ALDEN BRIDGE
family dental
Making beautiful smiles everyday.

New Patient Information

Today's Date: _____ Social security number: _____

Name: _____ Preferred name: _____ Birth Date: ____/____/_____

Address: _____ Apt#: _____ City: _____ State: _____ Zip: _____

Email: _____ Home Phone: _____ Cell Phone: _____

Check associated box: □ Minor □ Single □ Married □ Divorced □ Widowed □ Separated Preferred language: □ English □ Spanish

Patient Employer: _____ Work Phone: _____

Business Address: _____ City: _____ State: _____ Zip: _____

Spouse name: _____ Phone: _____ Date of birth: ____/____/_____

Spouse or Parent/Guardian's Name Employer: _____ Work Phone: _____

Whom May We Thank for Referring You? _____

Person to Contact in Case of Emergency: _____ Phone: _____

RESPONSIBLE PARTY □ (check if same as patient)

Name of Person Responsible for this Account: _____ Relationship to Patient: _____

Address: _____City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Driver' s License #: _____ State: _____ Birth Date: _____

Is this Person Currently a Patient in our Office? □ **yes** □ **no (check one)**

DENTAL INSURANCE COVERAGE? □ **yes** □ **no (check one)**

Insurance Company Name: _____ Insurance Company Phone: _____

Subscriber Name: _____ Subscriber Date of Birth: _____/_____/_____

Subscriber Employer: _____

Insurance Address: _____ City: _____ State: _____ Zip: _____

Insurance Company Phone: _____ Policy number (Member ID): _____

Group Number: _____ Plan Name: _____

Insured's Name: _____ Relation to policy holder: _____ Insured's Date of Birth: ____/____/_____

PREFERRED PHARMCY INFORMATION

Name: _____ Phone: _____

Street: _____ City: _____ State: _____ Zip: _____

PATIENT MEDICAL HISTORY

Patient name: _____

Physician: _____ Office Phone: _____ Date of Last Exam: _____

	Yes	No
1. Are you under medical treatment?.....	□	□
2. Have you ever been hospitalized for any surgical operations Or serious illness within the last 5 years?..... If yes, please explain: _____ _____	□	□
3. Currently taking any medication(s) including any non-prescription Medicine? ……... If yes, what medication(s) are you taking? _____ _____ _____	□	□
4. Have you ever taken Fen-Phen/Redux?.....	□	□
5. Do you use tobacco?.....	□	□
6. Do you used controlled substances?.....	□	□
7. Are you wearing contact lenses? ……	□	□
8. Do you have a persistent cough or throat clearing not associated With a known illness (lasting more than 3 weeks)……..	□	□

10. Are you **allergic** to or have you had reactions to the following;

	Yes	No
Local Anesthetics (e.g. Novocain) …… …….	□	□
Penicillin or any other Antibiotics ……..	□	□
Sulfa Drugs……..	□	□
Barbiturates……..	□	□
Sedatives……	□	□
Iodine……..	□	□
Aspirin……	□	□
Any Metals (e.g. Nickel, Mercury, etc)……	□	□
Latex Rubber……	□	□

11. Women Only:

	Yes	No
a) Are you pregnant or think you may be pregnant?	□	□
b) Are you nursing?.....	□	□
c) Are you taking oral contraceptives?.....	□	□

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

	Yes	No		Yes	No		Yes	No
High Blood Pressure	□	□	Heart Disease ……...	□	□	Chest Pains…….	□	□
Heart Attack…….	□	□	Cardiac Pacemaker…….	□	□	Easily Winded……	□	□
Rheumatic Fever……	□	□	Heart Murmur……	□	□	Stroke…….	□	□
Swollen Ankles……..	□	□	Angina……	□	□	Hay Fever/Allergies……...	□	□
Fainting/Seizures……	□	□	Frequently Tired……	□	□	Tuberculosis……	□	□
Asthma……	□	□	Anemia……..	□	□	Radiation Treatment……	□	□
Low Blood Pressure……	□	□	Emphysema……	□	□	Glaucoma……	□	□
Epilepsy/Convulsions…….	□	□	Cancer……	□	□	Recent Weight Loss……	□	□
Leukemia…….	□	□	Arthritis…….	□	□	Liver Disease……..	□	□
Diabetes……...	□	□	Joint Replacement or Implant	□	□	Heart Trouble……	□	□
Kidney Disease……...	□	□	Hepatitis/Jaundice……..	□	□	Respiratory Problems……	□	□
AIDS or HIV infection……	□	□	Sexually Transmitted Disease	□	□	Mitral Valve Prolapse……	□	□
Thyroid Problems……	□	□	Stomach Troubles/Ulcers…..	□	□	Other……..	□	□

