Advantage Dental+

INTAKE FORM (PATIENTS 14 YEARS AND OLDER)

Date (mm/dd/yyyy)

Welcome, and thank you for selecting our dental healthcare team! We strive to provide the best possible dental care. To help us achieve this goal, please fill out these forms as completely as you can, in ink. If you have any questions or need assistance, please feel free to ask us.

If you require a language interpreter specify language: Did an interpreter help you with these forms? ☐ YES ☐ NO

Last Name First Name MI Suffix (check one) ☐ Sr ☐ Jr ☐ I ☐ II ☐ III Preferred Name

Gender (check one) ☐ M ☐ F ☐ Choose Not to Disclose ☐ Other _____ Marital Status ☐ Married ☐ Single

Race/Ethnicity: ☐ Caucasian ☐ Black/African American ☐ Hispanic/Latino ☐ Asian ☐ Other: _____ ☐ Choose not to disclose

Drivers License # & State Date of Birth (mm/dd/yyyy) SSN

Address City State Zip

Mailing Address (if different) City State Zip

Were you referred to this practice? ☐ YES ☐ NO If yes, who referred you: _____

Contact Information: Please provide all phone numbers and email.

Email _____ Cell _____ Alternative Phone _____

By providing the contact information above you are consenting to receiving electronic communications from Advantage Dental Oral Health Center about your appointments and treatment.

Occupation Employer

Emergency Contact Relationship Home Phone Cell Phone

Do you have Dental Insurance? ☐ YES ☐ NO If yes, who is your insurance carrier?

Primary Carrier Policy Holder Group Number Subscriber I.D. Policy Holder DOB

Policy Holder SS#_____ Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other

Secondary Carrier Policy Holder Group Number Subscriber I.D. Policy Holder DOB Policy Holder SS#

Is this visit a result of a motor vehicle accident? ☐ Yes ☐ No Is this visit a result of a work accident? ☐ Yes ☐ No

If you are completing these forms for the patient, select your relationship and print your name:

_____ **MOTHER** ☐ **FATHER** ☐ **GUARDIAN** ☐ **OTHER** _____

Communication Agreement

Advantage Dental+ practices can communicate with me using the contact information provided above. These communications may include voicemail, text, and/or email. You may opt out at any time by responding appropriately to the messages received.

Signature of Patient or Guardian: _____ **Date:** _____

You can request a copy of our privacy policy at any time. You can always find a copy of this policy at AdvantageDental.com/privacy-policy.

Staff Initial _____

ADULT DENTAL AND HEALTH HISTORY

Age 14 and above

Advantage Dental+

What is the reason for your dental visit today? ☐ EXAMINATION ☐ EMERGENCY ☐ CONSULTATION ☐ PROCEDURE

How would you describe your current dental health? _____

Date of your last dental visit (Month/Year): _____ ☐ EXAM ☐ EMERGENCY ☐ CONSULTATION ☐ PROCEDURE ☐ OTHER _____

Have you had any problems with previous dental treatment? ☐ **YES** ☐ **NO** If yes, please specify**:** _____

Do you have any pain clicking, popping, discomfort, or limited opening in the jaw or jaw joints? ☐ **YES** ☐ **NO** If yes specify: _____

Please state any questions or concerns about dentistry, your dental health or appearance of your teeth/smile:

Do you normally take an antibiotic prior to dental treatment? ☐ YES ☐ NO

Check all the below that apply:

Are you currently experiencing dental pain or discomfort? ☐	Do you have problems with eating (trouble chewing, vomiting, etc.)? ☐
Do you have bad breath/halitosis, metallic taste, or unpleasant taste? ☐	Do you have any loose teeth? ☐
Do you clench, brux, or grind your teeth? ☐	Are your teeth sensitive to cold, hot, sweets or pressure? ☐
Have you ever had a serious injury to your head or mouth? ☐	Do you have swelling in or around your mouth, face, or neck? ☐

Are you now, or have you been in the past year, under the care of a physician? ☐ **YES** ☐ **NO**

If yes, what is/are the condition(s) being treated? _____

Do you have, or have you had any of the following? Check box next to all that apply

