Dental RESORT
COSMETIC, GENERAL & IMPLANT DENTISTRY

Welcome and Thank you for coming in today! Please share with us a little bit about you :)

PATIENT INFORMATION

Name_____ Sex ☐ M ☐ F

If Patient is a minor, Parent's Name_____

SS#_____ Birthday_____

Address_____

City_____ State_____ Zip_____

Mobile#_____ Alt#_____

Email_____ Marital Status_____

Who can we thank for referring us_____

EMPLOYER

Employer_____

Address_____ Occupation_____

City_____ State_____ Zip_____

Work Phone#_____

INSURANCE INFORMATION

Insurance Company_____ Other Coverage : Y N

Member#_____ Group#_____

Subscriber Name_____ Sub Date of birth_____

Patient Name if different from Sub_____

Relationship to Subscriber_____

ASSIGNMENT AND RELEASE

I, certify that I, or my dependent(s), have insurance coverage with _____ and assign directly to Dr. Aduddell all insurance benefits. If any, otherwise payable to me for services rendered, understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Dr. Aduddell may use my health care information and may disclose the information with the above insurance company and their agents for the purpose of obtaining payment for services, determining benefits, or the benefits payable for related services.

Signature_____ **Date**_____

EMERGENCY CONTACT

Emergency Contact Name_____

Phone#_____ Relationship_____

DENTAL HISTORY

Reason for today's visit_____

Former Dentist_____ Phone#_____

Last X-Ray Date_____ Last Cleaning Date_____ Last Dental Visit_____

Do you feel pain Yes No if yes, please explain_____

Do you feel numbness, swelling, or any other sensitivity? Yes No if yes, please explain_____

_____

Additional comments/concerns about your past/current needs or dental history_____

HEALTH HISTORY

Physician Name_____ Physician Phone#_____

Have you ever taken any of the group of drugs collectively referred to as "Fen-Phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentennine), Pondimin (fenfluramine) and Redux (dexfenfluramine). Yes No

Place a mark on "yes" or "no" to indicate if you have or have had any of the following:

AIDS/HIV	*Yes*	*No*	Epilepsy	*Yes*	*No*	Radiation Treatment	*Yes*	*No*
Anemia	*Yes*	*No*	Fainting/Dizzy	*Yes*	*No*	Respiratory Disease	*Yes*	*No*
Arthritis/Rheumatism	*Yes*	*No*	Glaucoma	*Yes*	*No*	Rheumatic Fever	*Yes*	*No*
Articial Heart Valve	*Yes*	*No*	Headaches	*Yes*	*No*	Scarlet Fever	*Yes*	*No*
Artificial Joint(s)	*Yes*	*No*	Heart Murmur	*Yes*	*No*	Shortness of Breath	*Yes*	*No*
Asthma	*Yes*	*No*	Heart Problems	*Yes*	*No*	Sinus Trouble	*Yes*	*No*
Back Problems	*Yes*	*No*	Hepatitis Type____	*Yes*	*No*	Skin Rash	*Yes*	*No*
Bleeding abnormally, with			Herpes	*Yes*	*No*	Special Diet	*Yes*	*No*
extractions/surgery	*Yes*	*No*	High Blood Pressure	*Yes*	*No*	Stroke	*Yes*	*No*
Blood Disease	*Yes*	*No*	Jaundice	*Yes*	*No*	Swollen Feet/Ankles	*Yes*	*No*
Cancer	*Yes*	*No*	Jaw Pain	*Yes*	*No*	Swollen Neck Glands	*Yes*	*No*
Chemical Dependency	*Yes*	*No*	Kidney Disease	*Yes*	*No*	Tonsillitis	*Yes*	*No*
Chemotherapy	*Yes*	*No*	Liver Disease	*Yes*	*No*	Tuberculosis	*Yes*	*No*
Circulatory Problems	*Yes*	*No*	Low Blood Pressure	*Yes*	*No*	Tumor/Growth on		
Congenital Heart	*Yes*	*No*	Mitral Valve Prolapse	*Yes*	*No*	head or neck	*Yes*	*No*
Cortisone Treatments	*Yes*	*No*	Nervous/Anxiety	*Yes*	*No*	Ulcer	*Yes*	*No*
Cough-bloody/constant	*Yes*	*No*	Pacemaker	*Yes*	*No*	Venereal Disease	*Yes*	*No*
Diabetes	*Yes*	*No*	Psychiatric Care	*Yes*	*No*	Weight Loss Unexplain	*Yes*	*No*
Emphysema	*Yes*	*No*	Contact Lenses	*Yes*	*No*	Thyroid Problems	*Yes*	*No*

Women: Are you pregnant? *Yes* *No* If yes, due date_____ Are you nursing *Yes* *No*

MEDICATION & ALLERGIES

Please list all the medication you are currently taking

_____

_____

_____

Are you allergic to any of the following? Yes No

If yes, please circle: Aspirin, Barbiturates(Sleeping pills), Codeine, Iodine, Latex, Local Anesthetic, Penicillin

Please List any other allergies_____

_____

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

You May Refuse to Sign this Acknowledgment

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 treatments, payments, activities, healthcare operation, the uses and disclosures we may make of your protected dental health information, and other important matters about your protected dental health information. A copy of our Notice is available at your request. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practice 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 dental health information that we maintain.

