Section A: The Patient.

Name:_____DOB:_____

Address:_____

Telephone:_____

Email:_____

Patient/Parent Social Security Number _____

Section B: Acknowledgment of Privacy Practice Notice. [HIPPA]

I,_____,acknowledge that I have received a Notice of Privacy Practices from the above named practice.

Signature:_____ Date:_____
If a personal representative signs this authorization on behalf of the individual, complete the following:

Personal Representative Name:

Relationship of Individual:_____

Purpose of visit:_____
Other Family member in this Practice:_____
Whom may we thank for this referral:_____
Please fill this section
Someone to notify in case of emergency:_____
Phone Number:_____

Consent:

I attest that the above information is correct

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

I consent to the dentist's use and disclosure of my records(or my child's records) to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payments.

I consent to the disclosure of my records (or my child's records) to the following persons who are involved in my care (or my child's care) or payment for that care.

_____

_

_____

My consent to disclosure of records shall be effective until i revoke it in writing. I authorize payment directly to the dentist and or dental group of insurance benefits other wise payable to me. I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services. and that i am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, by my dental care payor.

I ATTEST TO THE ACCURACY OF THE INFORMATION ON THIS PAGE.

PATIENT OR GUARDIAN'S SIGNATURE_____
DATE:_____

Patients Name: _____
First Last Initial Date Of Birth

1. Physicians Name _____
   Address _____
   Tel:(_____)_____
2. Are you under a physician's care? _____
   Since When? _____ why? _____

3. When was your last complete physical exam? _____
4. Are you taking any medication or substances? .....YES NO
   (If yes, please list medications in comments section or on the back of this form.)
5. Do you routinely take health related substances? (Vitamins, herbal supplements, natural products) ..YES NO
6. Are you allergic to any medications or substances? (please list) .....YES NO
7. Do you have any other allergies or hives? .....YES NO
8. Do you have any problems with penicillin, antibiotics, anesthetics or other medications? .....YES NO
9. Are you sensitive to any metals or latex? .....YES NO
10. Are you pregnant or suspect you may be? .....YES NO
11. Do you use any birth control medications? .....YES NO
12. Have you ever been treated for or been told you might have heart disease? .....YES NO
13. Do you have a pacemaker, an artificial heart valve implant, or been diagnosed with mitral valve prolapse? .....YES NO
14. Have you ever had rheumatic fever? .....YES NO
15. Are you aware of any heart murmurs? .....YES NO
16. Do you have high or low blood pressure? (please circle) .....YES NO
17. Have you ever had a serious illness or major surgery? .....YES NO
    If so, explain _____
18. Have you ever had radiation treatment, chemo treatment for tumor, growth or other condition? .....YES NO
19. Have you ever taken Fosamax, Zometa, Aredia or any other oral or intravenous treatment (bisphosphonates) for bone tumors, excessive calcium in your blood, or osteoporosis? .YES NO
20. Do you have inflammatory diseases, such as arthritis or rheumatism? .....YES NO
21. Do you have any artificial joints/prosthesis? .....YES NO
22. Do you have any blood disorders, such as anemia, leukemia, etc? .....YES NO
23. Have you ever bled excessively after being cut or injured? .....YES NO
24. Do you have any stomach problems? .....YES NO
25. Do you have any kidney problems? .....YES NO
26. Do you have any liver problems? .....YES NO
27. Are you diabetic? .....YES NO
28. Do you have fainting or dizzy spells? .....YES NO
29. Do you have asthma? .....YES NO
30. Do you have epilepsy or seizure disorders? .....YES NO
31. Do you or have you had venereal or any sexually transmitted disease? .....YES NO
32. Have you tested HIV positive? .....YES NO
33. Do you have AIDS? .....YES NO
34. Have you had or do you test positive for hepatitis? .....YES NO
35. Do you or have you had T.B.? .....YES NO
36. Do you smoke, chew, use snuff or any other forms of tobacco? .....YES NO
37. Do you regularly consume more than one or two alcoholic beverages a day? .....YES NO
38. Do you habitually use controlled substances? .....YES NO
39. Have you had psychiatric treatment? .....YES NO
40. Have you taken any prescription drugs fenfluramine, fenfluramine combined with phentermine (fen-phen), dexfenfluramine (redux), or other weight loss products? .....YES NO
41. Do you have any disease condition, or problem not listed? If so, explain _____
42. Is there Anything else we should know about your health that we have not covered on this form? _____
43. Would you like to speak to the Doctor privately about any problem? .....YES NO

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S / GUARDIAN'S SIGNATURE _____ DATE _____

DENTIST'S SIGNATURE _____ DATE _____

COMMENTS

ANEST.

MEDICAL HISTORY

Broken Appointment Fee Policy

Recognizing that everyone's time is valuable and the appointment time is limited, we ask that you provide a 24 hour notice if you are unable to keep your appointment. Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, American Dental Center reserves the right to charge a fee of **$40** for each missed or "No Show" appointment that is not canceled within a 24 hour advance notice. Broken appointment fees will be billed to the patient. This fee is not covered by insurance, and must be paid prior to your next appointment. Multiple "No Shows" in any 12 month period will result in dismissal from our practice. Thank you for you anticipated cooperation. By signing below, you acknowledge that you have received this notice and understand this policy.

_____

Printed Last Name, First

_____

Signature

_____

Date

FINANCIAL POLICY CONSENT FORM

We welcome you and your family to American Dental Center. We look forward to providing you with quality dental care at affordable prices. To provide you with the most beneficial and comprehensive service and care, we request you to review and complete our office and financial policy consent form. We will be happy to answer any questions you may have regarding the proposed treatment and available financial options. We strive to keep you informed and involved with your treatment as much as possible.

You need to be aware that:

•Although we file claims for you as a courtesy, your dental insurance policy is a contract between you, your employer and your insurance company. We are not a party to that contract.

It is your responsibility to thoroughly understand the coverage and exceptions of your insurance policy. Coverage issues can only be addressed by your employer or group plan administrator. We cannot act as a mediator with the carrier or your employer.

• As a courtesy to all of our insured patients, we will file your dental insurance claim forms. You are responsible at the TIME OF TREATMENT for payment to us of any applicable deductible and for your ESTIMATED co-insurance portion. Any payments made directly to you by your insurance company on unpaid balances should be forwarded immediately to our office so that your account may be credited accordingly.

Parents NOT accompanying their child to an appointment must make prior arrangements for any co-payments due on that date of service.

We do accept the following payment options- CASH, CHECK, MCNISA, DISCOVER, AMERICAN EXPRESS, CARE CREDIT

I _____ hereby authorize my insurance benefits to be paid directly to American Dental Center. I realize that I am responsible to pay for any deductible amount(s), my co-insurance portion and for any non-covered services. I understand that I am financially responsible for any and all charges of dental treatment and incurred fees, whether or not paid by said insurance and I agree to pay such charges in full. I also hereby authorize the release of pertinent medical/dental information to the insurance carrier(s). This order will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original

X_____ Date_____

Patient/Legal Guardian