Acid Reflux/GERD ☐	COPD ☐	Fainting spells/Dizziness ☐	Hepatitis A ☐	Psychiatric Care/Depression ☐
AIDS/HIV Positive ☐	Diabetes ☐	Glaucoma ☐	Hepatitis B ☐	Rheumatic Fever ☐
Alzheimer's Disease ☐	Drug Addiction ☐	Heart Attack/Heart Failure ☐	Hepatitis C ☐	Rheumatism ☐
Anaphylaxis ☐	Eating Disorder ☐	Hemophilia ☐	High Blood Pressure ☐	Sickle Cell Disease ☐
Angina/Chest Pain ☐	Emphysema/Shortness of Breath ☐	Heart Pacemaker/Artificial Heart Valve ☐	Low Blood Pressure ☐	Stroke ☐
Artificial Joint ☐	Epilepsy or Seizures/Convulsions ☐	Kidney Problems/Dialysis ☐	Liver Disease ☐	Thyroid Disease ☐
Asthma ☐	Excessive Bleeding ☐	Sexually Transmitted Disease ☐	Mitral Valve Prolapse ☐	Tuberculosis ☐
Cancer/Chemo/Radiation ☐	Excessive Thirst ☐	Ulcers/Intestinal Disease ☐	Osteoporosis ☐	Active TB ☐

Provide details to all YES answers here:

Are you taking, have you recently taken (within the last month), or are you supposed to be taking any medications? ☐ YES ☐ NO
(Prescription, over the counter, diet supplements, vitamins, natural, or herbal)

If yes, please specify medication(s), dosage, and frequency (If you take more than 4 medications, please provide us with a written list of all medications)

Medication Prescription or Over the Counter	**Dosage/Frequency**	**Supplements** Diet supplements, vitamins (natural or herbal)	**Dosage/Frequency**

Have you taken, are you taking, or are you scheduled to begin taking any bisphosphonates medication (list below)? ☐ **YES** ☐ **NO**

Clodronate (Bonefos), Pamidronate (Aredia), or Zoledronic Acid (Reclast, Zometa) (Alendronate (Fosamax, Fosamax Plus D), Etidronate (Didronel), Ibandronate (Boniva), Risedronate (Actonel), Tiludronate (Skelid)

What drug, dose and frequency? _____ What for? _____ When was last dose? _____

Do you use? Check the box next to any with a yes answer		
Tobacco (smoking, snuff, chew, bidis) ☐ If yes, are you interested in stopping ☐ Yes ☐ No	Recreational Drugs ☐	Prescription medication for non-medical reasons ☐

ALLERGIES

Are you allergic to any medications, metal, latex or certain materials? ☐ YES ☐ NO If so what are they? _____

DIABETIC PATIENTS

Diabetic Patients (please answer): When was your last A1C (blood sugar test)? _____ What was the number? _____

WOMEN ONLY

Are you pregnant? ☐ YES ☐ NO If yes, number of weeks: _____ Are you nursing? ☐ YES ☐ NO

Are you trying to become pregnant? ☐ YES ☐ NO

OTHER

Are there any other dental or health conditions that you would like to make us aware of to improve our delivery of care and better meet your oral health care needs?

_____

Primary Care Physician Information

Physician Name	Address	City	Phone Number

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Patient Name (print): _____ **Patient Date of Birth:** _____

Signature of Patient or Guardian: _____ **Date:** _____

Print Name of Signor if other than patient: _____ Relationship to Patient: _____

OFFICE USE

Blood Pressure: _____ /_____ Pulse: _____ Height: _____ Weight: _____ Temp: _____ Date: _____

HEALTH HISTORY REVIEWED BY _____

PROVIDER'S SIGNATURE **DATE**

PATIENT FINANCIAL POLICY

Advantage Dental+

You are fully responsible for all fees charged by this office regardless of your insurance coverage.

If you have dental insurance, your portion of the fee is due at the time of service. As a courtesy, this office may file your insurance claim, but we do not guarantee any benefit. The amount to be paid by insurance depends on the benefits of your particular plan. If you have any questions about the amount your plan will pay or the treatments your plan will cover, you should refer these questions to your insurance company. Additionally, there may be a deductible, a co-insurance factor, and/or a yearly maximum to be considered.

1. You authorize and direct payment to Advantage Dental+ of the dental benefits otherwise payable to you under any applicable dental insurance plan.
2. For our Medicaid patients, Medicaid will be billed for covered services. In the event a service is not covered by Medicaid, you will be informed prior to the service being performed.
3. Payment at the time of service is expected, including the estimated portion of the amount that insurance does notcover. Our office accepts the following payment methods: Cash, Check, Major Credit Cards, and third-party financing options (for those who qualify).
4. A statement for services rendered will be mailed to you on a monthly basis. Receipt of payment is expected within 30 days of the billing date on the statement. Payment should be mailed with the specified portion of the statement to establish the proper crediting of the account. If your insurance company hasn't made payment on a claim after 30 days, please contact your insurance company directly.
5. You may choose to pay the amounts due on your statement by phone using an acceptable form of payment. In the event you choose this payment option, we may securely store your payment information for future payments to be made at your direction.
6. Your account is considered delinquent if payment is not received within 30 days of the billing date on the statement. If payment is not received, a late charge of 1½% per month ($1.00 minimum) may be assessed and will appear on the next statement. The annual percentage rate shall be the lesser of 18% or the highest rate allowed under state law.
7. For any check that is returned for any reason, the original amount of the returned item plus a $35.00 charge will be billed to your account. If a check is returned, we may not accept payments by check from you in the future.
8. If you are the parent or legal guardian of a patient that receives treatment when you are not present (either accompanied by an authorized person or unaccompanied), you agree to pay for any services/treatments performed in your absence.

