

PATIENT INFORMATION

PATIENT

Name _____ Address _____
City _____ State _____ Zip _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____ Birth Date: _____
Social Security # _____ Sex (M/F) _____ Marital Status _____
Employer _____ Email Address _____

PERSON RESPONSIBLE FOR BILL (IF DIFFERENT THAN PATIENT)

Name _____ Billing Address _____
City _____ State _____ Zip _____
Home Phone: _____ Work Phone: _____ Birth Date: _____
Social Security # _____ Sex (M/F) _____ Marital Status _____
Relationship to Patient _____ Email Address _____

DENTAL INSURANCE COVERAGE (Y/N) _____

NO Skip to "Referred By" below.

YES Provide an insurance card to the desk and answer the following questions.

PERSON PROVIDING INSURANCE (IF DIFFERENT THAN PATIENT)

Name _____ Employer _____
Birth Date _____ Social Security # _____
Relationship to Patient _____ Work Phone _____

MORE THAN ONE DENTAL INSURANCE COVERAGE (Y/N) _____

If YES please explain to desk personnel.

REFERRED BY _____

IN CASE OF EMERGENCY NOTIFY _____ PHONE _____

All accounts are due and payable when services are rendered and shall be delinquent and bear interest at a rate of 1.5% per month thereafter. Should full payment not be made when due the undersigned agrees to pay all cost of collection, including a reasonable attorney fee not to exceed 33%. The undersigned further waives as to this debt or any renewal thereof all rights of exemption under the laws of Alabama as to real or personal property. The undersigned gives permission to contact employers as well as make inquiries pertaining to this applicant. Further, the undersigned agrees that time for payment may be extended or other indulgence granted by ALABAMA DENTAL ASSOCIATES but that any such action shall not constitute a waiver of any right by the said ALABAMA DENTAL ASSOCIATES.

Signed (By Responsible Party) _____

Today's Date _____

PATIENT MEDICAL HISTORY

PATIENT NAME _____

PHYSICIAN _____ OFFICE PHONE _____ DATE OF LAST EXAM _____

- | | YES | NO | | | |
|---|--------------------------|--------------------------|--|--------------------------|--------------------------|
| 1. ARE YOU UNDER MEDICAL TREATMENT NOW? | <input type="checkbox"/> | <input type="checkbox"/> | 7. ARE YOU ALLERGIC TO OR HAVE YOU HAD ANY REACTIONS TO ANY DRUGS? IF YES, PLEASE SPECIFY. | _____ | |
| 2. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS? | <input type="checkbox"/> | <input type="checkbox"/> | | _____ | |
| 3. ARE YOU TAKING ANY MEDICATION(S) INCLUDING NON-PRESCRIPTION MEDICINE? IF YES, WHAT MEDICATION(S) ARE YOU TAKING? | <input type="checkbox"/> | <input type="checkbox"/> | 8. WHEN WAS YOUR LAST COMPLETE PHYSICAL? | _____ | |
| | | | 9. WOMEN ONLY: | | YES NO |
| 4. DO YOU USE TOBACCO? | <input type="checkbox"/> | <input type="checkbox"/> | A) ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. DO YOU USE ALCOHOL, COCAINE OR OTHER DRUGS? | <input type="checkbox"/> | <input type="checkbox"/> | B) ARE YOU NURSING? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. ARE YOU WEARING CONTACT LENSES? | <input type="checkbox"/> | <input type="checkbox"/> | C) ARE YOU TAKING BIRTH CONTROL PILLS? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. PLEASE INDICATE WHICH OF THE FOLLOWING APPLIES TO YOU. CHECK ONLY IF ANSWER IS YES. | | | | | |

