Advanced Dental Solutions P.C

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Patient Information

Please take a moment to enter or update your information to help us ensure the quality of your care is excellent.

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____ (Last) _____ (First) ___ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ **Prev. Visit:** _____ **Email Address:** _____

Phone: _____ (Home) _____ (Mobile) _____ (Work) _____ (Ext) **Best time to call:** _____

Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) _____-____ (Zip Code)

Social Security Number: _____

Date of last Dental visit: _____

Name of person, office, or other source referring you to our practice:

_____

Responsible Party Information

The following is for: ◯ the patient's spouse ◯ the person responsible for payment ◯ both ◯ neither-not applicable

Name: _____ (Last) _____ (First) ___ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ **Email Address:** _____

Phone: _____ (Home) _____ (Mobile) _____ (Work) _____ (Ext) **Best time to call:** _____

Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) _____-____ (Zip Code)

If the Emergency Contact is different from the Responsible Party listed above, please provide their Name, Gender, Phone Number and Relationship to the patient.

_____

_____

Primary Insurance Information

Primary Dental Insurance:

Name of Insured: _____ _____ ____
Last First MI

Insured's Birth Date: _____ **ID #:** _____ **Group #:** _____

Insured's Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

If you have secondary insurance, what is the plan name and who is the subscriber?

_____

_____

Check all that apply, please do not leave any blank.

Allergies *	◯ Yes ◯ No	Amoxicillin Allergy *	◯ Yes ◯ No
Asthma *	◯ Yes ◯ No	Cancer *	◯ Yes ◯ No
Cardiac Pacemaker *	◯ Yes ◯ No	Clindamycin Allergy *	◯ Yes ◯ No
Codeine Allergy *	◯ Yes ◯ No	Diabetes *	◯ Yes ◯ No
HIV *	◯ Yes ◯ No	Hay Fever *	◯ Yes ◯ No
Heart Disease *	◯ Yes ◯ No	Hepatitis *	◯ Yes ◯ No
High Blood Pressure *	◯ Yes ◯ No	Hyperthyroidism *	◯ Yes ◯ No
Ibuprofen Allergy *	◯ Yes ◯ No	Joint Replacement *	◯ Yes ◯ No
Kidney Disease *	◯ Yes ◯ No	Latex Allergy *	◯ Yes ◯ No
Mental Disorders *	◯ Yes ◯ No	Nervous Disorders *	◯ Yes ◯ No
Pacemaker *	◯ Yes ◯ No	Penicillin Allergy *	◯ Yes ◯ No
Pregnancy *	◯ Yes ◯ No	Radiation Treatment *	◯ Yes ◯ No
Seizures *	◯ Yes ◯ No	Sinus Problems *	◯ Yes ◯ No
Stroke *	◯ Yes ◯ No	Tuberculosis *	◯ Yes ◯ No
Tumers *	◯ Yes ◯ No	Tumors *	◯ Yes ◯ No
Venereal Disease *	◯ Yes ◯ No		

Please list any medications you are currently taking, one medication per line:

_____

_____

_____

_____

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

If Yes, please explain:

Consent for Services / Office Policies

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. 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 unless other arrangements are made.

Patients with dental insurance understand that all dental services 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 patient's insurance forms or assist in making collections from insurance companies and will credit any 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 1.5% per month on the unpaid balance will be charged on all accounts exceeding 60 days, and will send to collection agency, unless previously written financial arrangements are satisfied.

I understand that any fee estimate 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 by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. 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 to discuss this statement or my treatment.

I understand that a 24 hour notice must be given for the cancellation of any appointment, failure to do so will result in a fee charged to my account based on the length of appointment. From $50 for short appointments to $100 for long appointments.

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

Patient Signature

Response Date: _____