PATIENT INFORMATION

Welcome to Abbella Dental Care! We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. If there have been any changes in your health, please tell us. If you have any questions, don't hesitate to ask.

Patient First name:_____ **Patient Last Name:**_____ **Sex:** _____

If Patient is a Minor, Legal Guardian(s)_____

Home address: _____**City**:_____ **State**:___ **Zip**:_____

Date of Birth_____ **Social Security #:**_____ **E-mail:**_____

Home Phone #:_____**Work Phone #:**_____ **Mobile Phone #:**_____

Best time to call/Pref Phone (ie–AM/PM, day of week):_____

Preferred contact method (choose 1 or more): □ **Home** □ **Work Phone** □ **Wireless Phone** □ **Text** □ **Email**

Emergency contact (name/relationship/phone):_____

Employer:_____ Occupation:_____

Name of your medical doctor: _____ Date of last visit to doctor:_____

Name of previous dentist: _____ Date of last visit to dentist:_____

Name of pharmacy_____ Phone_____

How did you find out about us?:_____

Insurance Information (This is Only Needed if you DO NOT have an insurance card)

Primary dental insurance_____ Subscriber name: _____

Subscriber Policy #:_____ Subscriber DOB:_____

Secondary dental insurance_____ Subscriber name: _____

Subscriber Policy #:_____ Subscriber DOB:_____

Patient (office use only)_____

PATIENT MEDICAL HISTORY

Correct answers to the following questions will allow your dentist to treat you on a more individual basis, providing the care appropriate for your particular needs

YES	NO	Check ☑the Appropriate Answer
□	□	Are you presently taking any medications or drugs? If Yes, Please List_____
□	□	Are you allergic to Latex? Local Anesthesia? Or other materials? If Yes, Please List_____
□	□	Are there any medications you cannot take? If Yes, Please List_____
□	□	Do you have any bleeding disorders? If Yes, Please List_____
□	□	Have you ever had prolonged bleeding from extraction of tooth or injury?
□	□	Do you have any autoimmune disorders? If Yes, Please List_____
□	□	Do you have any nervous disorders? If Yes, Please List_____
□	□	Do you have any artificial Prosthesis? If Yes, Please List_____
□	□	Do you use tobacco in any form? If yes, how much?_____How often?_____
□	□	Do you use alcoholic beverages? If yes, how much?_____How often?_____

	Yes	No		Yes	No	
□ □ AIDS or HIV Positive	□	□	Thyroid condition	□	□	Heart Murmur
□ □ Hepatitis	□	□	Artificial joints/limbs	□	□	Heart Attack or Coronary Surgery
□ □ Emphysema	□	□	Arthritis	□	□	Mitral valve prolapse
□ □ Tuberculosis	□	□	Shortness of breath	□	□	Artificial Heart valve
□ □ Asthma / Hay fever	□	□	Sinus problem	□	□	Pacemaker
□ □ Rheumatic fever	□	□	Headache	□	□	High or Low Blood Pressure
□ □ Cancer or Tumors	□	□	Kidney disease	□	□	Angina
□ □ Radiation treatment	□	□	Venereal disease	□	□	Diabetes
□ □ Chemotherapy	□	□	Herpes	□	□	Ulcers
□ □ Stroke						
□ □ Seizures Convulsions or Epilepsy						

IS THERE ANYTHING WE CAN TO DO TO IMPROVE YOUR DENTAL CARE EXPERIENCE? WHAT WOULD YOU LIKE TO GET OUT OF YOUR DENTAL CARE_____

_____

_____

PLEASE LIST ANY OTHER HEALTH INFORMATION OR MEDICAL CONDITIONS NOT LISTED ABOVE WHICH MAY INFLUENCE YOUR DENTAL TREATMENT_____

_____

_____

Patient (office use only)_____

PATIENT DENTAL HISTORY

YES **NO** Check ☑the Appropriate Answer

□ □ Is there any dental problem that you are currently having that you feel needs immediate attention?
If Yes, Please Describe_____

□ □ Are you happy with your smile?
If No, Please Describe_____

□ □ Have you ever had treatments for your gums?

□ □ Do your gums bleed or hurt when you brush them?

□ □ Do your teeth hurt when you chew?

□ □ Have you ever been aware of a bad odor or taste in your mouth?

□ □ Are your teeth sensitive to hot, cold, or sweets?

□ □ Do you clench or grind your teeth during the day or night?

□ □ Do you have any broken fillings?

□ □ Do you have clicking/popping of the jaw?

□ □ Have you ever had orthodontic treatment?

FEMALE ONLY

□ □ Are you now or think you may be pregnant?

□ □ Are you presently taking birth control pills?

□ □ Are you nursing?

AUTHORIZATION AND RELEASE:

I certify that I have read and understood 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 the records of any treatment or examination rendered to me or my child or person under my care during the period of such Dental care to third party payers 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 of services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

I give this dental office and members of office staff permission to call me prior to an appointment to remind me of the appointment date and time. I can be contacted via any of my given contact Information including E-mail address and phone numbers. The Dental office may leave me a voice-mail message at my home/work/cell number and/or messages with people at my home/work.

