## Information

Patient Name: ______________________________________________ Date:______________
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other ____________

Social Security #: ____________________________ Birth Date: _____________________________

Phone (Home): ______________ (Work): ______________ Ext: _____ (Cell):___________________

Email: ___________________________________________________________________________

Address: _________________________________________________________________________
Street Apartment #

_________________________________________________________________________
City State Zip Code

## Health Information

Date of Last Dental Visit: ________________ Reason for this visit:______________________________

**Have you ever had any of the following? Please check those that apply:**

☐ AIDS
☐ Allergies __________
__________
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Diabetes
☐ Dizziness
☐ Epilepsy

☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Growths
☐ Hay Fever
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis
☐ High Blood Pressure
☐ HIV
☐ Jaundice

☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Pacemaker
☐ Pregnancy
Due date:_________
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems

☐ Stomach Problems
☐ Stroke
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Venereal Disease
☐ Codeine Allergy
☐ Penicillin Allergy
OTHER:
☐ ________________
☐ ________________

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No

  If yes, please explain:_____________________________________________________________

- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No

  If yes, please explain:_____________________________________________________________

- Are you now under the care of a physician? ☐ Yes ☐ No

  If yes, please explain:_____________________________________________________________

- Name of Physician: ________________________________________ Phone:_________________

- Do you have any health problems that need further clarification? ☐ Yes ☐ No

  If yes, please explain:_____________________________________________________________

- Are you currently taking any medication? ☐ Yes ☐ No

  If yes, please list them: ____________________________________________________________

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____________________________________________________________ Date: ________________
Signature of patient, parent or guardian

## Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: ______________________ Occupation: ______________________

Address: ______________________
Street City State Zip Code

## Insurance Information

**Primary**

Name of Insured: ______________________ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: ________ ID #: ________ Group #: ________

Insured's Address: ______________________
Street City State Zip Code

Insured's Employer Name: ______________________

Address: ______________________
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other__________

Insurance Plan Name and Address: ______________________

______________________

**Secondary**

Name of Insured: ______________________ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: ________ ID #: ________ Group #: ________

Insured's Address: ______________________
Street City State Zip Code

Insured's Employer Name: ______________________

Address: ______________________
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other__________

Insurance Plan Name and Address: ______________________

______________________

## Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: ______________________

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other ________

Social Security #: ________ Birth Date: ________

Phone (Home): ________ (Work): ________ Ext: ______ Best time to call: ________

Address: ______________________
Street Apartment #

______________________
City State Zip Code

## Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time 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 you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

Please be aware that we participate both in and out of network. You are responsible for the remaining portion of your balance if a dental procedure is partially covered or not covered at all. Insurance is always subjected to change.

**Your appointment time is valuable and has been reserved specifically for you. If it is necessary to reschedule your appointment, please provide us with a 24 hour notice. Otherwise a charge of $100 will be incurred.**

I have read the above conditions of treatment and payment and agree to their content.

______________________ Date: ________ Relationship to Patient: ________

Signature of patient, parent or guardian

______________________ Date: ________ Relationship to Patient: ________

Signature of guarantor of payment/responsible party

# Advanced Dental Arts, P.C.

## Insurance Agreement

**Most importantly, please know our treatment is based on the dental need of the patient, not the insurance company benefits.**

1. As a service to our patients, we will do our best to ESTIMATE what your insurance company will pay. We will file your claim for you and we will collect your deductible, co-payments and fees for any non-covered services at the time of service. **We are not responsible for how your insurance company pays your claim. We cannot possibly know every clause in your dental contract.**

2. The financial responsibility for dental services lies solely with the patient. It is a contact between you, your employer and insurance company. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select services that they will not cover. **Whether your insurance plan pays based on a fee schedule, allowance or usual and customary, you may receive a statement for the portion your insurance did not cover, even after you paid your copayment.** If your insurance fails to pay their portion within 60 days from the date of service, the entire balance will be due from you. You can then obtain reimbursement from your insurance company.

3. For any account 30 days past due a monthly finance charge will be applied unless prior arrangements have been made.

4. Account with a balance over 90 days will be sent to an outside collection agency. Any service fee incurred by the agency will be your responsibility.

5. Please be aware that here at Advanced Dental Arts we do participate both in and out of network. You are responsible for the remaining portion of your balance if a dental procedure is partially covered or not covered at all. Insurances are always subjected to change.

I, ________________________________, agree to accept the standard fees of this office despite my insurance benefit agreement. I am aware that there may be a difference in the insurance plan fee and the standard fee.

Signature of Patient, Parent, Guardian ________________________________________

Date ________________________________________________________________

Relationship to Patient ______________________________________________________

Patient Name _____________________________ Date _____________________

# SMILE SURVEY

***PLEASE MARK AN "X" BY THE STATEMENTS BELOW THAT YOU AGREE WITH:***

_____ I wish the color of my teeth was whiter.

_____ I wish I had a broader smile.

_____ Some of my teeth are too small.

_____ Some of my teeth are too large.

_____ I wish my teeth were straighter.

_____ My gums show too much when I smile.

_____ My smile shows too much space between some of my teeth.

_____ I sometimes hesitate to smile.

_____ I wish I could change some of the features of my smile.

_____ I don't know all of the options available for enhancing my smile.

_____ I am concerned over what the end result might look like.

_____ I am concerned about the fees related to changing my smile.

## How Did You Hear About Us?

***PLEASE MARK AN "X" NEXT TO ALL SOURCES THAT LED YOU TO CHOOSING US:***

_____ ZocDoc

_____ Healthgrades

_____ Facebook/Twitter

_____ School/Work/Friends

_____ Different Practice

_____ Yelp

_____ RateMD

_____ Search Engine (Google, Yahoo, Bing)

_____ Family Member

_____ Other ________________________________

***WE WANT TO SHOW OUR APPRECIATION TO THE PEOPLE THAT REFERRED YOU TO US. IF YOU WERE REFERRED BY A SPECIFIC PERSON OR PRACTICE, PLEASE LET US KNOW BELOW.***

Referred by: __________________________________________________________