AMERICAN DENTAL CENTER

Welcome To Our Office!

PLEASE COMPLETE THE FRONT AND BACK PAGE.

Thank you for choosing Amalgamated Dental Center as your dental care provider. We are committed to providing you the best possible dental care. If you have any problems or questions while completing the form below, we will be happy to help.

Patient Name _____ Goes by _____

Address _____ Apt.# _____

City _____ State _____ Zip _____

Date of Birth _____ Age _____ Home Phone ( ) _____

Full Time Student? ☐ Yes ☐ No School Attending _____

Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Male ☐ Female

How did you hear about our office? _____

Other family members seen by us? _____

Person Responsible for Account

Name _____ Employer _____ Position _____

Address _____ Work Phone _____

City/State/Zip _____ Soc. Sec#. _____

Phone ( ) _____ DL# _____ Date of Birth _____

Relationship to Patient

☐ Self ☐ Father ☐ Mother ☐ Spouse ☐ Other _____

Today's visit will be paid by ☐ Cash ☐ Check ☐ Credit Card

Primary DENTAL Insurance

Ins. Co. Name _____

Ins. Address _____

Ins. Phone ( ) _____

Group Plan# _____

Effective Date _____

Insured Name _____

Address _____

_____

Date of Birth _____

Social Security _____

Employer _____

Secondary DENTAL Insurance

Ins. Co. Name _____

Ins. Address _____

Ins. Phone ( ) _____

Group Plan# _____

Effective Date _____

Insured Name _____

Address _____

_____

Date of Birth _____

Social Security# _____

Employer _____

Primary MEDICAL Insurance

Ins. Co. Name _____

Ins. Address _____

Ins. Phone ( ) _____

Group Plan# _____

Effective Date _____

Insured Name _____

Address _____

_____

Date of Birth _____

Social Security _____

Employer _____

Secondary MEDICAL Insurance

Ins. Co. Name _____

Ins. Address _____

Ins. Phone ( ) _____

Group Plan# _____

Effective Date _____

Insured Name _____

Address _____

_____

Date of Birth _____

Social Security# _____

Employer _____

Do You Have A Personal Physician? ☐ Yes ☐ No Medical Physician's Name _____

Physician's Phone _____ Date of Last Visit _____

Emergency Information: Please list the names and telephone numbers of two relatives (or friends) not living with you that we may contact in the case of an emergency.

Name _____ Relation _____

Address _____

Phone ( ) _____

Name _____ Relation _____

Address _____

Phone ( ) _____

MEDICAL / DENTAL HISTORY

Main problem that brought you to office? _____

_____

YES	NO	HAVE YOU EVER HAD ?
___	___	High Blood Pressure
___	___	Hepatitis or Liver Disease
		Epilepsy, convulsions or seizures
___	___	Cortisone-Steroid Treatment
___	___	Kidney or Bladder Disease
___	___	Diabetes
___	___	Tuberculosis or Emphysema
___	___	Asthma
___	___	Shortness of Breath
___	___	Swollen Ankles
___	___	Chest Pains
___	___	A Pacemaker
___	___	Artificial Heart Valve
___	___	Heart Murmur
___	___	Mitral Valve Prolapse
___	___	Rheumatic Fever
___	___	Artificial Joints
___	___	Stroke
___	___	Thyroid Trouble
___	___	Psychiatric Treatment
___	___	Arthritis or Rheumatism
___	___	Venereal Disease
___	___	Glaucoma
___	___	Chemotherapy
___	___	Radiation Therapy
___	___	Sinus Problems / Hayfever
___	___	Allergies
___	___	AIDS / HIV +
___	___	Blood Transfusion

If you are Female, Are you

___	___	Pregnant
___	___	Taking Birth Control Pills
___	___	Taking Hormone Medication

Are you presently under the care of a physician ___ YES ___ NO
If yes, for what?
_____

Are you presently taking any drugs or medication? ___ YES ___ NO
If yes, please list
_____

_____

_____

Are you allergic to any medication, local anesthetic materials or latex gloves? ___ YES ___ NO
If yes, what drugs or materials?
_____

_____

_____

Have you ever had a bleeding problem? ___ YES ___ NO
Do you use tobacco products? ___ YES ___ NO
Do you have a history of fainting? ___ YES ___ NO
Do you have any disease or condition not listed or anything about your health problem that we have not covered? ___ YES ___ NO
If yes, please list
_____

_____

_____

Date of last dental visit
_____

YES	NO		HISTORY UPDATE DOCTOR INITIAL	DATE
___	___	Were x-rays taken at that time?		
___	___	Were your teeth cleaned?		
___	___	Do you have well water (private)		
___	___	Does your water have fluoride in it?		
___	___	Have you ever been treated forgum disease?		
___	___	Do you have bad breath?		
___	___	Do you clench or grind your teeth?		
___	___	Are your teeth sensitive?		
___	___	Does your jaw click or pop?		
___	___	Have you experienced any pain or soreness in the muscles of your face or around your ear?		
___	___	Do you have any dental implants?		
___	___	Are you happy with your smile?		

