ADVANCED —DENTAL, INC.—

PATIENT INFORMATION	CONFIDENTIAL
NAME ____________	**BIRTHDATE** ____________
ADDRESS ____________	**SOCIAL SECURITY #**____________
CITY ________ **STATE** ________ **ZIP** ________	**HOME PHONE** ____________
WHOM MAY WE THANK FOR REFERRING YOU? ____________	**WORK PHONE** ____________
CIRCLE APPROPRIATE SELECTION:	**CELL PHONE** ____________
MINOR SINGLE MARRIED DIVORCED WIDOWED SEPERATED	**EMAIL** ____________
CONTACT PREFERENCE: (Please circle)	____________
HOME WORK CELL TEXT EMAIL	
RESPONSIBLE PARTY	
NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT ____________	**RELATIONSHIP TO PATIENT** ____________
____________	**HOME PHONE** ____________
ADDRESS ____________	**WORK PHONE** ____________
CITY ________ **STATE** ________ **ZIP** ________	**CELL PHONE** ____________
EMPLOYER ____________	**BIRTHDATE** ____________
ADDRESS ____________	**SS NUMBER** ____________
CITY ________ **STATE** ________ **ZIP** ________	
INSURANCE INFORMATION	
NAME OF INSURED ____________	**RELATIONSHIP TO PATIENT** ____________
INSURANCE COMPANY ____________	**BIRTHDATE** ____________
ADDRESS ____________	**SS NUMBER** ____________
CITY ________ **STATE** ________ **ZIP** ________	**GROUP NUMBER** ____________
	INSURANCE PHONE ____________
ADDITIONAL INSURANCE	
NAME OF INSURED ____________	**RELATIONSHIP TO PATIENT** ____________
INSURANCE COMPANY ____________	**BIRTHDATE** ____________
ADDRESS ____________	**SS NUMBER** ____________
CITY ________ **STATE** ________ **ZIP** ________	**GROUP NUMBER** ____________
	INSURANCE PHONE ____________

Medical History

To be completed for the past 2 years

Name:

Weight:

Date:

Height:

Do you have a primary Physician?	Physicians Name:	Physicians Phone #:
Your current Physical Health is: Good Fair Poor	Do you use tobacco in any form?	Cigarettes or Smokeless?

Question			
Are you currently under a phycians care?	Yes	No	Please Explain:
Have you ever had joint replacements?	Yes	No	Please List each medications you are taking:
Have you had any surgical procedures?	Yes	No	Please list each one:

Yes	No	Condition	Yes	No	Condition	Yes	No	Condition
		Abnormal Bleeding			Glaucoma			Sinus Problems
		Alcohol Abuse			HIV + AIDS			Stroke
		Anemia			Heart Attack			Thyroid Problems
		Angina Pectoris			Heart Murmur			Tuberculosis
		Arthritis			Heart Surgery			Ulcers
		Artificial Heart Valve			Hemophilia	**Yes**	**No**	**Allergies**
		Asthma			Hepatitis (circle) A/B/C			Aspirin
		Blood Transfusion			High Blood Pressure			Codeine
		Cancer			Joint Replacement			Dental Anesthetics
		Chemotherapy			Kidney Problems			Erythromycin
		Claustrophobia			Liver Disease			Jewelry
		Colitis			Low Blood Pressure			Latex
		Congenital Heart Defect			Mitral Valve Prolapse			Metals
		Diabetes			Osteoporosis			Penicillin
		Difficulty Breathing			Pace Maker			Sulfa
		Drug Abuse			Psychiatric Problems			Tetracycline
		Emphysema			Radiation Therapy			Other:
		Epilepsy			Rheumatic Fever			
		Fainting Spells			Seizures	**Yes**	**No**	**If Female, Please Answer**
		Fever Blisters			STD's			Are you taking birth control?
		Frequent Headaches			Shingles			Are you Pregnant?
		Gag Reflex			Sickle Cell Disease			Are you nursing?

Doctor's Comments:

Doctor's Signature:

Date:

Dental History

How may we help you today?

Your dental health is: Good Fair Poor

Do you require antibiotics before dental treatment?

Yes No Reason:

Are you currently in pain? Yes No	Have you ever had gum or Periodontal Treatment? Yes No	Do your gums bleed? Yes No

Do you now or have you had any pain/ discomfort in your jaw (TMJ)? Yes No	Are you under stress new job, moving, relationships? Yes No	Have you lost any teeth? Yes No

Do you like your smile?	Is there anything you would change about your smile?
Are you happy with the color of your teeth?	Have you ever had an unfavorable dental experience?
When was your last dental cleaning?	When was your last dental visit?
How many times do you: Floss/week? Brush/day?	Are your teeth sensitive to hot/cold/or anything else?
Have you ever had a serious/difficult problem with any previous dental work? Yes No	How can we accommodate you during your dental visit?

How would your rate your level of dental anxiety?

None High

0 2 4 6 8 10

Advanced Dental, Inc. offers a wide variety of services to enhance and keep your smile beautiful.
Please circle any services below you would like our friendly staff to discuss with you during your visit:

Smile Make over/Veneers	Extractions/Wisdom Teeth	Night/Sports Guards
Implants	Partials/Dentures	Teeth Whitening
Sedation		

Nearest relative not living with you:

Name: Relationship:

Address: Phone:

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Patients Signature: Date:

Consent to Disclose Personal Health Information

Help us communicate with you better.

