Welcome

Albany DENTAL CARE

.Thank you for selecting Albany Dental Care! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

Date:_____

Name_____ Birthdate_____ SS#_____

Address_____ City_____ State_____ Zip_____

Email_____ Home #_____ Cell #_____

Circle Which Applies MINOR SINGLE MARRIED DIVORCED WIDOWED SEPARATED

IF MINOR, PLEASE FILL OUT: Parent/Guardian Name_____

Address (If Different Than Patient)_____ City_____ State_____ Zip_____

Patient or Parent/Guardian Employer_____ Work # _____

Employer Address_____ City_____ State_____ Zip_____

If Student, Name of School/College_____

Emergency Contact Name_____ Relationship_____ Phone_____

Whom May We Thank For Referring You_____

Financial/Insurance Information

Name of Insured_____ Relationship to Patient_____

Birthdate_____ SS#_____ Name of Employer_____

Insurance Company_____ Group #_____ ID#_____

Insurance Claim Address_____ City_____ State_____ Zip_____

DO YOU HAVE ADDITIONAL INSURANCE? (Circle One) YES NO IF YES, COMPLETE THE FOLLOWING:

Name of Insured_____ Relationship to Patient_____

Birthdate_____ SS#_____ Name of Employer_____

Insurance Company_____ Group#_____ ID#_____

IMPORTANT DENTAL HISTORY

Reason for Today's Visit:_____

When Was Your Last Dental Visit? _____ Previous Dentist:_____

How Often Do You Brush:_____ How Often Do You Floss:_____

_____

Medical History

Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Who is your Primary Care Physician? _____

Are you under a physicians care now? ☐ Yes ☐ No If Yes, please explain:_____

Have you ever been hospitalized or had a major operation? ☐ 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 medications, pills or drugs? ☐ Yes ☐ No If Yes, please list:_____

_____

Do you take, or have you take Boniva, Actonel or any cancer medication containing biophosphonates? ☐ Yes ☐ No

Do you use Tobacco? ☐ Yes ☐ No If So, How Much Per Day? _____

Do you use controlled substances? ☐ Yes ☐ No

Women Only:

Are you Pregnant/ Trying to Get Pregnant? ☐ Yes ☐ No
Nursing? ☐ Yes ☐ No
Taking Oral Contraceptives? ☐ Yes ☐ No

Are you allergic to any of the following?

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

Other: (please list)_____

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

☐ Acid Reflux	☐ AIDS/HIV Positive	☐ Alzheimer's Disease	☐ Anaphylaxis	☐ Anemia	☐ Angina
☐ Arthritis/Gout	☐ Artificial Heart Valve	☐ Artificial Joint	☐ Asthma	☐ Blood Disease	☐ Blood Transfusion
☐ Bruise Easily	☐ Cancer	☐ Chemotherapy	☐ Chest Pains	☐ Cold Sores	☐ Cong. Heart Disorder
☐ Cortisone	☐ Diabetes	☐ Drug Addiction	☐ Easily Winded	☐ Emphysema	☐ Epilepsy/Seizures
☐ Exc. Bleeding	☐ Exc. Thirst	☐ Fainting/Dizziness	☐ Freq. Cough	☐ Freq. Diarrhea	☐ Freq. Headaches
☐ Genital Herpes	☐ Glaucoma	☐ Hay Fever/ Allergies	☐ Heart Attack	☐ Heart Murmur	☐ Heart Pacemaker
☐ Heart Trouble	☐ Hemophilia	☐ Hepatitis A	☐ Hepatitis B/C	☐ Herpes	☐ High Blood Pressure
☐ Hives/Rash	☐ Hypoglycemia	☐ Irregular Heartbeat	☐ Kidney Prob.	☐ Leukemia	☐ Liver Disease
☐ Low BP	☐ Lung Disease	☐ Mitral Valve Prolapse	☐ Osteoporosis	☐ Pain in Jaw	☐ Psychiatric Care
☐ Radiation	☐ Recent Weight Loss	☐ Renal Dialysis	☐ Shingles	☐ Sinus	☐ Stroke
☐ Swelling	☐ Thyroid Disease	☐ Tuberculosis	☐ Tumors	☐ Ulcers	☐_____

