Advanced Dental

Medical History questionnaire

Today's date: _____ *Patient name:*_____ *DOB:*_____

Do you currently have any allergies to the following:

□ *Aspirin* □ *Latex* □ *Sulfa drugs*

□ *Codeine* □ *Local anesthetics* □ *Sedatives*

□ *Metals* □ *Penicillin/Amoxicillin* □ *other:*_____

Please list any medications you are currently taking:

Name of medication:	*Milligrams:*	*How often:*
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please check any of the following that apply:

□ *Acid reflux* □ *COPD*

□ *Aids/HIV* □ *Diabetes*

□ *Arthritis* □ *Epilepsy*

□ *Artificial joints* □ *Hearing impaired*

□ *Asthma* □ *Osteoporosis*

□ *Auto immune disorder* □ *Hepatitis - if yes what type:* _____

□ *High or Low Blood pressure* □ *Currently pregnant - how many week:* _____

□ *Blood thinners* □ *Heart murmur (currently)*

□ *Cancer* - □ *Chemotherapy* □ *Heart surgery – date of surgery:*_____

*Has your primary physician ever told you that you need to take premedication prior to any type of dental treatment? If yes what is your preferred pharmacy:*_____

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Dental Questionnaire

Reason for your dental visit today? _____

Date of last dental visit: _____ Date of last x-rays taken: _____

What was done at your last dental visit? _____

Previous dentist name:_____ Phone number: _____

Please check any of the following that currently apply:

□ Clench or grind teeth

□ Chew or smoke tobacco

□ Sensitivity to hot or cold

□ Problems biting or chewing

□ Have any loose teeth

□ Often get cold sores or blisters

□ Mouth breathe while sleeping

□ Other:_____

I _____(print name) understand the information on this form is necessary to provide me with dental care that best fits my needs in a safe and efficient manner.

Would you like to keep your teeth a lifetime? □ YES □ NO

Are you satisfied with the appearance of your teeth? □ YES □ NO

Do you feel nervous about having dental treatment done? □ YES □ NO

Would you like to change anything about your smile? □ YES □ NO

Have you ever had an upsetting dental visit? □ YES □ NO

if so please explain: _____

_____

Patient signature: _____ Date: _____

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Insurance

We are happy to submit any insurance claims necessary to ensure that you receive the full benefits of your coverage; however we cannot guarantee any estimated coverage. Your insurance policy is a contract between you and your insurance provider, we often receive limited information from your insurance provider regarding your dental coverage. Prior to any treatment we will be happy to provide you with an estimation or explanation of benefits to help better maximize your insurance benefits. Any services not covered or not paid for by your insurance provider will be your responsibility and payment will be due at the time of service.

Payment options

We are partnered with Care Credit, Lending Club, and Compassionate Finance and we do accept all major credit cards as well as cash payments. Payments are due at the time of service unless a prior payment arrangement has been made. Checks that are returned to our office from your financial institution are subject to a $25 returned check fee that will become the patient's responsibility.

Collections

Any balance on the patient account that has not been paid in 90 days will be turned over to a collection agency that will pursue any monies owed to Advanced Dental. We do understand that financial situations may arise and affect timely payment of your account. If any problems should arise we ask that you promptly let our office know so that we can set up a payment arrangement that best fits your needs.

Deposit Policy

1/3 deposit of the total treatment cost is required to reserve an appointment for any cases that require extensive amounts of time and work.

Appointment Policy

Broken and missed appointments create scheduling problems for our team as well as other patients. If you should need to cancel or reschedule an appointment we do require a 24 to 48 hour notice so that we have time to accommodate other clients, if proper notice is not given to our office the patient is responsible for a $25 cancellation fee.

_____	_____	_____
Print name	Signature	Date