ADLONG DENTAL

CONWAY, ARKANSAS

FAMILY & COSMETIC DENTISTRY

Patient Information

Patient First Name: _____ Middle Initial: _____ Last Name: _____

Preferred Name: _____

Address: _____ City/State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Sex: Male / Female Marital Status: Married / Single / Divorced / Widowed / Child

Birth Date: _____ Social Security #: _____

Email: _____

Employer: _____ Employment Status: Full Time / Part Time / Retired

Student Status: Full Time / Part Time

Preferred Pharmacy: _____Pharmacy Phone #: _____

Emergency Contact Name: _____ Phone: _____

Relationship to Patient: _____

Referral Information

Name of person or doctor referring you to our practice: _____

Smile Questionnaire

My mouth is (circle one): very comfortable, moderately comfortable, uncomfortable

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- ☐ My smile is excellent.
- ☐ I would like to change my smile.
- ☐ I am unconcerned about my smile.

- ☐ I will do whatever I must to keep my teeth.
- ☐ I want to keep my teeth but only within a certain budget (time/money).
- ☐ I am indifferent about keeping my teeth.

- ☐ I have done the dentistry that has been recommended to me in the past.
- ☐ I have NOT done the dentistry that has been recommended to me in the past.
- ☐ I have not had dentistry recommended to me in the past.

PLEASE SELECT ONE WORD THAT BEST DESCRIBES YOUR DENTAL HEALTH TODAY:

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Important dental insurance and financial information for our patients

We know understanding your dental insurance coverage can be quite challenging. Our goal is to assist you in maximizing your benefits. We care for patients with many different insurance companies. Each employer pays an insurance premium for specific coverage, which fits into the company budget. Each plan is slightly different in its covered services. **We encourage you to become familiar with your policy exclusions, deductibles, maximum, anniversary date, and required co-payments. There are thousands of dental plans & we are not responsible for knowing the details of your particular plan.**

To help achieve this goal, we need your assistance and your understanding of our payment policy:

- Payment for services is due at the time services are rendered, unless our staff has approved payment arrangements in advance.
- We accept cash, personal checks, MasterCard, Visa, American Express, Discover, & Care Credit.
- Returned checks and balances over 30 days old are subject to Finance Charges
- Charges (of $75) may be incurred for broken appointments cancelled without 24 hours advance notice.
- Failure to confirm appointment 24 hours in advance can result in double booking.
- A 3% processing fee will be added to all debit/credit card transactions.

Please realize about your Dental Insurance:

- Your insurance is a contract between you, your employer, and the insurance company. We are not a party in the contract.
- Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
- Our fees are generally considered to fall with the UCR range. “UCR” is defined as usual, customary and reasonable charges. All restrictions are based on your employers’ plan & the premium paid for the insurance---not on our fees or recommended treatment.

Thank you for your cooperation with your dental insurance coverage. Please sign below & have your insurance card ready for us to copy for our file.

Insurance:

I authorize release of any information concerning my (or my child’s) health care and treatment provided for the purpose of evaluating and administering claims for insurance benefits.
I authorize payment of insurance benefits directly to this office (Adlong Dental) otherwise payable to me. I am aware no insurance company attempts to cover all dental costs and the agreement of the insurance company to pay for my dental care is a contract between me and the insurance company.
I understand the staff at this office (Adlong Dental) will file my insurance for me and my benefits are only **ESTIMATED**. If my dental insurance company does not respond to the submitted claim within 60 days, I understand I may be responsible for the balance in full (all estimated insurance payments as well as my estimated amount due).

_____ _____
Signature of Patient (Or parent/guardian, if patient is a minor) Date

Fees & Payments:

I agree to be responsible for this account. All balances are due in full unless other payment arrangements have been made. If I am unable to pay my account, I will inform the business office before treatment and will make definite payment arrangements. All accounts 31 days old will be billed a finance charge in accordance with Arkansas law. Any accounts without payment made with in 60 days will be considered for collection by an outside collection agency. Should this office refer my account to the outside collection agency, I agree to pay a collection fee and any unpaid balance.

_____ _____
Signature of Patient (Or parent/guardian, if patient is a minor) Date

DENTAL HISTORY

Patient Name _____

What is the reason for your visit today? _____

_____

Date of Last Dental Visit _____ **Last Dental Cleaning** _____ **Last Full Mouth X-rays** _____

What was done at your last dental visit? _____

Previous Dentist's Name _____ Telephone _____

Address _____ State _____ Zip _____

How often do you have dental examinations? _____

How often do you brush your teeth? _____ How often do you floss? _____

Have you ever used or are currently using topical fluoride? Yes No

What other dental aids do you use? (Interplak, toothpick, etc.) _____

Do you have any dental problems now? Yes No If yes, please describe: _____

Are any of your teeth sensitive to:

Hot or cold?	Yes	No
Sweets?	Yes	No
Biting or Chewing?	Yes	No
Have you noticed any mouth odors or bad tastes?	Yes	No
Do you frequently get cold sores, blisters or any other oral lesions?	Yes	No
Do your gums bleed or hurt?	Yes	No
Have your parents experienced gum disease or tooth loss?	Yes	No
Have you noticed any loose teeth or change in your bite?	Yes	No
Does food tend to become caught in between your teeth?	Yes	No

If yes, where _____

Do you:

Clench or grind your teeth while awake or asleep?	Yes	No
Bite your lips or cheeks regularly?	Yes	No
Hold foreign objects with your teeth? (pencils, pipe, etc.)	Yes	No
Mouth breathe while awake or asleep?	Yes	No
Have tired jaws, especially in the morning?	Yes	No
Snore or have any other sleeping disorders?	Yes	No
Smoke/chew tobacco or use other tobacco products?	Yes	No

