		STROKE	☐ YES	☐ NO
EXCESSIVE URINATION and/or THIRST	☐ YES	☐ NO		THYROID PROBLEMS	☐ YES	☐ NO
FAINTING SPELLS	☐ YES	☐ NO		TUBERCULOSIS or LUNG DISEASE	☐ YES	☐ NO
GLAUCOMA	☐ YES	☐ NO		ULCERS	☐ YES	☐ NO
HEART DISEASE	☐ YES	☐ NO		X-RAY TREATMENTS or CANCER	☐ YES	☐ NO

IF YOU HAVE ENTERED "YES" PLEASE EXPLAIN: _____

PATIENT SIGNATURE: _____ DATE: _____/_____/_____

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CUSTOMIZED TREATMENT & PRESENTATION QUESTIONAIRE

PATIENT NAME: _____

DATE OF LAST DENTAL VISIT: _____/_____/_____

WHAT IS YOUR PRIMARY CONCERN THAT YOU WOULD LIKE US TO ADDRESS FIRST?

_____

HAS ANYTHING EVER HAPPENED IN PREVIOUS EXPERIENCES AT THE DENTIST THAT WAS REASON NOT TO RETURN? YES NO

IF YES, PLEASE EXPLAIN:_____

PLEASE RATE YOUR SMILE FROM 1 TO 10 (1= I HATE MY SMILE, 10= AWESOME): _____

WOULD YOU LIKE TO SEE WHAT YOU WOULD LOOK LIKE WITH A NEW AND IMPROVED SMILE (AT NO ADDITIONAL CHARGE)?☐YES☐NO

PLEASE MARK ANY THAT APPLY TO YOU:

APPEARANCE

- ☐ DISCOLORED TEETH
- ☐ MISSHAPED TEETH
- ☐ CROOKED TEETH
- ☐ SPACES
- ☐ OVERBITE

FUNCTION

- ☐ GRINDING/ CLENCHING
- ☐ HEADACHES
- ☐ JAW JOINT (TMJ) PAIN
- ☐ JAW JOINT CLICKING/ POPPING
- ☐ BAD BITE
- ☐ SPEECH IMPEEDIMENT
- ☐ SOUR MUSCLES (NECK, SHOULDERS)
- ☐ DIFFICULTY OPENING/ CLOSING
- ☐ DIFFICULTY CHEWING

PAIN/ DISCOMFORT

- ☐ SENSITIVITY (HOT, COLD, SWEETS)
- ☐ PRESSURE
- ☐ BROKEN TEETH, FILLINGS,
- ☐ DRY MOUTH

HABITS

- ☐ THUMB SUCKING
- ☐ NAIL BITING
- ☐ CHEEK/ LIP BITING
- ☐ CHEWING ON ICE/ FOREIGN OBJECTS

PLEASE ADD ANYTHING YOU FEEL IS IMPORTANT:_____

_____

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AUTHORIZATION TO RECEIVE DENTAL RECORDS EXPRES UPON ONE TIME RELEASE

PATIENT INFORMATION

NAME OF PATIENT:_____

DATE OF BIRTH: _____/_____/_____PHONE:_____

I AUTHORIZE THE PRACTICE BELOW TO RELEASE MY DENTAL RECORDS (PLEASE INCLUDE PHONE # IF KNOWN):

_____

_____

HIPPA ACKNOWLEDGMENT

I UNDERSTAND THAT I MAY INSPECT OR COPY THE PROTECTED HEALTH INFORMATION DESCRIBED BY THIS AUTHORIZATION.

I UNDERSTAND THAT AT ANY TIME, THIS AUTHORIZATION MAY BE REVOKED, WHEN THE OFFICE THAT RECEIVES THIS AUTHORIZATION RECEIVES A WRITTEN REVOCATION. ALTHOUGH THAT REVOCATION WILL NOT BE EFFECTIVE AS TO THE DISCLOSURE OF RECORDS WHO'S RELEASE I HAVE PREVIOUSLY AUTHORIZED, OR WHERE OTHER ACTIONS HAVE BEEN TAKEN IN RELIANCE ON AN AUTHORIZATION I HAVE SIGNED. I UNDERSTAND THAT MY HEALTHCARE AND PAYMENT FOR MY HEALTHCARE WILL NOT BE AFFECTED IF I REFUSE TO SIGN THIS FORM.

I UNDERSTAND THAT INFORMATION USED OR DISCLOSED, PURSUANT TO THIS AUTHORIZATION, COULD BE SUBJECT TO RE-DISCLOSURE BY THE RECIPIENT AND, IF SO, MAY NOT BE SUBJECT TO FEDERAL OR STATE LAW, PROTECTING ITS CONFIDENTIALITY.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

PATIENT NAME: _____

ADDRESS:

_____

_____

I HAVE RECEIVED A COPY OF THE NOTICE OF PRIVACY PRACTICES FOR THE ABOVE-NAMED PRACTICE.

