Aduddell Dentistry

Patient Information

Patient Name _____ Date of Birth _____

If Patient is child, Parent's Name _____

Street Address _____ Male or Female

City _____ State _____ Zip _____ Cell# _____

Home# _____ Work# _____

Name of Employer _____ Email Address _____

SS# of Patient _____ Driver's License # _____

Dental Insurance ☐ Yes ☐ No

Policy Holder's Name Employer _____

Ins Company _____ Phone# _____ Group# _____

Insured SS# _____ Date of Birth

Whom may we contact in case of emergency? _____

Phone# _____ Relationship _____

How did you hear about our office? _____

Previous/Present Dentist (circle one): _____

Last visit date _____

Please Read Carefully

I authorize the doctor to perform any and all forms of treatment that may be indicated in connection with the dental care of the patient above and to choose and employ such assistance as he sees fit. I understand that prior to treatment; full explanation of the procedure(s) involved will be given by the doctor and/or his staff. I agree to pay for all services rendered at the time of treatment unless prior arrangements have been made. I understand the total balance for all services is my responsibility, including any remaining after insurance co-payment. (A $5.00 billing fee will be applied to any remaining balance after 60 days from service date.) We ask that you notify our office 48 hours in advance if circumstances require you to change your appointment.

Signed _____ Date _____

Relationship to Patient _____

Aduddell Dentistry

Medical History

PATIENT NAME: _____ BIRTH DATE _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions:

Are you under a physician's care now?	☐ Yes	☐ No	If yes, please explain:
Have you ever been hospitalized or had a major operation?	☐ Yes	☐ No	If yes, please explain:
Have you ever had a serious head or neck injury?	☐ Yes	☐ No	If yes, please explain:
Are you taking any medications, pills or drugs?	☐ Yes	☐ No	If yes, please explain:
Do you take, or have you taken, Phen-Fen or Redux?	☐ Yes	☐ No	
Have you ever taken Fosamx, Boniva, Actonel or any other medications containing bisphosphonates?	☐ Yes	☐ No	
Are you on a special diet?	☐ Yes	☐ No	
Do you use tobacco?	☐ Yes	☐ No	
Do you use controlled substances?	☐ Yes	☐ No	
Have you ever had a total joint replacement?	☐ Yes	☐ No	

Women: Are you Pregnant/Trying to get pregnant?	☐ Yes	☐ No	Taking oral contraceptives?	☐ Yes	☐ No	Nursing?	☐ Yes ☐ No

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Local Anesthetics	☐ Acrylic	☐ Metal	☐ Latex	☐ Sulfa Drugs
☐ Other	If yes, please explain:						

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

AIDS/HIV Positive	☐ Yes	☐ No	Cortisone Medicine	☐ Yes	☐ No	Hemophilia	☐ Yes	☐ No	Radiation Treatments	☐ Yes	☐ No
Alzheimer's Disease	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Hepatitis A	☐ Yes	☐ No	Recent Weight Loss	☐ Yes	☐ No
Anaphylaxis	☐ Yes	☐ No	Drug Addiction	☐ Yes	☐ No	Hepatitis B or C	☐ Yes	☐ No	Renal Dialysis	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Easily Winded	☐ Yes	☐ No	Herpes	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Angina	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Rheumatism	☐ Yes	☐ No
Arthritis/Gout	☐ Yes	☐ No	Epilepsy or Seizures	☐ Yes	☐ No	High Cholesterol	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Artificial Heart Valve	☐ Yes	☐ No	Excessive Bleeding	☐ Yes	☐ No	Hives or Rash	☐ Yes	☐ No	Shingles	☐ Yes	☐ No
Artificial Joint	☐ Yes	☐ No	Excessive Thirst	☐ Yes	☐ No	Hypoglycemia	☐ Yes	☐ No	Sickle Cell Disease	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Fainting Spells/Dizziness	☐ Yes	☐ No	Irregular Heartbeat	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No	Frequent Cough	☐ Yes	☐ No	Kidney Problems	☐ Yes	☐ No	Stomach/Intestinal Disease	☐ Yes	☐ No
Blood Transfusion	☐ Yes	☐ No	Frequent Diarrhea	☐ Yes	☐ No	Leukemia	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Breathing Problem	☐ Yes	☐ No	Frequent Headaches	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Swelling of limbs	☐ Yes	☐ No
Bruise Easily	☐ Yes	☐ No	Genital Herpes	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No	Thyroid Disease	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Lung Disease	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No	Hay Fever	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Chest Pains	☐ Yes	☐ No	Heart Attack/Failure	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No	Tumors or Growths	☐ Yes	☐ No
Cold Sores/Fever Blisters	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	Pain in Jaw Joints	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Congenital Heart Disorder	☐ Yes	☐ No	Heart Pacemaker	☐ Yes	☐ No	Parathyroid Disease	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Convulsions	☐ Yes	☐ No	Heart Trouble/Disease	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No	Yellow Jaundice	☐ Yes	☐ No

