

Welcome

Thank you for trusting us with your dental care.
WE promise to do our best to provide you with the finest care available!

PATIENT INFORMATION

Date: _____

Legal Name _____ Nickname _____ Sex _____ Male _____ Female

Full Name as shown on Insurance Card or Drivers License

Status: Single Married Divorced Widowed Separated

Birthdate _____ Social Security # _____ Drivers License # _____

Home Phone # _____ Cell/Beeper/Pager # _____ Work Phone # _____

Home Address _____ City _____ State _____ Zip _____

Mailing Address (if different from above) _____ City _____ State _____ Zip _____

Patient's Employer _____ Can we contact you at work? _____ Yes _____ No

Business Address _____ City _____ State _____ Zip _____

If Patient is a Student, Name of School/College _____ City _____ State _____

RESPONSIBLE PARTY

Name of person responsible for this account _____ Relation to Patient: _____

If not reflected above: Home Phone _____ Work Phone _____ Cell/Beeper/Pager# _____
Drivers License # _____ Are they a patient of this office? _____ Yes _____ No

EMERGENCY CONTACT INFORMATION

Name _____ Relationship to patient _____

Home Phone _____ Work Phone _____ Cell/Beeper/Pager# _____

Whom may we thank for referring you? _____

or - How did you hear about us? Newspaper Sign Yellow Pages Brochure Other

DENTAL HISTORY

Reason for today's visit _____	Cigarette, pipe, or cigar smoking	Now Have <input type="checkbox"/>	Have Had <input type="checkbox"/>	Mouth breathing	Now Have <input type="checkbox"/>	Have Had <input type="checkbox"/>
	Clicking or popping jaw	<input type="checkbox"/>	<input type="checkbox"/>	Mouth pain, brushing	<input type="checkbox"/>	<input type="checkbox"/>
Place a (✓) to indicate if any of the following apply:	Dry mouth	<input type="checkbox"/>	<input type="checkbox"/>	Orthodontic treatment	<input type="checkbox"/>	<input type="checkbox"/>
	Fingernail biting	<input type="checkbox"/>	<input type="checkbox"/>	Pain around ear	<input type="checkbox"/>	<input type="checkbox"/>
	Food collection between the teeth	<input type="checkbox"/>	<input type="checkbox"/>	Periodontal treatment	<input type="checkbox"/>	<input type="checkbox"/>
Bad Breath	Foreign objects	<input type="checkbox"/>	<input type="checkbox"/>	Sensitivity to cold	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Gums	Grinding teeth	<input type="checkbox"/>	<input type="checkbox"/>	Sensitivity to heat	<input type="checkbox"/>	<input type="checkbox"/>
Blisters on lips or mouth	Gums swollen or tender	<input type="checkbox"/>	<input type="checkbox"/>	Sensitivity to sweets	<input type="checkbox"/>	<input type="checkbox"/>
Burning sensation on tongue	Jaw pain or tiredness	<input type="checkbox"/>	<input type="checkbox"/>	Sensitivity when biting	<input type="checkbox"/>	<input type="checkbox"/>
Chew on one side of mouth	Lip or cheek biting	<input type="checkbox"/>	<input type="checkbox"/>	Sores or growths in your mouth	<input type="checkbox"/>	<input type="checkbox"/>
	Loose teeth or broken fillings	<input type="checkbox"/>	<input type="checkbox"/>	How often do you floss? _____		
				How often do you brush? _____		

Dentures? upper lower both How old are dentures? _____

Partial? upper lower both How old is partial? _____

MEDICAL / HEALTH HISTORY

The following information is to be reviewed by the doctor and will be held in the strictest confidence. It is important that you complete this medical history form in its entirety so that we may accurately diagnose and treat you, according to your general health and well-being. Thank you for allowing us to serve your dental needs.

Do you have a current medical problem? YES NO What
 Physician's Name _____ Date of last visit _____

Have you had any serious illnesses or operations? YES NO If yes, describe _____

Have you ever had a blood transfusion? YES NO If yes, give approximate dates _____

Place a mark (✓) to indicate if any of the following apply:

	Now Have	Have Had		Now Have	Have Had		Now Have	Have Had
AIDS/ HIV	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes, Type I or II	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis, Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Nervous Problems	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Heart Valve	<input type="checkbox"/>	<input type="checkbox"/>	Fainting or dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Joints	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Care	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Disease	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding abnormally, with extractions or surgery	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>	Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis Type _____	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>
Chemical Dependency	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Tumor or growth on head or neck	<input type="checkbox"/>	<input type="checkbox"/>
			Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>			

Women:

Are you pregnant? YES NO Due date _____ Are you nursing? YES NO
 Obstetrician's Name _____ Phone# _____

MEDICATIONS	ALLERGIES
List any other medications you are using: _____ _____ _____	<input type="checkbox"/> Latex <input type="checkbox"/> Penicillin <input type="checkbox"/> Sulfa <input type="checkbox"/> Other _____

I have read and understand the above questions to the best of my knowledge.

X _____ X _____
 Signature Date

DENTAL INSURANCE INFORMATION

The following information plus a copy of your insurance card is needed to verify your insurance coverage:

PRIMARY DENTAL INSURANCE

PLEASE PRINT:

Patient's Name: _____ Patient's Date of Birth: _____

Name of the Policy Holder/Insured: _____

Policy Holder's Relationship to the Patient: _____

Policy Holder's Date of Birth: _____ Social Security # _____

Employer of Policy Holder: _____

Employer's Telephone # _____ Name of the Insurance Company _____

Contract # _____ Group # _____

Insurance Card provided? Yes No

ADDITIONAL/SECONDARY INSURANCE

Patient's Name: _____ Patient's Date of Birth: _____

Name of the Policy Holder/Insured: _____

Policy Holder's Relationship to the Patient: _____

Policy Holder's Date of Birth: _____ Social Security # _____

Employer of Policy Holder: _____

Employer's Telephone # _____ Name of the Insurance Company _____

Contract # _____ Group # _____

Insurance Card provided? Yes No

I authorize the release of all dental records to the dental office, inc. as well as records necessary for the processing of insurance claims. I assign to and authorize directly to the dental office, inc. all benefits payable under such insurance policy.