PATIENT DENTAL HISTORY

Name of Previous Dentist and Location: _____ Date of Last Exam: _____

	Yes	No
1. Do your gums bleed when brushing or flossing?.....	□	□
2. Are your teeth sensitive to hot or cold liquids/foods?....	□	□
3. Are your teeth sensitive to sweet or sour liquids/foods?	□	□
4. Do you feel pain to any of your teeth?.....	□	□
5. Do you have any sores or lumps in or near your mouth	□	□
6. Have you had any head, neck or jaw injuries?.....	□	□
7. Have you ever experienced any of the following problems In your jaw?.....	□	□
-Clicking □ -Difficulty Chewing □		
-Pain (joint, ear, side of face) □		
-Difficulty opening or closing your mouth □		
8. Do you have frequent headaches?.....	□	□
9. Do you clench or grind your teeth?.....	□	□
10. Do your bite your lips or cheeks frequently?.....	□	□
11. Have you ever had any scaling and root planning or periodontal treatment in the past?.....	□	□
12. Have you ever had any difficult extractions in the past?	□	□
13. Have you had any orthodontic treatment?.....	□	□
14. Do you wear dentures or partials?.....	□	□
15. Do you like your smile? ……..	□	□
16. Have you ever received oral hygiene instructions?.....	□	□

AUTHORIZATION AND RELEASE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. 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 agree to be responsible for payments of all services rendered on my behalf or my dependance.

X_____ Date: _____

Signature or Patient (or parent/guardian of minor)

X_____ Date: _____

Doctor Signature

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ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES AND CONSENT/LIMITED AUTHORIZATION AND RELEASE FORM

You may refuse to sign the acknowledgement but, in refusing we ***will NOT be allowed*** to process your insurance claims.

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for **Alden Bridge Family Dental**, A copy of this signed, dated document shall be as effective as the original. MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTORS IN THE FUTURE.

_____	_____	_____
Please print your name	Please Sign your name	Date
_____	_____	_____
Legal Representative	Description of Authority	Date

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR DENTAL INFORMATION:
(This includes step parents, grandparents, and any care takers who can have access to this patient's records)

Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO CONFIRM MY DENTAL APPOINTMENTS, TREATMENT AND BILLING INFORMATION VIA: (CHECK ALL THAT APPLY)

- □ Cell Phone Confirmation
- □ Home Phone Confirmation
- □ Work Phone Confirmation
- □ Text Message Confirmation
- □ Email Confirmation
- □ U.S. Mail/Postcard

I AUTHORIZE INFORMATION ABOUT MY DENTAL HEALTH BE CONVEYED VIA: (CHECK ALL THAT APPLY)

- □ Cell Phone Confirmation
- □ Home Phone Confirmation
- □ Work Phone Confirmation
- □ Text Message Confirmation
- □ Email Confirmation
- □ U.S. Mail/Postcard

I APPROVE BEING CONTACTED ABOUT SPECIAL SERVICES, EVENTS or NEW DENTAL INFORMATION VIA:
(CHECK ALL THAT APPLY)

- □ Cell Phone Confirmation
- □ Home Phone Confirmation
- □ Work Phone Confirmation
- □ Text Message Confirmation
- □ Email Confirmation
- □ U.S. Mail/Postcard

Office use ONLY

As Privacy Officer, I attempted to obtain the patients (or representatives) signature on this Acknowledgement but did not because:

- □ It was emergency treatment
- □ I could not communicate with the patient
- □ The patient refused to sign
- □ The patient was unable to sign because:_____
- □ Other (please describe) : _____

Signature of Privacy Officer: _____ Date: _____

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Finances and Insurance Agreement

Welcome to our office and thank you for selecting us to serve your dental needs. We know that you are concerned about the cost of your dental care and we want you to know that we strive to keep our fees constant. You can help us by making prompt payment for services rendered thereby reducing the costs of billing and collecting.

These payment options are available;

*Payment in full at time of service by cash, check or credit card (Visa, Mastercard, Discover, American Express)

*If you have dental insurance, payment in full of the estimated portion including any deductibles at time of service.

PLEASE NOTE: Any dental insurance benefits that you may have are as a result of an agreement between your employer or your spouse's employer and an insurance company. We have no affiliation with any insurance company. You are responsible for knowing your insurance and coverage.

As a courtesy to you, we will accept assignment of your dental insurance benefits when you provide us with a completed and signed claim form that we can file for you. Please remember that you, not your insurance company, are responsible for the payment in full of the fees for services rendered.

We will estimate what your insurance will pay and what your portion will be for each visit. However, this is only an estimate and any balance remaining after we receive payment from your insurance company is your responsibility. If your insurance has not paid us within 60 days, we will bill you for any balance.

CANCELLATION FEE: If a scheduled appointment is cancelled within 24 hours it will be subject to a $40.00 cancellation fee. If a scheduled appointment is missed, without any notification of cancelation, it will be subject to a cancellation fee. Please see our office Cancelation policy for more details.

Your cooperation in this matter is greatly appreciated and allows us to continue to offer this service at no charge to you. Thank you for your understanding.

Welcome to our practice!

Patient name: _____ **Date**: _____

Patient Signature/Legal guardian: _____ **Date:** _____