X_____ Date_____

Signature of Patient/Parent or Guardian, If minor

Reviewed By_____ Date_____

(Doctor)

Patient (office use only)_____

2 Business Day/48 Business Hour Cancellation/Missed Appointment Policy

If you must reschedule/cancel an appointment, please note that we require **2 business days** notice to cancel or reschedule or a **fee will be charged**.

Appointment is on:	Need to reschedule/change by:
Monday	Thursday
Tuesday	Friday
Thursday	Monday
Friday	Tuesday

We need to have this policy to be fair to patients that would have liked your time slot, to keep our fees competitive, and continue accepting most insurance plans. Also, note that multiple missed appointments will result in loss of appointment privileges.

Appointment changes must be made **via phone call or in-person (no email/text)**. There is a charge for any appointment broken without a 48 business hour advance notice. **The charge will be $96.00 for every hour of appointment time ($50 minimum).**

I HAVE READ, UNDERSTAND, AND AGREE TO THE ABOVE OFFICE POLICY CONCERNING RESCHEDULING APPOINTMENTS.

_____ _____ _____

Patient Name **Signature of Patient / Signature of Parent or Guardian, if minor** **Date**

DENTAL OFFICE INFORMED CONSENT

It is important to our office that you understand your rights as a patient. We would like you to recognize that you, the patient, have the right to accept or reject dental treatment recommendations by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment. Make sure you discuss potential benefits, risks, and complications with your dentist. By consenting to treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

As with all surgery, there are commonly known risks and potential complications associated with dental treatment. No one can guarantee the success of the recommended treatment, or that you will not experience a complication or less than optimal result. Even though many of these complications are rare, they can and do occur occasionally.

Some of the more commonly known risks and complications of treatment include, but are not limited to the following: Pain, swelling and discomfort after treatment; Infection in need of medication, follow-up procedures or other treatment; Temporary, or, on rare occasion, permanent numbness, pain, tingling or altered sensation of the lip, face, chin, gums, and tongue along with possible loss of taste; Damage to adjacent teeth, restoration or gums; Possible deterioration of your condition which may result in tooth loss; The need for replacement of restorations, implants or other appliances in the future; An altered bite in need of adjustment; Possible injury to the jaw joint and related structures requiring follow-up care and treatment, or consultation by a dental specialist; A root tip, bone fragment or a piece of dental instrument may be left in your body, and may have to be removed at a later time if symptoms develop; If upper teeth are treated, there is a chance of sinus infection or opening between the mouth and sinus cavity resulting in infection or the need for further treatment; Allergic reaction to anesthetic or medication; and Need for follow-up care and treatment, including surgery.

It is very important that you provide your dentist with accurate information before, during, and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre- and post-treatment instructions, referrals to other dentists or specialist, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.

Do not sign this form or agree to treatment until you have read, understood, and accepted each paragraph stated above. Please discuss the potential benefits, risks and complications of recommended treatment with your dentist. Be certain all of your concerns have been addressed to your satisfaction by your dentist before commencing treatment.

FINANCIAL POLICY

1. **ALL PATIENTS:**
   a. Please note that all balances, payments, estimated co-pays, estimated coinsurance, and deductibles must be paid **prior to appointment**. All procedures involving lab work will require full payment on the day of the first appointment.
   b. There is a $20 minimum charge for all **Credit Cards**.
   c. Checks returned unpaid from the bank are subject to $45.00 service fee.
   d. Accounts delinquent more than 60 days from the date of billing are subject to a 24% annual finance charge (~2% per month). If your account is sent to our collection agency, you will be responsible for collection and court costs along with attorney's fees.
2. **PATIENTS WITH INSURANCE COVERAGE:**
   a. Please understand that your insurance policy is a contract between you and your insurance company. As a courtesy to you, we can help you obtain the appropriate benefits from your insurance carrier, however, you are ultimately responsible for the payments of your account.
   b. If your insurance company has not paid the claim within 45 days or paid less that the estimated amount, you will be billed for the balance. We will update your balance routinely with payments received by us from your insurance company. We may keep the credit balance, if any, towards your future treatment. It is your responsibility to request a statement of accounts or a refund of your credit balance.

We welcome you to our office and want to provide you with the best possible care. If you have any questions regarding our policies and your treatment, please do not hesitate to ask.

I HAVE READ, UNDERSTAND, AND AGREE TO THE ABOVE DENTAL OFFICE INFORMED CONSENT, AND FINANCIAL POLICY.

_____	_____	_____
Patient Name	**Signature of Patient / Signature of Parent or Guardian, if minor**	**Date**

Abbella Dental Care

Acknowledgement of Receipt of Notice of Privacy Practice

You may Refuse to Sign This Acknowledgement if you have not received
Abbella Dental Care's Notice of Privacy Practices

I, _____, have received a copy of this office's Notice of Privacy Practices
(Patient Name)

_____
Please Print Patient Name (or Guardian Name if minor)

_____
Signature of Patient (or Signature of Guardian if minor)

_____
Date

For Office Use Only

We Attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, as required by law, but acknowledgement could not be obtained because

☐ **Individual refused to sign**

☐ **Communications barriers prohibited obtaining acknowledgement**

☐ **An emergency situation prevented us from obtaining acknowledgement**

☐ **Other (Please Specify Reason):**

_____
_____
_____