Advanced Family Dentistry

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Medical History

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

Indicate which of the following conditions you have or have had. By checking the box it will indicate a "YES" response, leaving blank will indicate a "NO" response.

- [ ] Adderall
- [ ] Allergies
- [ ] Allergy Clindamycin
- [ ] Allergy Codeine
- [ ] Allergy Penicillin
- [ ] AMOX
- [ ] Anemia
- [ ] Arthritis
- [ ] Artificial Joints
- [ ] aspirin
- [ ] Asthma
- [ ] back problems
- [ ] Birth Control Pills
- [ ] Blood Disease
- [ ] Cancer
- [ ] Cephas Osporins
- [ ] Convulsion
- [ ] Cortisone treatments
- [ ] Cough
- [ ] Diabetes
- [ ] Dizziness
- [ ] Emphysema
- [ ] Epilepsy
- [ ] erthromycin
- [ ] Excessive Bleeding
- [ ] Fainting
- [ ] Glaucoma
- [ ] Growths
- [ ] Hay Fever
- [ ] Head Injuries
- [ ] Heart Disease
- [ ] Heart Murmur
- [ ] Hepatitis
- [ ] High Blood Pressure
- [ ] HIV
- [ ] Jaundice
- [ ] Kidney Disease
- [ ] Latex allery
- [ ] Liver Disease
- [ ] Low Blood Pressure
- [ ] M V P
- [ ] Mental Disorders
- [ ] Migrain Headaches
- [ ] Nervous Disorders
- [ ] Omnicef
- [ ] Other
- [ ] Pacemaker
- [ ] PREMEDICATE
- [ ] prilosec
- [ ] Psoriasis
- [ ] Quinolones
- [ ] Radiation Treatment
- [ ] Reaction To Codeine
- [ ] Reaction To Demeral
- [ ] Reaction To Epi
- [ ] Reaction to Iodine
- [ ] Reaction to Latex
- [ ] Reaction to Metals
- [ ] Reaction To Sulfur
- [ ] Respiratory Problems
- [ ] Rheumatic Fever
- [ ] Rheumatism
- [ ] Seizures
- [ ] shortness of breath
- [ ] Sinus Problems
- [ ] skin rash
- [ ] Stomach Problems
- [ ] Stroke
- [ ] sulfa, iodine
- [ ] tetracycline
- [ ] Thyroid
- [ ] Tobacco habit
- [ ] tonsillias
- [ ] Tuberculosis
- [ ] Tumors
- [ ] Ulcers
- [ ] Venereal Disease

Please explain/clarify any conditions or alerts selected above:

Conditions/Alerts:

____
____
____
____

Allergies not listed:

____
____

Do you take antibiotic premedication for your dental visits? If yes, please explain below: * ◯ Yes ◯ No

Pre-Med:

____

____

Name of your Physician and Phone Number:

____

____

Preferred Pharmacy and Phone Number: *

____

____

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment below:

____

____

Are you currently taking any medications (prescription and non-prescription) including regular doses of aspirin? If yes, please list all medications and dosages below: *

◯ Yes ◯ No

Please list any medications you are currently taking, one medication per line:

____

____

____

____

☐ ***By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes. This will serve as my electronic signature.**

THE FOLLOWING SECTION IS FOR EXISTING PATIENTS ONLY

Please review and update the following information if needed. Thank you.

Chart#: ____________________
FOR OFFICE USE ONLY

Patient Name: ____________________ (Last) ____________________ (First) ____ (MI) ____________________ (Preferred Name)

Title: __________ (Mr/Ms/Mrs/etc) **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: ____________ **Prev. Visit:** ____________ **Email Address:** ______________________________

Phone: ____________ (Home) ____________ (Mobile) ____________ (Work) ______ (Ext) **Best time to call:** ____________________

Address: ______________________________ (Address 1) ______________________________ (Address 2)

______________________________ (City) ________ (State) _____-____ (Zip Code)

FINANCIAL AGREEMENT

I acknowledge that payment is due at the time of treatment, unless other arrangements are made.

