advancedental

13350 Josey Ln. Suite A,
Farmers Branch, TX 75234

Office (972) 241-1934
Fax (972) 481-1906

1 Patient Registration

Patient Name					
Patient Number	Sex O M O F	Date of Birth	Age	Today's Date	
Home Address		City	State	Zip Code	
Please Check One O Single O Married O Separated O Widowed	Occupation			Are You a Full-Time Student? O Yes O No	
E-Mail Address		Mobile Phone Number	Home Phone Number		
Employer	Length of Employment	Social Security Number	Work Phone Number		

Name of Person Responsible for Account		Driver's License Number
Name of Spouse (Parent if Patient is a Minor)	E-Mail Address	Mobile Phone Number
Spouse's (Parent's) Employer	Spouse's Social Security Number	Work Phone Number

How Did You Hear About Our Office?	EMERGENCY CONTACT Name, Address & Telephone Number of a Relative NOT Living With You.
Reason For This Visit	

2 Dental Insurance Information

Name of Insured	Date of Birth	Social Security Number
Name of Employer		
Insurance Company		
Address		
Phone Number	Group Number	Local Number

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3 Dental History

Please check any of the following problems that apply to you.

o Sensitivity (hot, cold, sweet)
Where? o Upper Right o Lower Right o Upper Left o Lower Left

o Headaches, earaches, neck pain
o Jaw joint pain
o Teeth or fillings breaking
o Grinding or clenching teeth
o Bleeding, swollen or irritated gums
o Loose, tipped or shifting teeth
o Bad breath

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

o Dentures
o Partial dentures
o Braces
o Periodontal (gum) treatments
o Wisdom teeth removal?

Please share the following dates:

Your last cleaning _____/_____
Your last oral cancer screening _____/_____
Your last complete X-Rays _____/_____

Name of Previous Dentist _____

_____
City State

_____
Phone Number

What is the most important thing to you about your future smile and dental health?

_____

_____

_____

_____

If you could whiten your teeth for a cost anyone could afford, would you do it? o Yes o No

Do you smoke or use chewing tobacco?

How Much? _____ How Long? _____

If I could change my smile, I would:

o Make them whiter
o Make them straighter
o Close spaces
o Replace black metal fillings with tooth colored restorations
o Repair chipped teeth
o Repair missing teeth
o Replace old crowns that don't match
o Have a smile makeover

On a scale of 1-10, with 10 being the highest rating:

How important is your dental health to you?
1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health?
1 2 3 4 5 6 7 8 9 10

Where do you want your dental health to be?
1 2 3 4 5 6 7 8 9 10

Why did you leave your previous dentist?

_____

_____

What is the most important thing to you about your dental visit today?

_____

_____

_____

_____

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4 Financial Policy

Thank you for choosing our office as your dental health care provider. We are committed to providing you with the highest quality lifetime dental care, so that you may fully attain optimum oral health. Please understand that payment of your bill is considered part of your treatment.

Payment is due at the time service is provided. Our office accepts cash, personal checks, Visa, MasterCard and Discover. Outside financing is available upon request and approval.

o **Please check if you would like more information about financing options.**

Please Note: Returned checks will be subject to additional fees. In the case it becomes necessary for our office to enlist a collection service and/or legal assistance; you will be responsible for any collection and/or legal charges incurred.

Do You Have Insurance?

- As a courtesy to you we will help you process all your insurance claims. Please understand that we will provide an insurance estimate to you, however, it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits ultimately determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible.
- All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company. Our office is not a party to that contract.
- Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
- We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office.
- We ask that you pay the deductible and co-payment, which is the estimated amount not covered by your insurance company by cash, check, Visa, MasterCard or Discover at the time we provide the service to you.
- Insurance payments are ordinarily received within 30-60 days from the time of filing. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or if your claim is denied, you will be responsible for paying the full amount at that time.
- We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.

We thank you for the opportunity to serve your dental health care needs and welcome any questions you may have concerning your care or our Financial Policy.

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO MY DENTAL OFFICE.