SIGNATURE: _____ DATE: _____/_____/_____

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PATIENT PHOTO RELEASE FORM

I, _____ HEREBY AUTHORIZE CENTER FOR ADVANCED DENTISTRY TO TAKE PHOTOGRAPHS, SLIDES, AND VIDEOS OF MY TEETH, JAWS, BODY, AND FACE. I UNDERSTAND THAT THE PHOTOGRAPHS, AND VIDEOS WILL BE USED AS A RECORD OF MY CARE, AND MAY BE USED FOR COMMUNICATION WITH OTHER HEALTH CARE PROFESSIONALS, EDUCATIONAL PUBLICATIONS (DENTAL JOURNALS), AND EDUCATIONAL LECTURES. THE CONTENT MAY ALSO BE USED FOR ADVERTISING PURPOSES (INCLUDING WEBSITE PUBLICATION, FACEBOOK POSTS, ETC.). I FURTHER UNDERSTAND THAT IF THE PHOTOGRAPHS, SLIDES, AND VIDEOS ARE USED IN ANY PUBLICATION OR AS A PART OF A DEMONSTRATION, MY IDENTIFYING INFORMATION (FIRST NAME ONLY) COULD BE USED UNLESS STATED DIFFERENTLY BELOW. I DO NOT EXPECT COMPENSATION, FINANCIAL OR OTHERWISE, FOR THE USE OF THESE PHOTOGRAPHS. IF I WISH TO REVOKE THIS CONSENT, I MAY DO SO IN WRITING. IF DECLINING THIS CONSENT, LEAVE BLANK.

PLEASE INITIAL ONE OPTION:

_____ I DO NOT MIND IF MY PHOTOGRAPHS ARE USED IN ANY OF THE ABOVE STATED SITUATIONS.

_____ I ONLY AGREE TO HAVE MY TEETH SHOWN WITHOUT ANY IDENTIFYING FEATURES.

SIGNATURE: _____

APPOINTMENT AGREEMENT

AT CENTER FOR ADVANCED DENTISTRY, WE UNDERSTAND THAT YOUR TIME IS VERY VALUABLE. WE ARE CONSTANTLY STRIVING TO MAKE YOUR EXPERIENCE HERE MORE PLEASANT THAN ANY OTHER PLACE YOU HAVE PREVIOUSLY BEEN. WE MAKE EVERY EFFORT TO STAY ON TIME SO THAT OUR PATIENTS WILL NOT WAIT UNNECESSARILY. WE DO PROVIDE A COURTESY REMINDER CALL A WEEK PRIOR TO YOUR APPOINTMENT.

IF YOU FIND THAT YOU CANNOT KEEP YOUR APPOINTMENT, WE DO REQUIRE A MINIMUM OF 2 BUSINESS DAYS NOTICE SO THAT WE ARE ABLE TO ASSIST OTHER PATIENTS WITH THEIR DENTAL NEEDS. IF OUR OFFICE IS NOT NOTIFIED WITHIN THE 2 BUSINESS DAYS, YOU WILL BE SUBJECT TO A LATE, CANCELLATION, OR NO SHOW FEE OF $35.

BY SIGNING BELOW, I AGREE TO FULFILL MY OBLIGATION AS A PATIENT AT CENTER FOR ADVANCED DENTISTRY AND AGREE TO THE “BROKEN APPOINTMENT” FEE SHOULD I NOT GIVE PROPER NOTIFICATION.

SIGNATURE: _____

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FINANCIAL AGREEMENT

AS A CONDITION OF THE TREATMENT PERFORMED BY THE PROVIDERS OF THE OFFICE, FINANCIAL ARRANGEMENTS MUST BE MADE IN ADVANCE FOR THE FULL COST OF PROPOSED TREATMENT. THE PRACTICE'S VITALITY DEPENDS UPON PAYMENT FOR SERVICES AS RENDERED AND IT IS THE RESPONSIBILITY OF THE PATIENT OR PATIENT'S PARENT/GUARDIAN TO SATISFY THE COSTS INCURRED IN DENTAL CARE. FINANCIAL ARRANGEMENTS ON THE PART OF EACH INDIVIDUAL MUST BE DETERMINED PRIOR TO TREATMENT COMPLETION.

ALL EMERGENCY DENTAL SERVICES, OR ANY DENTAL SERVICES PERFORMED WITHOUT PREVIOUS FINANCIAL ARRANGEMENTS, MUST BE PAID FOR AT THE TIME SERVICES ARE RENDERED. ADDITIONALLY, A DISCOUNT CAN BE EXTENDED, AT THE DOCTOR'S DISCRETION, FOR PAYMENTS IN FULL WITH CASH OR CHECK. (INQUIRE FOR MORE DETAILS)