X _____
Signature of Patient or Responsible Party

Today's Date

INSURANCE AND FINANCIAL INFORMATION FOR OUR PATIENTS

Thank you for considering our office for your dental needs. Whether you have dental insurance or not, we realize that every person's financial situation is different. For this reason, we have worked hard to provide a variety of payment options to help you receive the dental care you need. Your dental health is an excellent investment in your medical and psychological well-being. Financial considerations should not be an obstacle to obtaining this important, life-enhancing care. We are always available to answer your questions or assist you in any way we can.

INSURANCE

We gladly verify your insurance coverage and share with you the information your insurance company allows us access to. Please note that ultimately the policy belongs to you and your employer and that the amount of information we receive about your policy is limited. For complete coverage information concerning your coverage your policy booklet or your human resources can supply total information. We file your claims in a timely manner and provide your insurance company with complete information, x-rays and doctor's notes as needed to process your claims in a timely manner.

BILLING STATEMENTS

We make every effort to give you an estimate of what you owe on the date of your dental services. Our estimates are based on what your insurance company will share with us about your dental coverage and therefore is limited. If your company rejects your claim or does not pay as estimated we will notify you by phone or by a billing statement or letter. Questions concerning statements should be directed to our financial department. Please note that our billing policy is to send three (3) statements. If at that time you have not paid your balance or made financial arrangements your account will be turned over to a collection agency. Collection agencies add additional fees of as much as 33 1/2 % of your balance due. They will also charge you all collection costs, court costs and filing fees.

METHODS OF PAYMENT

We do not offer in-house financing except on orthodontic cases. This allows us to keep our prices reasonable and competitive. We do accept MasterCard, Visa, American Express and Discover. We also offer CareCredit as an outside financing option. We accept your flexible spending cards and personal checks with proper I.D. Checks returned for non-payment are worked through electronic check recovery systems. If this option cannot recover your payment it is then turned over to the county and a warrant is issued.

AGREEMENT TO PAY

The undersigned accepts the fee charged as a lawful debt and promises to pay said fee including the cost of collection, attorney fees, and court costs if such be necessary, waiving now and forever the right to claim exemption under the constitution and laws of the State of Alabama, or any other state. These fees will be added to your existing balance.

I have read and understand the above policies of the dental office, inc. I also agree to pay any and all additional fees for collection of bad debts and returned checks.

I also understand that the dental office, inc. requires each and every patient read and sign this form and reserve the right to deny me dental services if I refuse to sign this or any of their office forms.

X _____

Signature of responsible party

_____ Date



TH

(205) 640-1717 fax 640-5197 2323 Moody Parkway Moody, AL 35004

RECORDS RELEASE AUTHORIZATION

Date of Request : _____

My permission is granted to _____ located at
Name of Dental Office / Doctor

Address _____ City _____ St _____ Zip _____

and whose telephone number is () _____ to disclose to

THE DENTAL OFFICE, INC. the complete information concerning the dental / medical

findings & treatment of _____ - ____/____/____

Print Name of Patient

Birthdate

Including but not limited to:

1. Dental Panorex X-ray (dated within last 5 yrs)
2. Dental BiteWing X-rays (dated within last 2 yrs)
3. Any Pictures (photos) and/or Disketts / CD's
Regarding dental findings
4. Complete Charting by the Doctor and/or Hygienist
(Including Periodontal charting)

I hereby release you, the doctor and the staff from any laws related to disclosure of confidential or privileged information.

Thanking you in advance for your cooperation in regards to this matter.

Signature of Patient/Guardian : _____

The Dental Office, Inc.

CONSENT FOR USE & DISCLOSURE OF HEALTH INFORMATION

By signing this form, you will consent to our use & disclosure of your protected health information to carry out treatment, payment activities & healthcare operations.

Date: _____

Patient Name : _____ Date of Birth : _____

Patient Address : _____

SSN : _____ Most Reliable Phone # : _____

The Privacy Act generally requires healthcare providers to take responsible steps to limit the use of disclosure of and requests for protected health information to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of protected health information disclosures. Information provided below, if completed properly, will constitute an adequate record.

Note : Uses & Disclosures for protected health information may be permitted without prior consent in an emergency.

I give The Dental Office, Inc. permission to release medical/dental information to the following persons:
(Please check all that apply and list first & last name)

<input type="checkbox"/> None	<input type="checkbox"/> Spouse _____
<input type="checkbox"/> Parents _____	<input type="checkbox"/> Guardian _____
<input type="checkbox"/> Mother (only) _____	<input type="checkbox"/> Father (only) _____
<input type="checkbox"/> Child (only) _____	<input type="checkbox"/> Other _____

ACKNOWLEDGMENTS:

I acknowledge that I have received the Notice of Privacy Practices from The Dental Office, Inc. I understand that this organization reserves the right to change its Notice of Privacy Practices in which case a revised Notice of Privacy Practices will be issued.

Print Name of Patient

Signature of Patient

Print Name of Personal Representative

Signature of Personal Representative

Relationship of Personal Representative to Patient

FOR OFFICE USE ONLY

Acknowledgment could not be obtained because :
(Check those that apply)

Patient Refused to Sign
 Prohibited by Communication Barriers
 Prohibited due to an Emergency Situation
 Other (please specify)