RELEASE:

I AUTHORIZE THE DENTIST TO PERFORM DIAGNOSTIC PROCEDURES AND TREATMENT AS MAY BE NECESSARY FOR PROPER DENTAL CARE. I AM RESPONSIBLE TO INFORM THIS OFFICE OF ANY CHANGE IN HEALTH HISTORY.

Signature _____ **Date**_____

FINANCIAL POLICY

We ask that all patients read and sign our Financial Policy as well as complete our Patient Infor nation form prior to seeing the dentist. Payment of services are at the time services are rendered or in a timely payment plan.

We accept assignment of Insurance benefits. However, you must understand that:

1. Your insurance policy is a contract between you, your employer and the insurance company. We are NOT a party to that contract. Our relationship is with you, not the insurance company. We cannot become involved in disputes between you and your insurer regarding deductibles, co-payments, covered charges, secondary insurance, and "usual and customary" charges. Our involvement will be limited to supplying factual information to facilitate claim processing.

2. All charges are your responsibility whether your insurance company pays or does not pay. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

3. I understand that employees of Amalgamated Dental Center are NOT representatives for my insurance company and the estimate I receive from them is not a guarantee of payment from my insurance company.

4. There will be fees charged for returned checks.

5. I authorize payment from my insurance carrier be made directly to the dentist.

6. I authorize this office to release necessary medical or dental information about me to my insurance carrier.

We understand that temporary financial problems may affect timely payment of your balance.

We encourage you to communicate any such problems to us, so we may assist you in the management of your account.

FIXED OR REMOVAL PROSTHETICS, such as dentures, crowns, bridges or partial dentures, are understood to be a product that is uniquely suited to each particular patient. Prosthetics must be seated in a timely manner to insure your comfort, and proper fit. If you fail to have your prosthetics permanently seated within 60 days from date of impression and a second impression must be made, you may be charged an additional amount.

All X-rays taken are a part of our permanent records. There is a Duplication charge for any x-rays removed from this office.

Thank you for choosing Amalgamated Dental Center as your dental care provider. We appreciate your trust in us and the opportunity to serve you.

_____ _____

Patient or Guardian Signature Today's Date

OFFICE POLICY

Appointments

We schedule hours of service by appointment only.
This time is reserved especially for you,
Please arrive 5 – 10 minutes before your appointment.
A broken appointment fee of **$50.00** will be posted to your account
for any same day or late cancellation.
If you arrive **20 minutes** late for your appointment,
your appointment will be rescheduled.

Office Hours

Monday 9:00am –12:00pm
Tuesday 9:00am – 7:00pm
Wednesday 9:00am – 6:00pm
Thursday 9:00am – 7:00pm
Friday 9:00am - 6:00pm
Saturday 9:00am – 3:00pm

Financial

In order to maintain the cost of treatment to a comfortable minimum by not billing out statements,
co-payments and/or patient portion are due at time of services rendered.
We accept American Express, MasterCard, Visa, Discover, Personal Checks and Cash.
If in the event, your check is returned due to insufficient funds,
a $25.00 charge will be added to the original amount of the check.
A finance fee will be applied to all accounts with a 30-day balance or more.

Care Credit

Our financial arrangements consist of interest free plans from 3 – 18 months
and extended payment plans with a 13% interest.
Care Credit applications processed while you wait.

Insurance

As a **courtesy** to you, we investigate your insurance plan, and offer to accept patient portion in
anticipation of receiving forthcoming estimated insurance portions.
However, dental insurance estimate is not a guarantee of payment and
you will be responsible for any fees your insurance plan **does not** cover.
You are responsible for payment in full at time of service.

I _____, have read, understand and accept the office policy procedure and agree to act accordingly.

_____

Signature of Patient or Guardian ***Date***

Amalgamated Dental Center

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, have reviewed a copy of this Office's Notice of Privacy Practices.

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, 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)

_____

_____

_____