Patient Information

Patient name: _____ Date of birth: ____/____/_____
First Last

What name do you wish to be addressed? _____

Sex: Male / Female / I identify as: _____ Marital status: Married / Single / Child / Widowed

SS #: _____-_____-_____ Driver's license #: _____

Home address: _____

City: _____ State: _____ Zip: _____

Home #: _____ **Cell #:** _____ **E-mail:** _____

Emergency contact: _____ ***Phone #***: _____
First Last

Referred to us by / how did you hear about us: _____

Are you currently under a physician's care? NO / YES Reason: _____

Name of your medical doctor: _____

Name of previous dentist: _____

Preferred Pharmacy: _____

Are you pregnant? NO / YES Expected delivery date: _____

Are you nursing? NO / YES Are you taking birth controls? NO / YES

Dental Health History

Reason for your visit: _____

Are you apprehensive about dental treatment: No Somewhat Yes

Do you snore or have been told that you snore? NO / YES

Do you have any of the following? (Mark all that applies)

☐ Aching or sensitive teeth	☐ Broken tooth	☐ Dry mouth	☐ Lumps in mouth
☐ Areas of food traps	☐ Chewing on one side	☐ Grinding or clenching	☐ Missing teeth
☐ Bad breath	☐ Clicking or popping in jaw	☐ Gum infection	☐ Sensitivity
☐ Bleeding gums	☐ Cold sores	☐ Jaw pain or tiredness	☐ Swelling in mouth
☐ Braces	☐ Difficulty opening wide	☐ Loose teeth	☐ Swollen glands
☐ Broken filling	☐ Other: _____		

If you could change your smile, what would you change? (Mark all that applies)

☐ Remove silver fillings	☐ Replace missing teeth	☐ Straighten teeth
☐ Close gaps between teeth	☐ Change shape of teeth	☐ Whitening

☐ Other: _____

Patient / Guardian Signature: _____ **Date:** ____/____/_____

Medical History

Do you have any of the following? (Mark all that applies)

☐ Abnormal bleeding	☐ Cold sores / Herpes	☐ Hepatitis _____	☐ Rheumatic fever
☐ AIDS / HIV	☐ Congenital heart disorder	☐ High / Low blood pressure	☐ Scarlet fever
☐ Alzheimer's	☐ Diabetes	☐ High cholesterol	☐ Shingles
☐ Anemia	☐ Emphysema	☐ Hives / Rash	☐ Shortness of breath
☐ Arthritis	☐ Epilepsy / Seizures	☐ Hypoglycemia	☐ Sinus trouble
☐ Artificial heart valve	☐ Excessive thirst	☐ Inner ear disorders	☐ Stroke
☐ Artificial joints	☐ Fainting or dizzy spells	☐ Jaundice	☐ Surgical prosthesis
☐ Asthma	☐ Frequent headaches	☐ Leukemia	☐ Taking heart medications
☐ Blood disease	☐ Glaucoma	☐ Liver disease	☐ Thyroid problems
☐ Blood thinners	☐ Hay fever	☐ Lung problems	☐ Tuberculosis
☐ Bruise easily	☐ Heart attack	☐ Osteoporosis	☐ Ulcers / Stomach problems
☐ Cancer	☐ Heart murmur	☐ Pacemaker	☐ Venereal disease
☐ Chemotherapy	☐ Heart valve problems	☐ Persistent cough	☐ Vertigo
☐ Chest pain	☐ Hemophilia	☐ Psychiatric care	

Do you have any disease, condition, or problem not listed previously that you feel we should know about?

If so, please describe: _____

_____

List all medications and dietary supplements you are taking including the dosage: _____

_____

_____

Are you required to pre-medicate before a dental appointment? NO / YES

Allergies

Mark all medications or health care related substances to which you have experienced an adverse reaction.

☐ Penicillin ☐ Sulfa drugs ☐ Latex ☐ Epinephrine ☐ Codeine ☐ Local anesthetics
☐ None ☐ Other: _____

Privacy Policy

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations. A copy of our Privacy Policy is available upon request.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I, (please print name)_____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Patient / Guardian Signature: _____ **Date:** ____/____/_____

Dental Insurance Information and Insurance Agreement

Primary Dental insurance: _____Phone #: _____

Subscriber's name: _____ Date of birth: ____/____/_____

Subscriber's SS #: _____-_____-_____

ID#: _____ Group #: _____

Secondary Dental insurance: _____ Phone #: _____

Subscriber's name: _____ Date of birth: ____/____/_____

Subscriber's SS #: _____-_____-_____

ID #:_____ Group #: _____

I certify that the insurance information provided is accurate and active. I understand it is my responsibility to know and understand my dental insurance policy, including benefits, limitations, and exclusions. I acknowledge that any estimated portion is due at the time of service and is based on anticipated coverage, which is not guaranteed. I understand I may owe more if my insurance does not pay as expected. I also understand that treatment is provided regardless of insurance reimbursement.

Patient / Guardian Signature: _____ **Date:** ____/____/_____

Consent for Dental Treatment and Financial Responsibility

I, the undersigned, hereby give my consent to the attending doctor to perform any necessary diagnostic procedures, including but not limited to radiographs, study models, photographs, and any other diagnostic tools deemed appropriate for the comprehensive evaluation of my dental health.

I further authorize the doctor to administer and perform any and all recommended treatments, medications, and therapies necessary for my dental care. I also consent to the involvement of any qualified clinical personnel the doctor considers appropriate to assist in my care.

I understand that the proposed treatment plan may be modified as a result of unforeseen circumstances or new findings during the course of treatment. I accept responsibility for all services rendered.

Additionally, I authorize the release of my dental records, including diagnostic images, examination findings, and treatment details, to my insurance provider, other healthcare professionals involved in my care, or any party legally entitled to request such information.

I acknowledge that I am personally responsible for payment of all services provided for myself or my dependents, regardless of insurance coverage or reimbursement. I understand that insurance benefits are not guaranteed and that any fees collected at the start of treatment are based on estimates only.

I agree that *full payment is due at the time services are rendered* unless alternative financial arrangements have been made in advance.

Patient / Guardian Signature: _____ **Date:** ____/____/_____

Alpha Omega Dental Care

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Fax: (609)655-7477

Updated Office and Treatment Deposit Policy

Our office understands that emergencies happen and our patients may not always be able to keep their originally scheduled appointments. In order to be respectful of other patients' needs and to manage our schedule effectively, we kindly ask that you **notify us at least 24 hours in advance** if you are unable to attend your appointment. As a courtesy, we send reminder texts and phone calls prior to each scheduled visit. **If you do not receive a reminder, or have opted out of our messaging system, this policy still remains in effect.**

Due to the time and resources involved in more advanced procedures, we have implemented the following deposit policy to ensure smooth scheduling and equitable access to care.

A **non-refundable deposit** of **$75** is required when scheduling an appointment for procedures lasting **60 minutes or longer**, including but not limited to:

- Crowns and Bridges

- Root Canal Therapy

- Dental Implants

The deposit will be **applied to your treatment cost** at the time of your visit.

If you **cancel or reschedule with less than 24 hours' notice, or fail to attend the appointment**, the deposit will be **forfeited**.

If you provide **at least 24 hours' notice**, your deposit will remain as credit and be **applied to your rescheduled appointment.**

We appreciate your understanding and continued trust in our care

The Team at Alpha Omega Dental Care

Print Name:

Patient Signature: