

TELL US ABOUT YOURSELF

Name _____ Date _____
First Last

Preferred Name _____ SSN _____

Birthdate ____ / ____ / ____ Gender _____

Marital Status Married Single Child Other: _____

Phone _____ Email _____

Address _____

How did you choose our office? _____

SPOUSE OR PARENT INFORMATION

Name _____ Phone _____

Birthdate ____ / ____ / ____ SSN _____

Relationship _____

Do you have legal custody of this child if patient is a minor? Yes No

DENTAL INFORMATION RELEASE

I give Albany Dental Group permission for my Protected Health Information to be disclosed to family or others. This may include, but is not limited to; examination and treatment rendered, diagnosis, detailed treatment plans, accounting, insurance claims and billing. The release of information will remain effective until terminated by myself in writing. This information may be released to the following individuals:

- Spouse or parent
- Child(ren)
- Other _____
Name
- Information is not to be released to anyone other than myself.

Signature _____

Date _____

PRIMARY DENTAL INSURANCE

Insurance Co. Name _____

Insurance Co. Phone _____

Subscriber Member # _____

Group # _____

Policy Owner's Name _____

Relationship to Patient _____

Policy Owner's Birthdate ____ / ____ / ____ SSN _____

Policy Owner's Employer _____

SECONDARY DENTAL INSURANCE

Insurance Co. Name _____

Insurance Co. Phone _____

Subscriber Member # _____

Group # _____

Policy Owner's Name _____

Relationship to Patient _____

Policy Owner's Birthdate ____ / ____ / ____ SSN _____

Policy Owner's Employer _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of Albany Dental Group's Notice of Privacy Practices. (You may refuse to sign this acknowledgement.)

Print Name _____

Signature _____

Date _____

EMERGENCY CONTACT

Name _____

Relationship _____ Phone _____

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
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (please specify) _____

AUTHORIZATION

I authorize the Doctor to take any diagnostic aids he/she deems necessary to make a thorough diagnosis of my dental needs and to perform any and all forms of treatment, medication and therapy that may be indicated utilizing assistance as appropriate. I authorize Albany Dental Group to release any information including the diagnosis and/or records of treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I understand that my dental insurance may pay less than the actual fee for services and that I am responsible for payment of all services/fees rendered, regardless of insurance coverage, on my behalf and that of the dependents on the account. I agree to pay the expected patient portion at the time services are rendered unless other financial arrangements have been made in advance.

Signature _____

Print Name _____

Date _____

Main reason for today's visit _____ Date of last dental visit _____

Previous dentist _____ City/State _____

DENTAL HISTORY

Mark "YES" or "NO" to indicate if you have, or have had, any of the following:

<table border="0"><tr><td>Yes</td><td>No</td><td></td><td></td><td>Bleeding gums</td></tr><tr><td></td><td></td><td></td><td></td><td>Bad breath</td></tr><tr><td></td><td></td><td></td><td></td><td>Blisters on lips or mouth</td></tr><tr><td></td><td></td><td></td><td></td><td>Burning sensation on tongue</td></tr><tr><td></td><td></td><td></td><td></td><td>Cigarette, pipe, or cigar smoking</td></tr><tr><td></td><td></td><td></td><td></td><td>Clicking or popping jaw</td></tr><tr><td></td><td></td><td></td><td></td><td>Dry mouth</td></tr><tr><td></td><td></td><td></td><td></td><td>Fingernail biting</td></tr><tr><td></td><td></td><td></td><td></td><td>Food collection between teeth</td></tr></table>	Yes	No			Bleeding gums					Bad breath					Blisters on lips or mouth					Burning sensation on tongue					Cigarette, pipe, or cigar smoking					Clicking or popping jaw					Dry mouth					Fingernail biting					Food collection between teeth	<table border="0"><tr><td>Yes</td><td>No</td><td></td><td></td><td>Foreign objects</td></tr><tr><td></td><td></td><td></td><td></td><td>Grinding teeth</td></tr><tr><td></td><td></td><td></td><td></td><td>Gums swollen or tender</td></tr><tr><td></td><td></td><td></td><td></td><td>Jaw pain or tiredness</td></tr><tr><td></td><td></td><td></td><td></td><td>Lip or cheek biting</td></tr><tr><td></td><td></td><td></td><td></td><td>Loose teeth or broken fillings</td></tr><tr><td></td><td></td><td></td><td></td><td>Mouth breathing</td></tr><tr><td></td><td></td><td></td><td></td><td>Mouth pain while brushing</td></tr><tr><td></td><td></td><td></td><td></td><td>Orthodontic treatment</td></tr></table>	Yes	No			Foreign objects					Grinding teeth					Gums swollen or tender					Jaw pain or tiredness					Lip or cheek biting					Loose teeth or broken fillings					Mouth breathing					Mouth pain while brushing					Orthodontic treatment	<table border="0"><tr><td>Yes</td><td>No</td><td></td><td></td><td>Pain around ear</td></tr><tr><td></td><td></td><td></td><td></td><td>Periodontal treatment</td></tr><tr><td></td><td></td><td></td><td></td><td>Sensitivity to cold</td></tr><tr><td></td><td></td><td></td><td></td><td>Sensitivity to heat</td></tr><tr><td></td><td></td><td></td><td></td><td>Sensitivity to sweets</td></tr><tr><td></td><td></td><td></td><td></td><td>Sensitivity when chewing</td></tr><tr><td></td><td></td><td></td><td></td><td>Sores or growths in your mouth</td></tr><tr><td></td><td></td><td></td><td></td><td>Unable to chew on one side of mouth</td></tr></table>	Yes	No			Pain around ear					Periodontal treatment					Sensitivity to cold					Sensitivity to heat					Sensitivity to sweets					Sensitivity when chewing					Sores or growths in your mouth					Unable to chew on one side of mouth
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How often do you: Floss? _____ Brush? _____

