ADVANCED DENTAL TECHNIQUES

WELCOME!

Please fill this form out completely. The better we communicate, the better we can care for you!

Patient Information

Today's Date:________________

Patient Name: ____ Preferred Name: ______________ ☐ Male ☐ Female
Last First MI ☐ Married ☐ Single ☐ Child ☐ Other

Occupation: _______________ Birth Date: ____/____/____ SS#:______-_____-_______ Driver's License #: _______________

Phone (Home): _________________ (Work): _________________ Ext:_______ (Cell):__________________
Circle preferred contact number

Address: ____
Street Apartment #

____ Email: __________________________
City State Zip Code

Employer Name: ______________________________________ Address:____
Street City State Zip

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: ____ ☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other

Occupation: _______________ Birth Date: ____/____/____ SS#:______-_____-_______ Driver's License #: _______________

Phone (Home): _________________ (Work): _________________ Ext:_______ (Cell):__________________
Circle preferred contact number

Address: ____
Street Apartment #

____
City State Zip Code

Employer Name: ______________________________________ Address:____
Street City State Zip

Referral Information

Whom may we thank for referring you to our practice? ____

Dental Insurance Information

Primary

Name of Insured: ___________________________________ Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other
Last First MI

Insured's Birth Date: ____/____/____ ID #: _________________ SS#:_____-____-______ Group #:______________

Insured's Address: ____
Street City State Zip Code

Insured's Employer Name & Address: ____
Name Street City State Zip Code

Insurance Plan Name & Address: ____ Phone Number: ______________

Secondary

Name of Insured: ___________________________________ Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other
Last First MI

Insured's Birth Date: ____/____/____ ID #: _________________ SS#:_____-____-______ Group #:______________

Insured's Address: ____
Street City State Zip Code

Insured's Employer Name & Address: ____
Name Street City State Zip Code

Insurance Plan Name & Address: ____ Phone Number: ______________

HIPPA -- I have received a copy of this office's Notice of Privacy Practices.

X____ Date: ___________ Relationship to Patient: _______________

PERMISSION TO DISCUSS YOUR MEDICAL INFORMATION

If you are 18 years of age or older we need your permission to discuss your account and healthcare information with your spouse, parents or others you designate. If you want us to be able to discuss a child with the other spouse or parent, you must list them below. If you want to grant us permission to do so, fill in the names of those you designate and sign below.

I grant permission to Advanced Dental Techniques and its employees to discuss my protected information with:
____

X____ Date: ___________ Relationship to Patient: ___________

Health Information

Date of Last Dental Visit: ___________________ Reason for today's visit:_____________________________________

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS/HIV
- ☐ Alcohol/drug abuse
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints/ Valves
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Congenital Heart Defect
- ☐ Diabetes
- ☐ Dizziness
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur/Prolapse
- ☐ Hepatitis
- ☐ Herpes/ Fever Blisters
- ☐ High Blood Pressure
- ☐ Hyper/Hypothyroidism
- ☐ Irregular Heart Beat
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Osteoporosis/ Osteopenia
- ☐ Psychiatric Problems
- ☐ Pacemaker
- ☐ Pregnancy Due date_____
- ☐ Radiation Treatment
- ☐ Recreational Drugs
- ☐ Respiratory Problems
- ☐ Rheumatic/Scarlet Fever
- ☐ Shingles/ Chickenpox
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease

Allergies:

- ☐ Aspirin Allergy
- ☐ Codeine Allergy
- ☐ Dental Materials
- ☐ Latex Allergy
- ☐ Penicillin/Amoxicillin Allergy
- ☐ Erythromycin Allergy
- ☐ Sulfa Allergy
- ☐ Tetracycline Allergy
- ☐ Other _____________

Please list any Prescription Medications you are currently taking: ____

____

Please list any Non-prescription Drugs, Herbal Medicines or Supplements you are currently taking: _________________

____

Have you EVER taken ACTONEL, AREDIA, BONEFOS, BONIVA, DIDRONEL, FOSAMAX, SKELIDE, ZOMETA? CIRCLE ALL

Do You Pre-Medicate for Dental Appointments? ☐ Yes ☐ No If so, with what? ___________________________

Have you ever had any complications following dental treatment? ☐ Yes ☐ No
If yes, please explain:____

Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
If yes, please explain: ____

Are you now under the care of a physician? ☐ Yes ☐ No Name of Physician: ___________________
Phone:____________

If yes, please explain: ____

Do you have any health problems that need further clarification? ☐ Yes ☐ No
If yes, please explain: ____

CONSENT FOR TREATMENT

1. The undersigned hereby authorizes doctor to take x-rays, study models, photographs, or other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs.
2. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (name of patient) ________________**.** I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.
3. I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made *in advance of treatment*. I understand that non-binding estimates of insurance coverage may be provided as a service, and I am responsible for any portion that is not paid by insurance regardless of reason. In the event payments are not received by the agreed upon dates, I understand that a 1.5% finance charge (18% APR) may be added to my account, in addition to any collection charges.
4. I understand that where appropriate, credit bureau reports may be obtained or made.
5. To the best of my knowledge the preceding answers and information are true and correct. I understand that it is my responsibility to advise your office of any changes in the information collected for my patient records.
6. Photographs of teeth are routinely taken for communication with laboratories, case documentation, insurance company payment determinations and educational purposes. All photographs are the property of Advanced Dental Techniques and may be used for publication or presentation purposes. A separate modeling consent will be obtained if any identifiable face photos are desired for publication.

PLEASE SIGN BELOW:

If my insurance allows it, I authorize assignment/payment of dental benefits directly to Dr. Breiterman. I understand that I am responsible for payment of any portion not paid by my insurance.

X____ Date: ____________ Relationship to Patient: __________________