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> HEART DISEASE | <input type="checkbox"/> CHEST PAINS | <input type="checkbox"/> KIDNEY DISEASES |
| <input type="checkbox"/> HEART ATTACK | <input type="checkbox"/> CARDIAC PACEMAKER | <input type="checkbox"/> EASILY WINDED | <input type="checkbox"/> AIDS OR HIV INFECTION |
| <input type="checkbox"/> RHEUMATIC FEVER | <input type="checkbox"/> HEART MURMUR | <input type="checkbox"/> STROKE | <input type="checkbox"/> THYROID PROBLEM |
| <input type="checkbox"/> SWOLLEN ANKLES | <input type="checkbox"/> ANGINA | <input type="checkbox"/> HAY FEVER / ALLERGIES | <input type="checkbox"/> HEPATITIS / JAUNDICE |
| <input type="checkbox"/> FAINTING / SEIZURES | <input type="checkbox"/> MITRAL VALVE PROLAPSE | <input type="checkbox"/> TUBERCULOSIS | <input type="checkbox"/> SEXUALLY TRANSMITTED DISEASE |
| <input type="checkbox"/> ASTHMA | <input type="checkbox"/> ANEMIA | <input type="checkbox"/> RADIATION THERAPY | <input type="checkbox"/> STOMACH TROUBLES / ULCERS |
| <input type="checkbox"/> LOW BLOOD PRESSURE | <input type="checkbox"/> EMPHYSEMA | <input type="checkbox"/> GLAUCOMA | <input type="checkbox"/> RESPIRATORY PROBLEMS |
| <input type="checkbox"/> EPILEPSY / CONVULSIONS | <input type="checkbox"/> CANCER | <input type="checkbox"/> RECENT WEIGHT LOSS | <input type="checkbox"/> OTHER _____ |
| <input type="checkbox"/> LEUKEMIA | <input type="checkbox"/> ARTHRITIS | <input type="checkbox"/> LIVER DISEASE | _____ |
| <input type="checkbox"/> DIABETES | <input type="checkbox"/> JOINT REPLACEMENT OR IMPLANT | <input type="checkbox"/> HEART TROUBLE | _____ |

COMMENTS _____

PATIENT DENTAL HISTORY

PLEASE INDICATE WHICH OF THE FOLLOWING APPLIES TO YOU. CHECK ONLY IF ANSWER IS YES.

- | | | | |
|---|--------------------------|---|--------------------------|
| 1. DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING? | <input type="checkbox"/> | 8. DO YOU HAVE FREQUENT HEADACHES? | <input type="checkbox"/> |
| 2. ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOODS? | <input type="checkbox"/> | 9. DO YOU CLENCH OR GRIND YOUR TEETH? | <input type="checkbox"/> |
| 3. ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS/FOODS? | <input type="checkbox"/> | 10. DO YOU BITE YOUR LIPS OR CHEEKS, FREQUENTLY? | <input type="checkbox"/> |
| 4. DO YOU FEEL PAIN TO ANY OF YOUR TEETH? | <input type="checkbox"/> | 11. HAVE YOU EVER HAD ANY DIFFICULT EXTRACTIONS IN THE PAST? | <input type="checkbox"/> |
| 5. DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH? | <input type="checkbox"/> | 12. HAVE YOU HAD ANY ORTHODONTIC WORK? | <input type="checkbox"/> |
| 6. HAVE YOU HAD ANY HEAD, NECK OR JAW INJURIES? | <input type="checkbox"/> | 13. HAVE YOU EVER HAD PROLONGED BLEEDING FOLLOWING EXTRACTIONS? | <input type="checkbox"/> |
| 7. HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING PROBLEMS IN YOUR JAW? | | 14. HAVE YOU EVER HAD INSTRUCTION ON THE CORRECT METHOD OF BRUSHING YOUR TEETH? | <input type="checkbox"/> |
| A) CLICKING? | <input type="checkbox"/> | 15. HAVE YOU EVER HAD INSTRUCTIONS ON THE CARE OF YOUR GUMS? | <input type="checkbox"/> |
| B) PAIN (JOINT, EAR, SIDE OF FACE)? | <input type="checkbox"/> | | |
| C) DIFFICULTY IN OPENING OR CLOSING? | <input type="checkbox"/> | | |
| D) DIFFICULTY IN CHEWING? | <input type="checkbox"/> | | |

I certify that I have read and understand the above information, to the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

X

PATIENT, PARENT OR GUARDIAN

DATE

PATIENT ACKNOWLEDGEMENT OF PRIVACY PRACTICES CONSENT & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing, we may not be allowed to process your insurance claims.

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original. MY SIGNATURE WILL ALSO SERVE AS A PERSONAL HEALTH INFORMATION DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR/ FACILITY'S IN THE FUTURE.

Patient's Name (print)

Signature
(Parent or Guardian signature for minors)

Date

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR
HEALTH INFORMATION:

(This includes stepparents, grandparents and any caretakers who can have access to this patient's records):

Name: _____

Relationship: _____

Name: _____

Relationship: _____

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

OFFICE USE ONLY

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

- ☐ It was emergency treatment
- ☐ I could not communicate with the patient
- ☐ The patient refused to sign
- ☐ The patient was unable to sign because: _____
- ☐ Other (please describe) _____

Signature of Privacy Officer