Dental History

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

- ☐ Do your gums bleed while brushing or flossing?
- ☐ Are your teeth sensitive to Hot or Cold?
- ☐ Are your teeth sensitive to Sweet or Sour Liquids/Foods?
- ☐ Do you feel any pain to any of your teeth?
- ☐ Do you have any sores or lumps in or near your mouth?
- ☐ Have you ever had any Head, Neck or Jaw Injuries?
- ☐ Have you experienced any of the following
  - ☐ Clicking
  - ☐ Pain (Joint, Ear, Side of Face)
  - ☐ Difficulty in opening or closing
  - ☐ Difficulty in chewing
  - ☐ Do you have frequent headaches?
- ☐ Do you clench or grind your teeth?
- ☐ Do you bit your lips or cheeks?
- ☐ Does food get caught in between your teeth?
- ☐ Have you ever had periodontal treatment?
- ☐ Have you worn a bite plate or other appliance?
- ☐ Have you ever had any difficult extractions?
- ☐ Do you wear partials or dentures?

  If Yes, Date of Placement_____

If you could change ANYTHING about your smile, what would you change? _____

_____

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect or insufficient information can be dangers to my or (patient's) health. It is my responsibility to inform the dental office of any changes in medical status. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I understand that payment is due at the time of service.

Patient/Guardian Signature:_____ Date:_____

Dr. Signature:_____ _____ Date:_____

Acknowledgement of Receipt of Notice of Privacy Practices (HIPPA)

ALBANY DENTAL CARE
996 W. State St. Suite #2
PO Box 238
Albany, IN 47320

You May Refuse To Sign This Acknowledgement

I have received and reviewed a copy of the Albany Dental Care privacy, security and breach notification policies and procedures.

I understand that I should ask the Albany Dental Care Privacy Official if I have any questions about these policies and procedures.

Please list anyone that we are allowed to discuss your account with (i.e. Spouse, Parent)

Name:_____ Relationship:_____

Name:_____Relationship:_____

Please be aware if someone is not listed on this page we will not discuss any aspect of your account with them.

Albany Dental Care Financial Policy

I authorize Albany Dental Care to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I understand that my dental insurance carrier may pay less than the actual bill for services. **I UNDERSTAND THAT PAYMENT IS DUE AT THE TIME OF SERVICE UNLESS ACCEPTABLE ARRANGEMENTS HAVE BEEN MADE PRIOR TO MY APPOINTMENT**. I understand that in consideration of the services provided to me or my dependent, I /we guarantee payment in full in accordance with arrangements made at the time of service. If payment is not received by the due date, I/we will be assessed interest in the amount of 1.5% per month on my/our unpaid balance. If no such arrangements are made, in event of default in payment, reasonable collection agency fees equal to 30% of the delinquent balance and reasonable attorney fees shall be added to the amount due on the account, plus any applicable court costs.

****I FURTHER UNDERSTAND THAT WITHOUT A 24 HOUR NOTICE WHEN CANCELLING OR RESCHEDULING MY APPOINTMENT, I WILL BE CHARGED A FEE OF NO LESS THAN $45.00.**

*****WE REQUIRE THAT YOU CONFIRM YOUR APPOINTMENT AT LEAST 24 HOURS IN ADVANCE. WE SUPPLY AMPLE WAYS TO ACCOMODATE THIS. WE HAVE THE USE OF OUR REMINDER SYSTEM THAT SENDS OUT EMAILS AND TEXT MESSAGES, IF YOU HAVE NOT CONFIRMED BY EITHER ONE OF THESE METHODS WITHIN 48 HOURS OF YOUR APPOINTMENT YOU WILL RECEIVE A PHONE CALL FROM OUR STAFF FOR CONFIRMATION OF YOUR APPOINTMENT. IF NO CONFIRMATION CAN BE OBTAINED AND WE NEED TO UTILIZE YOUR APPOINTMENT TIME, YOUR APPOINTMENT WILL BE CANCELLED.**

Patient/Guardian
Signature:_____Date:_____