Persons Involved in Your Care: By signing this form, you will consent to our use of your dental care records to the following person(s), including those involved in your care or payment for that care. Please list the person(s) you would like involved in your care or payment for that care:

_____

I understand that by signing this Consent form, I am giving my consent to your use and disclosure of my protected dental health information, to carry out treatment, payments, dental health care operations, and releasing information to the individual(s) listed above.

Print Name(If Parent or Legal Guardian Print Name Also) -_____

Signature-_____ ***Date-***_____

For Office Use Only

We attempted to obtain written acknowledgment of receipt of acknowledgment of our Notice of Privacy Practices, but acknowledgment could not be obtained:

- ☐ ***Patient refused to sign***
- ☐ ***Communication barrier prohibited obtaining acknowledgment***
- ☐ ***Other (Please Specify)***

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FINANCIAL POLICIES

In order to accommodate the needs and requests of our patients, Dental Resort does file dental insurance. While we are pleased to be able to proved this service to you, it is not possible for our staff to keep track of all individual requirements of each plan. Dental benefit plans will never pay for completion of your dental care; it is only meant to assist you. We are not contracted with all insurance companies. It is the insured person's responsibility to understand their benefits and confirm that our dental providers are in network. Dental Resort can only provide an ***estimate*** of what your insurance will pay on a specific treatment and it is not a guarantee of coverage or payment. If applicable, secondary insurance can also be filed for you; however secondary insurance benefits are not taken into consideration when estimating coverage. If your insurance carrier pays a lesser amount than estimated, you will be billed for the difference.

Please initial on each line

_____All co-payments, estimated co-insurance, and deductibles are due at the time of service, or before your procedure. We accept cash, check, credit cards and outside patient financing. Any check dishonored by your bank will result in a $35.00 returned check charge added to your account.

_____If your insurance company does not pay within 60 days, Dental Resort reserves the right to request payment in full for services from you and let you collect the insurance funds that are due to you.

_____It is your responsibility to provide us with your current address, telephone number, and insurance information at each visit. If you do not have proof of active insurance at your visit, you will be considered a self-pay patient for that visit and payment will be due in full on that same day.

_____It is your responsibility to provide us with any legal documentation or divorce decree dictating a specific parent/guardian responsible for primary dental coverage.

_____If you do not inform us of any special requirements in your insurance contract, such as referrals or pre-authorization for treatment and we subsequently complete services that are not covered, you will be billed directly for those charges.

In the event your account is turned over to an outside agency for collections, you will be responsible for all collection fees, cost and such additional sums as the court may adjudge responsible.

Our team will gladly assist you in filling out necessary forms to maximize your dental benefits and discuss your financial options. Excellent dental care is available with or without dental benefits. We welcome you to our family and look forward to helping you get the healthy, beautiful smile you've always wanted.

I have read, understand and agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to Dental Resort.

By signing below, you are authorizing us to call, text or email you at all number(s) and email address you provide for any lawful purpose. You agree to any fees or charges that you may incur for any incoming or outgoing call to us or from us without reimbursement from us.

Signature (Parent/Legal Guardian if minor)_____ ***Date***_____

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BROKEN APPOINTMENT POLICY

We attempt to make confirmation calls, send texts, as well as emails at least 48 hours in advance of your scheduled appointment as a courtesy. When we call you, we will leave a reminder message on your voicemail. Therefore, we ask our patients to kindly give us a 24 hour notice if there is a need to cancel or reschedule your appointment. A one-time courtesy will be made for failure to give notice. Any cancellation or no shows after that will be charged a **$95.00 fee**.

Thank you for your understanding of this matter, as we strive to provide the best quality care for you.

I have read the above Broken Appointment Policy, and I understand that I will be charged if I fail to show up or cancel my scheduled appointment less than a 24 hour notice.

Printed Name_____ **Date**_____

Signature (If Minor patient, Parent/Guardian's Signature)_____

CONSENT TO DENTAL PHOTOGRAPHY

I, _____(Patient), authorize Dr. Kevin Aduddell DDS, to take photographs, and videos of my face, jaws and teeth, before, during and after treatment. I consent to allow the photographs to be used for the following:

- Dental Records
- Dental Research
- Dental Education including but not limited to lectures, seminars, demonstrations, and professional publications such as journals or books
- Marketing material including websites, printed material, and patient education

I further understand that if the photographs and/or videos are used, your name or other identifying information will be kept confidential. I do not expect or accept compensation, financial or otherwise, for the use of these photographs.

☐ Check here if you do not want your full face shot used for any of the above purposes.

Signature_____ **Date**_____

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Examination Questionnaire

Have you ever had any complications associated with past dental work? If so, please explain

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Is there anything you would like to change about your smile?

Has the fear of pain kept you from regular dental visits?

What did you like the most about any former dentist?

What may we do to make your dental visits more pleasant?

We believe that if all we care about is teeth, we don't care enough. Is there anything we could be praying about for you?