Signature of Patient or Guardian

Date

Eaglesoft Medical History Customized

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, c

Are you under a physician's care now? Please list their contact information here.	Yes No	If yes
Have you ever been hospitalized or had a major operation?	Yes No	If yes
Have you ever had a serious head or neck injury?	Yes No	If yes
Are you taking any medications, pills, or drugs?	Yes No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? If so, when?	Yes No	If yes
Are you on a special diet?	Yes No	If yes
Do you use tobacco?	Yes No	

Women: Are you...

☐ Pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics

Do you have other allergies?	Yes No	If yes
Do you use controlled substances?	Yes No	If yes

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

AIDS/HIV Positive Yes No	Cortisone Medicine Yes No	Hemophilia Yes No	Radiation Treatments Yes No
Alzheimer's Disease Yes No	Diabetes Yes No	Hepatitis A Yes No	Recent Weight Loss Yes No
Anaphylaxis Yes No	Drug Addiction Yes No	Hepatitis B or C Yes No	Renal Dialysis Yes No
Anemia Yes No	Easily Winded Yes No	Herpes Yes No	Rheumatic Fever Yes No
Angina Yes No	Emphysema Yes No	High Blood Pressure Yes No	Rheumatism Yes No
Arthritis/Gout Yes No	Epilepsy or Seizures Yes No	High Cholesterol Yes No	Scarlet Fever Yes No
Artificial Heart Valve Yes No	Excessive Bleeding Yes No	Hives or Rash Yes No	Shingles Yes No
Artificial Joint Yes No	Excessive Thirst Yes No	Hypoglycemia Yes No	Sickle Cell Disease Yes No
Asthma Yes No	Fainting Spells/Dizziness Yes No	Irregular Heartbeat Yes No	Sinus Trouble Yes No
Blood Disease Yes No	Frequent Cough Yes No	Kidney Problems Yes No	Spina Bifida Yes No
Blood Transfusion Yes No	Frequent Diarrhea Yes No	Leukemia Yes No	Stomach/Intestinal Disease Yes No
Breathing Problems Yes No	Frequent Headaches Yes No	Liver Disease Yes No	Stroke Yes No
Bruise Easily Yes No	Genital Herpes Yes No	Low Blood Pressure Yes No	Swelling of Limbs Yes No
Cancer Yes No	Glaucoma Yes No	Lung Disease Yes No	Thyroid Disease Yes No
Chemotherapy Yes No	Hay Fever Yes No	Mitral Valve Prolapse Yes No	Tonsillitis Yes No
Chest Pains Yes No	Heart Attack/Failure Yes No	Osteoporosis Yes No	Tuberculosis Yes No
Cold Sores/Fever Blisters Yes No	Heart Murmur Yes No	Pain in Jaw Joints Yes No	Tumors or Growths Yes No
Congenital Heart Disorder Yes No	Heart Pacemaker Yes No	Parathyroid Disease Yes No	Ulcers Yes No
Convulsions Yes No	Heart Trouble/Disease Yes No	Psychiatric Care Yes No	Venereal Disease Yes No
Yellow Jaundice Yes No			

Have you ever had any serious illness not listed above?	Yes No	If yes

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 patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X_____ Date:_____

COVID 19 Pandemic Dental Treatment Informed Consent Form

Thank you for your continued trust in our practice. As with the transmission of any communicable disease like a cold or flu; COVID19 exposure can occur at any time and in any place. Be assured we are and have always followed state and federal recommendations and regulations to limit transmission of all diseases in our office. While we take every effort to minimize exposure, exposure and transmission is possible. Persons over the age of 65 or preexisting health conditions are recommended to postpone elective dental treatment at this time.

- I confirm that I am not presenting with any of the following symptoms listed below: Shortness of breath, fever, dry cough, runny nose, sore throat

- I confirm I have not been diagnosed with Covid19+ or suspected Covid19+ in the past 14 days
- I confirm I have not been in the proximity of someone who has tested Covid19+ in the past 14 day
- I confirm I have not traveled by air in the past 14 days
- I consent to dental treatment and accept risk at this time

Signature_____

Date_____