DENTAL AVENUE

Welcome To Our Office!
Please Complete All 5 Pages

Thank you for choosing Dental Avenue as your dental care provider. We are committed to providing you the best possible dental care. If you have any problems or questions while completing the form below, we will be happy to help.

Patient Name _____ Date _____/_____/_____

Address _____ City/State/Zip _____

Phone ( )_____ Date of Birth _____/_____/_____ Age _____

Email _____ Sex M / F

Social Security _____-_____-_____

Status: □ Married □ Single □ Child

How did you hear about our office? □ Yellow Pages □ Drive-By □ Insurance List □ Friend or Family

□ Other _____

Other family members seen by us?_____

Parents or Guardian Informations:

Relationship to Patient_____

Name_____ Date of Birth _____/_____/_____

Address_____ City/State/Zip_____

Social Security _____ Driver's License_____

Home Phone ( ) _____ Work Phone ( ) _____

Employer_____ Position_____

Emergency Information: Please list the names and telephone numbers of two relatives (or friends) *not living with you* that we may contact in the case of an emergency.

Name_____ Name_____

Relationship_____ Relationship_____

Phone ( ) _____ Phone ( ) _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Dental Avenue
300 S. Cottonwood Dr.
Suite F
Richardson, TX 75080
214-703-0044

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change it's Notice to Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment of health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name:_____

Relationship to Patient: _____

Signature: _____

Date: _____

Yes	No	N/A	May we leave messages concerning your appointment with a co-worker, receptionist, or secretary that regularly answers your call?
Yes	No	N/A	May we leave messages on a voicemail at work?
Yes	No	N/A	May we discuss your appointments and/or treatments with your spouse?
Yes	No	N/A	If you are over the age of 18, still living at home, may we discuss your appointments and/or treatment with your parents/guardian?
Yes	No	N/A	If you are over the age of 18, may we discuss your appointments and/or treatment with your children?

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

Date:	Initials:	Reason:

MEDICAL / DENTAL HISTORY

Main problem that brought you to office?_____

Have you ever had:

□ High Blood Pressure □ Epilepsy, convulsions or seizures □ Cortisone-Steroid Treatment □ Diabetes
□ Kidney or Bladder Disease □ Asthma □ Shortness of Breath □ Swollen Ankles □ Chest Pains □ Cancer
□ Artificial Heart Valve □ Heart Murmur □ Stroke □ Mitral Heart Valve □ Heart Disease □ Pacemaker
□ Artificial Joints □ Thyroid Problems □ Arthritis or Rheumatism □ Glaucoma □ Leukemia □ Rheumatic
□ Allergies □ AIDS / HIV+ □ Blood Transfusion □ Other _____

☐ **Have you ever taken BISPHOSPHONATES, FOSAMAX, ACTONEL, BONIVA, RECLAST, ZOMETA**

If you are female, are you

☐ Pregnant ☐ Taking birth control pills ☐ Taking hormone medication

Date of last dental visit: _____

☐ Yes ☐ No Were x-rays taken at that time? ☐ Yes ☐ No Does your jaw click or pop?
☐ Yes ☐ No Were your teeth cleaned? ☐ Yes ☐ No Do you have bad breath?
☐ Yes ☐ No Do you have well water (private)? ☐ Yes ☐ No Are your teeth sensitive?
☐ Yes ☐ No Does your water have fluoride in it? ☐ Yes ☐ No Do you have dental implants?
☐ Yes ☐ No Have you ever been treated for gum disease? ☐ Yes ☐ No Are you happy with your smile?
☐ Yes ☐ No Have you experienced any pain or soreness in the muscles of your face or around your ear?
☐ Yes ☐ No Do you clench or grind your teeth?

Are you presently under the care of a physician? □ Yes □ No Date of Last Visit _____/_____/_____
Medical Physician's Name _____ Physician's Phone _____
If yes, for what? _____

Are you presently taking any drugs or medication? □ Yes □ No
If yes, please list _____

Are you allergic to any medication, local anesthetic, materials or latex gloves? □ Yes □ No
If yes, what drugs or materials? _____

Have you ever had a bleeding problem? □ Yes □ No
Do you use tobacco products? □ Yes □ No
Do you have a history of fainting? □ Yes □ No
Do you have any disease or condition not listed or anything about your health problem that we have not covered?
□ Yes □ No
If yes, please list _____

RELEASE:
I AUTHORIZE THE DENTIST TO PERFORM DIAGNOSTIC PROCEDURES AND TREATMENT AS MAY BE NECESSARY FOR PROPER DENTAL CARE. I AM RESPONSIBLE TO INFORM THIS OFFICE OF ANY CHANGE IN HEALTH HISTORY.

_____ _____
Patient or Guardian Signature Today's Date

DENTAL INFORMATION & ACCEPTANCE FORM

Patient Name: _____

1. HEALTH INFORMATION
I agree to disclose all previous illness, medical and dental history, (e.g. gum disease) including all medications. Undisclosed medical information and current medication, allergies, or illnesses are risk factors. I agree to allow the use of my information only where is necessary, for treatment or to process insurance claims.

2. DRUGS, LATEX AND MEDICATION
I understand that the antibiotics and other medications can cause allergic reactions and/or anaphylaxis, which is a potentially life-threatening condition that can interfere with normal breathing. Also, some antibiotics interfere with birth-control pills. Latex allergy can cause rashes and itching. Epinephrine, which is used in some dental injections, increases heartbeat, and depending on my health status, may be dangerous.

3. NEEDLE STICK
If a staff member is inadvertently stuck with a needle used on me, I consent to my blood drawn for analysis.