Have you ever had:

Orthodontic treatment?	Yes	No
Oral Surgery?	Yes	No
Periodontal treatment?	Yes	No
Your teeth ground or the bite adjusted?	Yes	No
A bite plate or mouth guard?	Yes	No
A serious injury to the mouth or head?	Yes	No

Please describe, including cause _____

Have you experienced:

Clicking or popping of the jaw?	Yes	No
Pain? (joint, ear, side of face)	Yes	No
Difficulty in opening or closing the mouth?	Yes	No
Difficulty in chewing on either side of the mouth?	Yes	No
Headaches, neckaches or shoulder aches?	Yes	No
Sore muscles (neck, shoulders)?	Yes	No
Are you satisfied with your teeth's appearance?	Yes	No
Would you like to replace your silver fillings?	Yes	No
Would you like to keep all of your teeth all of your life?	Yes	No

Do you feel nervous about having dental treatment?	Yes	No
Please describe _____		
Have you ever had an upsetting dental experience?	Yes	No
Please describe _____		
Have you ever been told to take a pre-medication prior to dental treatment?	Yes	No
Is there anything else about having dental treatment that you would like us to know?	Yes	No

If yes, please describe _____

_____

Signature: _____ **Date:** _____

Patient Medical History

Patient Name:_____ Date of Birth: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems you may have or medication you are taking could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?
○ Yes ○ No If yes, with whom and for what? Please explain: _____
Have you been hospitalized or had a recent operation in the last 12 months?
○ Yes ○ No If yes, please explain: _____
Have you ever had a serious head or neck injury?
○ Yes ○ No If yes, please explain: _____
Are you taking any medication, pills, or drugs?
○ Yes ○ No If yes, please **LIST COMPLETELY**: _____
_____
Do you take or have you taken Phen-Fen or Redux?
○ Yes ○ No When? _____
Do you take any Bisphosphonates?
○ Yes ○ No If yes, for how long: _____
Do you use tobacco?
○ Yes ○ No If yes, how often: _____
Do you use controlled substances?
○ Yes ○ No If yes, please LIST: _____
WOMEN
Are you: ○ Pregnant/Trying to get pregnant? ○ Nursing ○ Taking oral contraceptives?

Are you allergic to any of the following?
○ Aspirin ○ Penicillin ○ Codeine ○ Acrylic ○ Metal ○ Latex ○ Local anesthetics ○ Sulfa Drugs ○ Other _____

Do you have or have you had any of the following?

○ AIDS/HIV	○ Chest Pains	○ Frequent Headaches	○ Irregular Heartbeat	○ Rheumatism
○ Alzheimer's disease	○ Cold Sores/Fever Blisters	○ Glaucoma	○ Kidney Problems	○ Scarlet Fever
○ Anaphylaxis	○ Congenital Heart Disorder	○ Hay Fever	○ Leukemia	○ Shingles
○ Anemia	○ Convulsions	○ Heart Attack/Failure	○ Liver Disease	○ Sickle Cell Disease
○ Angina	○ Cortisone Medicine	○ Heart Murmur	○ Low Blood Pressure	○ Sinus Trouble
○ Arthritis/Gout	○ Diabetes	○ Heart Pace Maker	○ Lung Disease	○ Spina Bifida
○ Artificial Heart Valve	○ Drug Addiction	○ Heart Trouble/Disease	○ Mitral Valve Prolapse	○ Stomach/Intestinal Disease
○ Artificial Joint	○ Easily Winded	○ Hemophilia	○ Osteoporosis	○ Stroke
○ Asthma	○ Emphysema	○ Hepatitis A	○ Pain Jaw Joints	○ Swelling of Limbs
○ Blood Disease	○ Epilepsy or Seizures	○ Hepatitis B or C	○ Parathyroid Disease	○ Thyroid Disease
○ Blood Transfusion	○ Excessive Bleeding	○ Herpes/Genital Herpes	○ Psychiatric Care	○ Tonsillitis
○ Breathing Problem	○ Excessive Thirst	○ High Blood Pressure	○ Radiation Treatment	○ Tuberculosis
○ Bruise Easy	○ Fainting Spells/Dizziness	○ High Cholesterol	○ Recent Weight Loss	○ Tumors/Growths
○ Cancer	○ Frequent Cough	○ Hives or Rash	○ Renal Dialysis	○ Ulcers
○ Chemotherapy	○ Frequent Diarrhea	○ Hypoglycemia	○ Rheumatic Fever	○ Yellow Jaundice

Have you ever had any serious illness or medical condition not listed above? ○ Yes ○ No If yes, please explain: _____
Additional Comments:_____
_____

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 the patients) health. It is my responsibility to inform the dental office of any changes in my medical status. I authorize the dentist to release any information including the diagnosis & the records of any treatment or examination rendered to my child or myself during the period of dental care to third party payers and/pr health practitioners.

_____ _____
Signature of patient, parent or guardian Date

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HIPAA POLICY

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

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 this information can & will be used to:

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

I have had the opportunity to obtain, read, and understand your **NOTICE OF PRIVACY PRACTICES** containing a more complete description of the uses and disclosures of my health information. I understand Luke Adlong, DDS and his staff have the right to change its NOTICE OF PRIVACY PRACTICES from time to time.
I understand I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or 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.

I give consent for this office, Luke Adlong, DDS, to contact the following (family, friends, etc) for appointment reminders or to share personal information regarding my treatment.

Name of family member/friend	Relationship	Phone Number

Patient Name:_____

Relationship to Patient (if a minor):_____

Signature: _____ **Date**: _____

Office Use Only

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

_____