INDIVIDUALS WHO CARRY DENTAL INSURANCE UNDERSTAND THAT ALL DENTAL SERVICES FURNISHED ARE CHARGED DIRECTLY TO THE PATIENT AND THAT SAID PATIENT IS PERSONALLY RESPONSIBLE FOR PAYMENT OF ALL DENTAL SERVICES PROVIDED, REGARDLESS OF DENTAL INSURANCE REIMBURSEMENT. AS A CUSTOMER COURTESY, THIS OFFICE WILL HELP PREPARE AND SUBMIT PATIENTS' INSURANCE FORMS AS WELL AS ASSIST IN MAKING COLLECTIONS FROM INSURANCE COMPANIES. WE WILL CREDIT ANY SUCH COLLECTIONS TO THE APPROPRIATE ACCOUNT. HOWEVER, THIS DENTAL OFFICE CANNOT RENDER SERVICES ON THE ASSUMPTION THAT OUR CHARGES WILL BE PAID IN PART OR IN FULL BY AN INSURANCE COMPANY. (PLEASE UNDERSTAND THAT THE AMOUNT TO BE PAID BY YOUR PARTICULAR POLICY IS PRE-DETERMINED AND AGREED TO BY YOUR EMPLOYER AND THE INSURANCE COMPANY. IF YOU HAVE ANY QUESTIONS ABOUT THE AMOUNT THE PLAN WILL PAY OR THE TREATMENTS YOUR PLAN WILL COVER, YOU SHOULD REFER THESE QUESTIONS TO YOUR EMPLOYER). ADDITIONALLY, THERE MAY BE A DEDUCTIBLE, A CO-INSURANCE FACTOR, AND A YEARLY MAXIMUM TO BE CONSIDERED. MOST POLICIES COVER WHAT THEY CONSIDER A "USUAL AND CUSTOMARY FEE." HOWEVER, THE INSURANCE COMPANY SETS THESE FEES, AND THEY ARE NOT ALWAYS THE SAME AS THE FEES THAT MAY BE CHARGED IN THIS OR ANY OFFICE. ALL THESE FACTORS MAY COMBINE TO REDUCE THE BENEFITS YOU WILL ULTIMATELY RECEIVE. OUR OFFICE WILL FILE YOUR CLAIM ONCE SERVICES HAVE BEEN RENDERED. WE WILL DO OUR BEST TO SEE THAT YOU RECEIVE YOUR FULL BENEFITS WITHIN THE STRUCTURE OF YOUR PARTICULAR DENTAL PLAN BUT ANY BALANCE THAT REMAINS ON YOUR ACCOUNT, WHETHER YOUR INSURANCE COMPANY COVERED THE PROCEDURE IN QUESTION OR NOT, IS ULTIMATELY YOUR RESPONSIBILITY TO PAY.

A SERVICE CHARGED OF 2% PER MONTH (24% PER ANNUM) ON ANY UNPAID BALANCE WILL BE CHARGED ON ALL ACCOUNTS EXCEEDING 60 DAYS FROM DATE OF SERVICE, UNLESS PREVIOUSLY WRITTEN FINANCIAL ARRANGEMENTS ARE AGREED UPON AND SATISFIED. I UNDERSTAND THAT THE FEE ESTIMATE LISTED FOR ANY PROPOSED DENTAL CARE CAN ONLY BE EXTENDED FOR A PERIOD OF SIX MONTHS FROM THE DATE OF DIAGNOSIS AND/OR EXAMINATION. I FURTHER ACKNOWLEDGE THAT THE PROPOSED TREATMENT PLAN CAN SHIFT AND/OR CHANGE FROM THE DIAGNOSED TREATMENT PLAN ONCE TREATMENT IS BEGUN DUE TO UNFORESEEN CIRCUMSTANCES BEYOND THE DOCTORS' CONTROL.

IN CONSIDERATION FOR THE PROFESSIONAL SERVICES RENDERED TO ME BY THE DOCTOR, AT THE PROVIDER'S RECOMMENDATION, OR AT MY OWN REQUEST, I AGREE TO PAY THE REASONABLE VALUE OF SAID SERVICES TO SAID DOCTOR, OR HIS ASSIGNEE, AT THE TIME SAID SERVICES ARE RENDERED, OR WITHIN FIVE (5) BUSINESS DAYS OF BILLING IF CREDIT SHALL BE EXTENDED. I FURTHER AGREE THAT THE REASONABLE VALUE OF SAID SERVICES SHALL BE BILLED UNLESS OBJECTED TO, BY ME, IN WRITING, WITHIN THE TIME ALLOTTED FOR PAYMENT THEREOF. I FURTHER AGREE THAT A WAIVER OF ANY BREACH OF ANY TIME OR CONDITION HEREUNDER SHALL NOT CONSTITUTE A WAIVER OF ANY FURTHER TERM OR CONDITION, AND I FURTHER AGREE TO PAY ALL COSTS AND REASONABLE ATTORNEY FEES IF SUIT BE INSTITUTED HEREUNDER.

I GRANT MY PERMISSION TO CENTER FOR ADVANCED DENTISTRY'S FINANCIAL COORDINATOR TO TELEPHONE ME AT HOME OR AT MY PLACE OF BUSINESS TO DISCUSS MATTERS RELATED TO THIS FORM.

I HAVE READ THE ABOVE CONDITIONS OF TREATMENT AND PAYMENT AND AGREE TO THEIR CONTENT.

SIGNATURE: _____ DATE: _____/_____/_____