ALBEMARLE
DENTAL ASSOCIATES

WELCOME!

Thank you for selecting our dental office. To help us to best meet all of your dental health care needs, please complete this form as completely and accurately as possible. If you have any questions or need assistance, please ask us and we will be glad to help.

PATIENT INFORMATION

Social Security #: ☐☐☐-☐☐-☐☐☐☐

Patient Name: _____ _____ ____ _____
Last First MI Preferred Name

Title: _____ Gender: ◯ Male ◯ Female
Mr/Ms/Mrs/etc

Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

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

Phone: _____ _____ _____ _____ Best time to call: _____
Home Work Ext Mobile

Address: _____

_____ ____ _____
City State Zip Code

Whom may we thank for referring you to our practice?

☐ Dental Office ☐ Medical Office ☐ Yellow Pages ☐ Internet

☐ Newspaper ☐ Work ☐ Other (name below)

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

_____

Do you have dental insurance coverage?

◯ Yes ◯ No

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Spouse or Responsible Party Information

Social Security #: ☐☐☐-☐☐-☐☐☐☐

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

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 _____ Work ____ Ext _____ Mobile Best time to call: _____

Address: _____

_____ City ____ State _____ Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Phone: _____

Address: _____

_____ City ____ State _____ Zip Code

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HEALTH HISTORY

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

Date of last dental visit

Reason for today's visit

Do you have a primary physician?

◯ Yes ◯ No

Name address and phone number of physician

Please list any medications you are now taking

Do you require premedication for dental treatment?

◯ Yes ◯ No

Are you allergic to or had an adverse reaction to any of the following? (Please check)

☐ Penicillin ☐ Erythromycin ☐ Sulfa Drugs ☐ Aspirin

☐ Codeine ☐ Latex ☐ Any metals (List)

Are you allergic to any drug not listed above? (List)

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Have you ever had any of the following medical problems or conditions? (Please check)

- ☐ Abnormal bleeding
- ☐ Abnormal blood pressure
- ☐ Allergies / hay fever / sinus
- ☐ Alcohol / drug abuse
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting spells
- ☐ Frequent headaches
- ☐ Glaucoma
- ☐ HIV / AIDS
- ☐ Heart attack
- ☐ Heart murmur
- ☐ Heart surgery
- ☐ Hepatitis
- ☐ Herpes / fever blisters
- ☐ Joint replacement
- ☐ Liver disease
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Pacemaker
- ☐ Are you Pregnant
  Due date _____
- ☐ Seizures
- ☐ Shingles
- ☐ Sickle cell disease
- ☐ Sinus problems
- ☐ Stroke
- ☐ Transplant
- ☐ Tobacco use
- ☐ Radiation treatment

Assignment and Release

I, the undersigned, assign directly to Albemarle Dental Associates all benefits of my insurance, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

Signature_____ Date: _____

I, being the parent or guardian of _____, do hereby authorize the dental staff to perform all necessary dental services for my child, including but not limited to x-rays, and for the administration of anesthetics which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered.

Signature_____ Date: _____

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Informed Consent Form For Dental Procedures

You the patient have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment. By consenting to treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

It is very important that you provide us with accurate information before, during and after treatment. It is equally important that you follow your dentist's recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialists, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.

As with all surgery, there are commonly known risks and potential complications associated with dental treatment. No one can guarantee the success of the recommended treatment, or that you will not experience a complication or less than optimal result. Even though many of these complications are rare, they can and do occur occasionally.

Some of the more commonly known risks and complications of treatment include, but are not limited to the following:

1. Pain, swelling, discomfort, and possible infection requiring medication after treatment.
2. On rare occasion, temporary or permanent numbness, pain, tingling or altered sensation of the lip, face, chin, gums, and tongue along with possible loss of taste.
3. Damage to adjacent teeth, restorations or gums.
4. The need for replacement of restorations, implants or other appliances in the future.
5. Possible injury to the jaw joint or jaw fracture requiring follow-up care and treatment, or consultation by a dental specialist.
6. On rare occasions, a root tip, bone fragment, or a piece of dental instrument may be left in your body, and may have to be removed at a later time if symptoms develop.
7. If upper teeth are treated, there is a chance of a sinus infection or opening between the mouth and sinus cavity resulting in infection or the need for further treatment.
8. Allergic reaction to anesthetic or medication

This form is intended to provide you with an overview of potential risks and complications. Be certain all of your concerns have been addressed to your satisfaction by your dentist before commencing treatment.

_____ _____

Patient / Parent Signature Date

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Financial Policy

Comprehensive dental treatment is an excellent investment in the overall health and well being of children and adults. Financial considerations should not be an obstacle to obtaining this important health servic
Neither-nor applicablee. We are sensitive to the fact that different people have different needs in fulfilling their financial obligations, so we offer the following payment options:

1. Unless previous payment arrangements have been made, payment is expected at the time services are rendered.
2. We accept cash, checks, and debit or credit cards as payment.
3. Payment arrangements are as follows
   - Payment arrangements are available only on amounts exceeding $300.
   - A 5% accounting discount is offered on treatment over $500 if payment in full is made at the beginning of treatment.
   - We accept 50% down at the beginning of treatment and payment of the balance of 50% at the last appointment (or any variation thereof-for example, if the treatment will take 4 appointments, 25% could be made at each appointment)
   - We are aware that unexpected dental care costs can significantly impact your budget and we want to make our services as affordable as possible. For this reason we have adopted Care Credit as our office monthly payment plan. Care Credit is a credit account that with approved credit is offered in our office to help with your bill. Care Credit has multiple payment options to choose from, including some that are interest free.
   - We are happy to submit the claims necessary to see that you receive the full benefits of your dental insurance coverage; however, we cannot guarantee any estimated coverage. You may direct the insurance company to pay their share of the cost directly to our office. We do ask that you pay your estimated share at the time treatment is rendered. Upon receipt of the insurance payment we will reconcile your account and bill or credit any difference. Because the insurance policy is an agreement between you and the insurance company, we ask that patients are directly responsible for all charges. All deductibles and copayments are due at the time of service. If for some reason your insurance company has not paid their portion within 45 days, you will be responsible for payment at that time.
4. Interest charges in the amount of 18% annually and 1 1/2% monthly will be assessed on any unpaid balances of 60 days or more. Thank you for taking the time to read our financial policy. Please let us know if you have any questions or concerns. I agree to abide and understand all the parameters within this agreement. I also give consent for Albemarle Dental Associates to file claims with the insured party's insurance company.

_____ _____

Patient / Parent / Guardian **Date**