You understand and agree that if you fail to make timely payments, you will be responsible for all costs of collection monies owed, including court costs, collection agency fees, and attorney fees.

By signing below, you acknowledge you have read and understand the financial policy of Advantage Dental+ and agree to all the terms described in it.

Signature of Patient (or Person Authorized to Sign for Patient)

Patient Name

Relationship to Patient

Date

CONSENT FOR DENTAL PROCEDURE

Advantage Dental+

Patient(s): _____ Date: _____

I, the undersigned, for myself or another person for whom I have authority to sign, hereby consent to dental care and treatment while such care and treatment is provided through Advantage Dental+This consent includes my consent for all treatment performed by a Advantage Dental+ dentist and any other dental care provider or other designees under the supervision of the dentist, as deemed reasonable and necessary.

I understand that any current or future treatment may include, but is not limited to examinations, oral prophylaxis (cleanings), fluoride treatments, sealants, restorations (amalgam or composite fillings, crowns and bridges), periodontal (gum) treatments, endodontic (root canal) treatments, extractions, and the use of anesthetics. Such current or future treatment may involve the use of secure electronic communications and technologies to deliver virtual dental health and education services on a remote basis rather than in a traditional dental office setting. Dental treatment is not without potential complications, which may include (but are not limited to) pain, infection, swelling, bleeding, bruising, delayed healing, sinus complications, allergic reactions, stiffness, discomfort and decreased range of motion in the jaw joint(s), loosening of teeth or restoration in teeth, injury to other tissues and need for additional treatment outside scope of treating dentist. I understand topical anesthesia, local anesthesia and/or nitrous oxide inhalation anesthesia may be used if needed during treatment and I consent for their use in my care and that the use of anesthetics may carry a small risk for swelling, bruising, allergic reaction, changes in pain perception, prolonged or in extremely rare instances permanent numbness. I further understand that in the course of any treatment, it may be necessary to modify the intended treatment because of conditions discovered during the ordinary course of dental care and treatment. I further understand and acknowledge that my dental treatment may result in an increased risk of exposure to certain viruses and other pathogens present in the community at the time of my visit (including but not limited to the novel coronavirus/COVID-19, flu, cold virus, etc.). It is possible for such pathogens to be transmitted through respiratory droplets or fine water spray (aerosols) that may be present in a dental practice. I understand that these risks can be mitigated through the dental practice's infection control protocols and other preventative measures designed to reduce the potential for infection, but that these risks cannot be completely eliminated.

I understand that I have the right to discuss and ask questions of any current or future treatment and the purpose, potential risks and benefits of such treatment, as well as any alternative treatments, in order to make an informed decision regarding my care. I further understand that I have the right to refuse treatment and accept any potential consequences of refusing treatment and that I have the right at any time to discontinue treatment.

By signing below, I am indicating that (1) I intend that this consent continue in nature even after a specific diagnosis has been made and treatment recommended; and (2) I consent to treatment at this office or any other Advantage Dental+ office. The consent will remain fully effective until it is revoked in writing.

Signed Consent
I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____ [ ] Patient under 18 years of age _____
Signature of Patient or Legal Guardian Date

_____ _____
Printed Name of Patient or Legal Guardian Relationship to Patient

I hereby give my consent to treat the minor child/children below, who is/are under the legal age of eighteen years of age, to receive dental care and/or treatment from a Advantage Dental+ dentist. Any care and/or treatment deemed reasonable and necessary may be provided with or without my presence:

_____ _____
Child Date of birth

_____ _____
Child Date of birth

_____ _____
Child Date of birth

Advantage Dental+

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES AND NON-DISCRIMINATION NOTICE

Patient Name: _____

Additional Patients in same Family: _____

_____

_____

_____

_____

* You May Refuse to Sign This Acknowedgement*

I, _____, have been offered a copy of this office's Notice of Privacy Practices and Non-Discrimination Notice.

_____ _____

Please Print Name Relationship to Patient

_____ _____

Signature Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices and Non-Discrimination Notice, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communications barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (please specify)