

DENTAL HISTORY

Please check any of the following that apply to you:

- Sensitivity (hot, cold, sweet)
Where? UR LR UL LL
- Headaches, ear aches, neck or jaw joint pain
- Mouth ulcers or cold sores
- Teeth or fillings breaking
- Grinding or clenching teeth
- Bleeding, swollen or irritated gums
- Loose, tipped or shifting teeth
- Bad breath

Do you have or have you had any of the following?

- Dentures
- Partial dentures
- Braces
- Gum treatments

Please share the following dates:

- Your last cleaning _____ / _____
- Your last oral cancer screening _____ / _____
- Your last complete X-Rays _____ / _____

Name of Previous Dentist _____

City _____ **State** _____

Phone Number _____

What is the most important thing to you about your future smile and dental health? _____

If you could whiten your teeth for a cost anyone could afford, would you do it?

Do you smoke or use chewing tobacco?
How much? _____ For how long? _____

If I could change my smile, I would:

- Make my teeth whiter
- Make my teeth straighter
- Close spaces
- Replace metal fillings with tooth colored restorations
- Repair chipped teeth
- Replace missing teeth
- Replace old crowns that don't match
- Have a smile makeover

On a scale of 1 – 10, with 10 being the highest rating:

- How important is your dental health to you?
1 2 3 4 5 6 7 8 9 10
- Where would you rate your current dental health?
1 2 3 4 5 6 7 8 9 10

Why did you leave your previous dentist?

What is the most important thing to you about your dental visit today? _____

MEDICAL HISTORY

Please check any of the following that apply to you:

- | | |
|---|--|
| <input type="checkbox"/> Allergies (Seasonal) | <input type="checkbox"/> Excessive Bleeding |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Heart Conditions |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Heart Murmur |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis A |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Hepatitis B |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Hepatitis C |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Dizziness/Fainting | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Mitral Valve Prolapse |

Do you have an allergy to any of the following?

- | | | |
|---|---------------------------------------|--|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Codeine | What medications are you currently taking?

_____ |
| <input type="checkbox"/> Erythromycin | <input type="checkbox"/> Other: _____ | |
| <input type="checkbox"/> Latex | _____ | |
| <input type="checkbox"/> Local Anesthetic | _____ | |
| <input type="checkbox"/> Nitrous Oxide | _____ | |
| <input type="checkbox"/> Penicillin | _____ | |

- | | |
|---|---|
| <input type="checkbox"/> Nervousness/Depression | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> OTHER (please list):

_____ |
| <input type="checkbox"/> Phen Fen (1 month +) | _____ |
| <input type="checkbox"/> Radiation (head/neck) | _____ |
| <input type="checkbox"/> Respiratory Problems | _____ |
| <input type="checkbox"/> Rheumatic Fever | _____ |
| <input type="checkbox"/> Rheumatism | _____ |
| <input type="checkbox"/> Scarlet Fever | _____ |

For WOMEN Only

- Birth Control Pills
- Breast-feeding
- Pregnant
1-3 mos, 3-6 mos, 6-9 mos,

Are you under a physician's care? For what?

Family Physician _____ **Phone Number** _____

ASSIGNMENT & RELEASE OF INFORMATION

The information I have provided is accurate and complete to the best of my knowledge. I understand it will be used for my treatment, billing and processing of my insurance benefits for which I am entitled. I will not hold my dentist or any staff member responsible for an error or omission that I may have made in the completion of this form. I understand and agree to pay the estimated patient portion at the time of service. In the event that payment in full for charges incurred is not made I agree to pay all costs of collections including a 50% collection fee, attorney fees, court costs and interest at the rate of 1.5% per month (18% per annum). I hereby authorize my insurance benefits to be paid directly to Advanced Dental Concepts. I am responsible for services not covered by my insurance benefit and authorize the release of any dental information necessary to assist in processing my insurance claim. I understand that if my insurance does not pay my claim within 45 days of my appointment date the amount is due in full 10 days after my statement is mailed. Furthermore, if I do not have insurance benefits I understand payment in full is due at the time of service.

I understand there will be a charge to my account in the amount of \$25.00 per one-half hour for any appointment missed if a 24-hour notice is not given to cancel and/or reschedule my appointment.

Signature _____ Date _____
(Parent or Legal Guardian)

NOTICE OF PATIENT PROTECTION HEALTH INFORMATION PERTAINING TO ADVANCED DENTAL CONCEPTS AND HIPPA COMPLIANCE

The following is the Advanced Dental Concepts HIPPA policy that is required by an act of the Department of Health and Human Services, a federal agency. This notice describes how Dental information about you may be used and disclosed and how you may obtain access to this information. Please review it carefully. It is to assure the Advanced Dental Concepts will protect your health information. Disclosures will be made only to ethically conduct treatment, refer to another physician or specialist and correspond as needed to process your insurance. Other disclosures will require your written authorization.

You as a patient have the right to inspect, discuss and amend your records. You may also request an accounting of disclosures.

By signing this form I acknowledge receipt of the Advanced Dental Concepts "Notice of Privacy Practices," and understand the content, my rights as a patient and the responsibilities of Advanced Dental Concepts with respect to protected health information.

Patient Signature (Parent or Legal Guardian), _____ Date _____

Patient's Printed Name _____