Have you ever had any serious illness not listed above?	☐ Yes	☐ No	

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GAURDIAN _____ DATE _____

Aduddell Dentistry

Examination Questionnaire

1	What is the reason for today's visit?	
2	Are you currently in pain?	
3	How long since your last dental exam?	
4	Were x-rays taken at that time?	
5	Have you ever had any complications associated with past dental work?	
6	Have you experienced any discomfort from your teeth or gums lately?	
7	Do your gums bleed easily, feel tender, or irritated?	
8	Are your teeth sensitive to hot, cold, or sweets?	
9	Are you troubled by bad breath?	
10	Has the fear of pain kept you from regular dental visits?	
11	Are you aware of grinding or clenching your teeth?	
12	Are you satisfied with the appearance of your teeth?	
13	What did you like the most about any former dentist?	
14	Whom may we credit with referring you to our care?	
15	What may we do to make your dental visits more pleasant?	

Financial Policy

Thank you for allowing us the privilege of providing your oral health care. As part of our commitment to communication and transparency, we ask that all patients please read the below information and sign before any treatment is rendered.

- Payment of your bill is considered part of your treatment, and payment is due at the time services are rendered, unless prior financial arrangements have been made and agreed upon by both parties. CareCredit is an outside financing company available upon request and approval. We also accept Visa, MasterCard, Discover, cash, and personal checks.

- Our office will help you in filing your insurance claims. While we may provide you with an estimate of benefits, please note that this is only an estimate, not a guarantee that your insurance company will pay exactly as estimated. We make every effort to provide you with as accurate of an estimate as possible, but ultimately, your insurance company and your plan's terms and benefits will determine the actual amount paid.

- Regardless of your insurance coverage, all charges you incur are your responsibility. Dental insurance is based upon a contract between you, your employer, and your insurance company. Our relationship is with our patients, not to their insurance companies.

- Our commitment to providing you with quality oral health care and building lasting relationships with our patients means that we make every effort to contain costs and pass on these savings to you, our valued patients. We believe that our fees are fair and reasonable, usual and customary for our area of service. Please note that you are responsible for payment regardless of what your insurance company arbitrarily determines their "usual, customary, and reasonable" reimbursement rates.

- Dental insurance is a misleading term - Dental "assistance" may be more descriptive. Dental plans cover only a certain percentage of the actual cost of your treatment. Please pay the deductible and co-payment estimated to not be covered by your insurance company at the time services are provided. We accept cash, check, MasterCard, Visa, and Discover.

- Most insurance claims are paid within 30 days of filing. If your claim has been denied or payment is not received, it is your responsibility to pay the full amount at that time. Note: we will attempt to work with your insurance company in helping you receive your claims, but we will not enter into a dispute with your insurance company.

Thank you for your understanding and cooperation regarding these matters. We look forward to the opportunity to provide your oral healthcare needs. Please don't hesitate to contact us with any questions you may have regarding this policy or your care.

Consent:

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENE FITS DIRECTLY TO MY DENTAL OFFICE. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance, rebilling, collection charge and/or attorney fee will be added to any overdue balance

By signing below, you are authorizing us to call you at any number you provide including calls to mobile/cellular or similar devices for any lawful purpose. You agree to any fees or charges that you may incur for an incoming call from us, and/or outgoing calls to us, to or from any such number, without reimbursement from us.

_____

Signature