Please use this form to tell us when you would like us to discuss your health with others, and how we should contact you with non-urgent news such as appointment reminders. If you are completing this form on behalf of another patient (i.e. minor child), please use the patient's information

1. **What name I prefer to be called: ________________________**
2. **How I like *routine* messages**
   Email:____
   Cell Phone:_______________________ Work:____________________ HM:_______________

3. **Where is it okay to leave messages about my health:**
   At home At Work Mobile number Email

4. **Who is it okay to discuss my health with:**
   ☐ No one
   ☐ Any of the people listed below:

   ____
   ____
   ____

5. **What is okay to discuss or leave a message about:**

___ **Any** information about my treatment and account*, **OR:**
___ Appointment Information ___Prescription drug information ____Release of Records
___ Post-op instructions ____Account balance ____Needed treatment only
____ Other (specify):______________________________
*This may include detailed personal medical information including dental services to be provided, notification that items such as lab cases are ready, as well as any information listed in #5 above.

______________________________________ ___________________
Patient's Name **Date**

____
Signature of Patient or Guardian/Parent

This consent will remain in effect until revoked by the patient/parent/guardian, or in the case of minor, on the date the minor becomes an adult under the state law. Please advise us of any changes to your preference

OFFICE POLICIES

PAYMENT: Payment must be rendered before services will be performed on each date of service. If you are set up on a payment agreement, payment arrangements must be approved prior to appointment.

IF YOU HAVE INSURANCE, We will submit your insurance claim to your insurance carrier as a courtesy to you. The amount of coverage paid by your insurance company may be based on your insurance company's Usual and Customary Rates and/or Fee Schedule. You are responsible at the time of your appointment for any deductible or co-payment not covered by the insurance company, as well as any remaining balance that the insurance company fails to pay.

BROKEN APPOINTMENT POLICY Appointments in our office are reserved exclusively for each patient and are also customized according to individual needs. For this reason, if you are unable to keep your reserved appointment, please give us at least 48 hours notice. If you have a Monday appointment and need to cancel or reschedule, you need to contact our office no later than Thursday the week before. **We charge $35.00 for all broken appointments, no shows, and rescheduled appointments if less than 48 hours notice is not given.**

If a second broken appointment occurs, we will NOT reschedule your appointment at that time, instead we will place you on a short-notice list and we will call you when we have an appointment time available. In addition, you will also be required to PRE-PAY for your next appointment in FULL, as well as any broken appointment fee(s). In the event you break an appointment for the 3rd time, we will NOT reschedule your appointment. We will provide 30 days emergency care, to allow you time to find another dental provider.

ADDITIONAL COSTS

I understand and agree to pay for ALL cost involved with a collection agency, small claims court and/or an attorney's fees if my account is not paid in full.

RETURNED CHECKS

There will be a $35.00 returned check fee applied to your account if a check is returned. The account then must be paid by Cash, MasterCard, or Visa.

Minor Children (under the age of 18) must be accompanied by a parent/guardian for the full duration of their appointment.

Signature of Responsible Party: ____ Date: _______________________

This notice describes how medical/ Dental information about you may be used and disclosed and how you can get access to this information. Please read it carefully.

We understand that the privacy of your personal information is important to you. As your Dental office, we believe your right to privacy is a fundamental part of your treatment; as such, we want you to understand our privacy practices and procedures. Should you have any questions regarding these policies please do not hesitate to call the office at 307-634-6020.

Information We Collect About You

We collect personal information about you and your family as part of our new patient process, during the course of your care, and from other health care entities you utilize such as, other Dentists and specialists, imaging facilities, laboratories and your insurance company. This personal information includes items such as your name, address, phone number, birth date, social security number, employer, health history, insurance policy and coverage information and any information you provide. During the course of your treatment we will collect Dental information regarding diagnosis, treatment plans, progress and any test results or films.

How Your Information Is Used

The personal and health information gathered may be used and disclosed with your general consent for purposes of treatment, payment, or routine healthcare operations. This means we may send your information to other Dentists or facilities involved in your treatment as well as to your insurance company or a collection agency to obtain payment. Any other uses of your information require a signed authorization by you, the patient or guardian and can be revoked in at any time with a written request. Advanced Dental, Inc. does not sell patient information to marketing or pharmaceutical companies. In certain cases of public health interest we may be required to disclose certain information to local, state or national health organizations or government agencies.

We may contact you to provide appointment reminders or information about treatment.

Safeguarding Your Personal and Health Information

We are required by law to (1) make sure that medical information that identifies you is kept private (2) provide you with our privacy policy (3) follow the terms laid out in the privacy policy. As a means of protecting your privacy, we restrict access to your personal and health information to only those employees who require the information to complete their jobs and provide quality service to you.

Advanced Dental, Inc. maintains physical, electronic and procedural safeguards to comply with state and federal regulations that guard your personal and health information. If you feel your privacy has been violated you have the right to file a complaint with the Department of Health and Human Services. The complaint in no way influences your course of treatment with Advanced Dental, Inc.

Changes to Our Privacy Policy

All new patients will review a copy of our privacy policy. Advanced Dental, Inc. occasionally reviews its privacy policy and reserves the right to amend it. Notification of changes will be available at the front desk prior to the effective date of any changes.

Your Right to Restrict Use of Information

You have the right to request restrictions to our uses or disclosures of your personal or health information, although we are not required to agree to those restrictions. Once your request has been processed it will remain in effect until you request a change.

Patient Acknowledgement

I ______________________________ have reviewed Advanced Dental, Inc. Privacy Policy.

Signed____ Date