4. FILLING, CROWNS AND UNANTICIPATED ROOT CANALS
It is possible that a tooth will need a root canal, even after a simple filing or crown is done.

5. ROOT CANAL POSSIBLE FAILURE
Root Canals can fail and may require additional treatment or require extractions (removal) of the tooth.

6. PORCELAIN CROWNS, VENEERS, BONDING, AND COSMETIC FILLINGS
Once a crown, veneer, bonding, or filling is placed, I understand the color cannot be changed without a remark, and that they can chip or break, just like teeth. I have been counseled, informed, and educated on how it is important to maintain a healthy balanced occlusion (bite). I know that this may be complicated due to stress, clenching, muscles, teeth, and genetics. I am aware that most people grind their teeth subconsciously, which is damaging to the teeth and can break teeth or dental restorations. I have been informed about the need to wear an occlusal splint for protection.

7. GUM TREATMENT VS. "JUST CLEANING"
If I do not floss or if I smoke, I can expect to have a deteriorating gum condition called periodontal (gum) disease. I am aware that periodontal (gum) disease requires more treatment than a simple cleaning.

8. EXTRACTIONS AND SURGERY
I understand that all tooth extractions or dental surgeries carry risks. Some are minor, like a dry socket following an extraction. Some could be life threatening, such as post-surgical infection or anaphylaxis.

9. FEES FOR ADDITIONAL CARE OR SPECIALTY CARE
I understand that I may need treatment beyond what is originally planned (e.g. a crowned tooth may still need a root canal and may be referred to a specialist for additional care).

10. LIMITATION OF INSURANCE COVERAGE
Often there are charges beyond what insurance will pay, (e.g. sterilization fee, nitrous oxide, temporary dentures, bleaching, or cosmetic work). Also, as a service to our patients, this office will file insurance claims on their behalf; however, I understand that what may be quoted as my portion or co-pay) it is only an **ESTIMATE. I AGREE TO BE FINANCIALLY RESPONSIBLE FOR WHAT MY INSURANCE DOES NOT COVER OR DEEMED NOT DENTALLY NECESSARY.**

11. CHANGES IN TREATMENT PLAN
I understand that during treatment it may be necessary to change or add procedure that was originally planned because of conditions found while working on the teeth that were not discovered during examination or patient requesting changes in types of fillings, dentures, materials, precious metal, or etc... I understand there is an additional charge and I am financially responsible for these changes.

12. OFFICE MISUNDERSTANDING
The staffs of Dental Avenue, P.A. are human and can make mistakes from time to time regarding scheduling, billing, collection, or paperwork. When it comes to billing, it is **ultimately your responsibility for all charges to treatment rendered**. We thank you, in advance, for your considerations.

_____

Patient or Guardian Signature Date Witness

FINANCIAL POLICY

We ask that all patients read and sign our Financial Policy as well as complete our Patient Information form prior to seeing the dentist. Payment of services is due at the time services are rendered. We accept cash, check, credit cards and approved financing.

We may accept assignment of insurance benefits. However, you must understand that:

1. Your insurance policy is a contract between you, your employer, and the insurance company. We are **NOT** a party to that contract. Our relationship is with you, not your insurance company. We cannot become involved in disputes between you and your insurer regarding deductibles, co-payments, covered charges, secondary insurance, and "usual and customary" charges. Our involvement will be limited to supplying factual information to facilitate claim processing.
2. All charges are your responsibility whether your insurance company pays or does not pay or deemed not dentally necessary. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
3. Fees for these services, along with unpaid deductibles and co-payments, are due at the time of treatment.
4. I understand that employees of Dental Avenue, P.A. are NOT representatives for my insurance company and the estimate I receive from them is not a guarantee of payment from my insurance company.
5. If your insurance company does not pay your claim within 30 days, it is your responsibility to contact your insurer to expedite payment. If your insurance company does not pay, you are responsible for your payment.
6. If your insurance company does not pay in full within 45 days, we may require you to pay the balance.
7. There will be a $35 fee charged for returned checks.
8. Balances older than 60 days may be subject to collection placement and fees. A finance charge of 1.5% per month (Annual Rate of 18%) on the unpaid balance will be added monthly. I understand that I am liable for all costs if my account is sent to collection.
9. I authorize payment from my insurance carrier be made directly to the dentist.
10. I authorize this office to release necessary medical or dental information.

We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems to us, so we may assist you in management of your account. We have a number of different financial arrangement options available.

FIXED OR REMOVABLE PROSTHETICS, such as dentures, crowns, bridges or partial dentures, are understood to be a product that is uniquely suited to each particular patient. The full amount contracted for such services is, therefore, considered to be due and payable when the initial impression is made. We accept insurance for payment for the covered portion, however, you must pay your portion at the time services are rendered. PROSTHETICS MUST BE SEATED IN A TIMELY MANNER TO INSURE YOUR COMFORT, AND PROPER FIT. If you fail to have your prosthetics permanently seated within 60 days from date of impression, a second impression must be made, you will be charged an additional amount. ALL X-RAYS TAKEN ARE A PART OF OUR PERMANENT RECORDS. THERE IS A DUPLICATION CHARGE FOR ANY X-RAYS REMOVED FROM THIS OFFICE.

We will make every effort to confirm your appointment the day before. If an appointment cannot be kept, kindly give **24 hours notice** during business hours so another patient may have your time slot. There will be a **$25** charge if 24 hours notice is not given. If a patient is more than 10 minutes late, we do reserve the right to reschedule if the procedure interferes with another patient's appointment time.

Again, thank you for choosing Dental Avenue as your dental care provider. We appreciate your trust in us and the opportunity to serve you.

_____ _____

Patient or Guardian Signature Today's Date