HEALTH HISTORY

Mark "YES" or "NO" to indicate if you have, or have had, any of the following:

<table border="0"><tr><td>Yes</td><td>No</td><td></td><td></td><td>AIDS/HIV Positive</td></tr><tr><td></td><td></td><td></td><td></td><td>Alzheimer's Disease</td></tr><tr><td></td><td></td><td></td><td></td><td>Anaphylaxis</td></tr><tr><td></td><td></td><td></td><td></td><td>Anemia</td></tr><tr><td></td><td></td><td></td><td></td><td>Angina</td></tr><tr><td></td><td></td><td></td><td></td><td>Arthritis/Gout</td></tr><tr><td></td><td></td><td></td><td></td><td>Artificial Heart Valve</td></tr><tr><td></td><td></td><td></td><td></td><td>Artificial Joint</td></tr><tr><td></td><td></td><td></td><td></td><td>Asthma</td></tr><tr><td></td><td></td><td></td><td></td><td>Blood Disease</td></tr><tr><td></td><td></td><td></td><td></td><td>Blood Transfusion</td></tr><tr><td></td><td></td><td></td><td></td><td>Boniva/Fosamax/Zometa Use</td></tr><tr><td></td><td></td><td></td><td></td><td>Breathing Problems</td></tr><tr><td></td><td></td><td></td><td></td><td>Bruise Easily</td></tr><tr><td></td><td></td><td></td><td></td><td>Cancer</td></tr><tr><td></td><td></td><td></td><td></td><td>Chemotherapy</td></tr><tr><td></td><td></td><td></td><td></td><td>Chest Pain</td></tr><tr><td></td><td></td><td></td><td></td><td>Cold Sores/Fever Blisters</td></tr><tr><td></td><td></td><td></td><td></td><td>Congenital Heart Disorder</td></tr><tr><td></td><td></td><td></td><td></td><td>Convulsions</td></tr></table>	Yes	No			AIDS/HIV Positive					Alzheimer's Disease					Anaphylaxis					Anemia					Angina					Arthritis/Gout					Artificial Heart Valve					Artificial Joint					Asthma					Blood Disease					Blood Transfusion					Boniva/Fosamax/Zometa Use					Breathing Problems					Bruise Easily					Cancer					Chemotherapy					Chest Pain					Cold Sores/Fever Blisters					Congenital Heart Disorder					Convulsions	<table border="0"><tr><td>Yes</td><td>No</td><td></td><td></td><td>Cortisone Medication</td></tr><tr><td></td><td></td><td></td><td></td><td>Dementia/Memory Loss</td></tr><tr><td></td><td></td><td></td><td></td><td>Diabetes</td></tr><tr><td></td><td></td><td></td><td></td><td>Drug Addiction</td></tr><tr><td></td><td></td><td></td><td></td><td>Easily Winded</td></tr><tr><td></td><td></td><td></td><td></td><td>Emphysema</td></tr><tr><td></td><td></td><td></td><td></td><td>Epilepsy or Seizures</td></tr><tr><td></td><td></td><td></td><td></td><td>Excessive Bleeding</td></tr><tr><td></td><td></td><td></td><td></td><td>Excessive Thirst</td></tr><tr><td></td><td></td><td></td><td></td><td>Fainting Spells/Dizziness</td></tr><tr><td></td><td></td><td></td><td></td><td>Frequent Cough</td></tr><tr><td></td><td></td><td></td><td></td><td>Frequent Diarrhea</td></tr><tr><td></td><td></td><td></td><td></td><td>Frequent Headaches</td></tr><tr><td></td><td></td><td></td><td></td><td>Genital Herpes</td></tr><tr><td></td><td></td><td></td><td></td><td>Glaucoma</td></tr><tr><td></td><td></td><td></td><td></td><td>Hay Fever</td></tr><tr><td></td><td></td><td></td><td></td><td>Hearing Impairment/Loss</td></tr><tr><td></td><td></td><td></td><td></td><td>Heart Attack/Failure</td></tr><tr><td></td><td></td><td></td><td></td><td>Heart Murmur</td></tr><tr><td></td><td></td><td></td><td></td><td>Heart Pacemaker</td></tr></table>	Yes	No			Cortisone Medication					Dementia/Memory Loss					Diabetes					Drug Addiction					Easily Winded					Emphysema					Epilepsy or Seizures					Excessive Bleeding					Excessive Thirst					Fainting Spells/Dizziness					Frequent Cough					Frequent Diarrhea					Frequent Headaches					Genital Herpes					Glaucoma					Hay