I agree that parents, guardians, or personal representatives are responsible for all fees and services rendered for treatment of a minor/child.

I accept full financial responsibility for all charges for services or items provided to me, to my child/minor, or to the patient for whom I have legal responsibility.

I understand that filing a claim with insurance company does not relieve me from my responsibility for the payment of all charges.

I acknowledge that all returned checks, for any reason, are subject to a charge of the check amount plus an additional $35.00 return check fee.

I understand all bills, regardless if I have insurance or not, must be paid within 90 days. If balance run past 90 days on my account, I will be charged interest of 2.5% monthly until balance is paid.

I am aware that if any outstanding balance forces Advanced Dental of Denville to pursue debt with an attorney or collect ions agency, additional charges/fees will be applied to my account.

I acknowledge and agree to pay a broken appointment fee of $50.00 if I do not show to my scheduled appointment or cancel the same day of my appointment. I also acknowledge that if this occurs more than 3 times, I may be subject to a side-booked appointment in the future until the habit has ceased.

I understand that copies of records are always available within 5 business days and fees are as follows:

Search fee $10.00
Copy fee per page $1.00 (not to exceed $100.00)
X-rays copy fee $20.00 per copy (digital print out or email)
Same day Cancelation fee $50 (Dr. or Hygiene. Not to exceed 1 Hr.)
Any appointment longer than 1 Hr. (if cancel less than 48 hrs.) $100 fee

☐ * **By checking this box, I acknowledge that I have read the above statement and agree to its contents.**

AGREEMENT TO RECEIVE ELECTRONIC COMMUNICATION

By selecting YES below, I permit Advanced Family Dentistry to communicate with me electronically at the email address and/or mobile phone number listed below.

I am aware that there is some level of risk that third parties might be able to read unencrypted emails. I further agree that I am responsible for providing the dental practice any updates to my email address and/or mobile phone number.

☐ ***By checking this box, I acknowledge that I have read the above statement and agree to its contents.**

My most preferred method of electronic communication: *

☐ Phone call ☐ Text message ☐ Email

MOBILE #: ______________________

EMAIL: ______________________

HIPAA COMPLIANCE CONSENT FORM

Our notice of privacy practice provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature you have reviewed our notice before signing this consent.
The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPPA (Health Insurance Portability and Accountability Act of 1996) law allows for this consent in writing, signed by you. However, such revocation will not be retroactive.

*Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
*The practice reserves the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
*The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
The practice may condition receipt of treatment upon execution of this consent.

☐ ***By checking this box, I acknowledge that I have read the above statement and agree to its contents.**

INSURANCE AGREEMENT

Advanced Family Dentistry will always do our best to maximize the benefits you receive from your insurance plan. Please bring your insurance card and update us on all and any changes with your insurance.

Please be aware that:
1. All insurance policies are a contract between the patient & their insurance. If there are any issues in collecting benefits, the pt is ultimately responsible to promptly pay all balances in full.

2. Your insurance must be active on the actual date that the service are rendered.

3. Assignment benefits: Advanced Family Dentistry will accept direct payment of from your carrier. We will require that the patients make regular payments at each visit to cover any deductible & co-insurance so that there will be no balance due at completion of care.

4. Patients with 2 insurance plans: Recently there has been many changes in the coordination of benefits with two policies. In a growing percentage of cases this can still leave the patient with a required co-payment depending on how the second plan coordinates with the primary. Please ask your insurance about this.

5. Full time college students: Insurance now requires a letter/transcript from your school.

6. Children: It is the responsibility of parents/guardian who brings the child to our office at the initial visit to have necessary insurance information. The parent/guardian who brings the child at the first visit will ultimately have the responsibility of any and all unpaid balances on the account.

7. Policy Changes: Please notify us immediately if you have any insurance changes, terminates or you know that you will be terminating/changing your insurance at a future date.

8. Please keep all correspondence and stubs you receive from your carrier. In addition, should you receive any statements from us please review them carefully and contact us immediately if you feel there is a discrepancy.

☐ * **By checking this box, I acknowledge that I have read the above statement and agree to its contents.**

Response Date: ___________