Fever					Hearing Impairment/Loss					Heart Attack/Failure					Heart Murmur					Heart Pacemaker	<table border="0"><tr><td>Yes</td><td>No</td><td></td><td></td><td>Heart Trouble/Disease</td></tr><tr><td></td><td></td><td></td><td></td><td>Hemophilia</td></tr><tr><td></td><td></td><td></td><td></td><td>Hepatitis Type _____</td></tr><tr><td></td><td></td><td></td><td></td><td>Herpes</td></tr><tr><td></td><td></td><td></td><td></td><td>High Blood Pressure</td></tr><tr><td></td><td></td><td></td><td></td><td>High Cholesterol</td></tr><tr><td></td><td></td><td></td><td></td><td>Hives or Rash</td></tr><tr><td></td><td></td><td></td><td></td><td>Hypoglycemia</td></tr><tr><td></td><td></td><td></td><td></td><td>Irregular Heartbeat</td></tr><tr><td></td><td></td><td></td><td></td><td>Kidney Problems</td></tr><tr><td></td><td></td><td></td><td></td><td>Leukemia</td></tr><tr><td></td><td></td><td></td><td></td><td>Liver Disease</td></tr><tr><td></td><td></td><td></td><td></td><td>Low Blood Pressure</td></tr><tr><td></td><td></td><td></td><td></td><td>Lung Disease</td></tr><tr><td></td><td></td><td></td><td></td><td>Mitral Valve Prolapse</td></tr><tr><td></td><td></td><td></td><td></td><td>Neurological Condition(s)</td></tr><tr><td></td><td></td><td></td><td></td><td>Osteoporosis</td></tr><tr><td></td><td></td><td></td><td></td><td>Pain in Jaw Joints</td></tr><tr><td></td><td></td><td></td><td></td><td>Parathyroid Disease</td></tr><tr><td></td><td></td><td></td><td></td><td>Psychiatric Care</td></tr></table>	Yes	No			Heart Trouble/Disease					Hemophilia					Hepatitis Type _____					Herpes					High Blood Pressure					High Cholesterol					Hives or Rash					Hypoglycemia					Irregular Heartbeat					Kidney Problems					Leukemia					Liver Disease					Low Blood Pressure					Lung Disease					Mitral Valve Prolapse					Neurological Condition(s)					Osteoporosis					Pain in Jaw Joints					Parathyroid Disease					Psychiatric Care	<table border="0"><tr><td>Yes</td><td>No</td><td></td><td></td><td>Radiation Treatments</td></tr><tr><td></td><td></td><td></td><td></td><td>Recent Weight Loss</td></tr><tr><td></td><td></td><td></td><td></td><td>Renal Dialysis</td></tr><tr><td></td><td></td><td></td><td></td><td>Rheumatic Fever</td></tr><tr><td></td><td></td><td></td><td></td><td>Rheumatism</td></tr><tr><td></td><td></td><td></td><td></td><td>Scarlet Fever</td></tr><tr><td></td><td></td><td></td><td></td><td>Shingles</td></tr><tr><td></td><td></td><td></td><td></td><td>Sickle Cell Disease</td></tr><tr><td></td><td></td><td></td><td></td><td>Sinus Trouble</td></tr><tr><td></td><td></td><td></td><td></td><td>Spina Bifida</td></tr><tr><td></td><td></td><td></td><td></td><td>Stomach/Intestinal Disease</td></tr><tr><td></td><td></td><td></td><td></td><td>Stroke</td></tr><tr><td></td><td></td><td></td><td></td><td>Swelling of Limbs</td></tr><tr><td></td><td></td><td></td><td></td><td>Thyroid Disease</td></tr><tr><td></td><td></td><td></td><td></td><td>Tonsillitis</td></tr><tr><td></td><td></td><td></td><td></td><td>Tuberculosis</td></tr><tr><td></td><td></td><td></td><td></td><td>Tumors or Growths</td></tr><tr><td></td><td></td><td></td><td></td><td>Ulcers</td></tr><tr><td></td><td></td><td></td><td></td><td>Venereal Disease</td></tr><tr><td></td><td></td><td></td><td></td><td>Yellow Jaundice</td></tr></table>	Yes	No			Radiation Treatments					Recent Weight Loss					Renal Dialysis					Rheumatic Fever					Rheumatism					Scarlet Fever					Shingles					Sickle Cell Disease					Sinus Trouble					Spina Bifida					Stomach/Intestinal Disease					Stroke					Swelling of Limbs					Thyroid Disease					Tonsillitis					Tuberculosis					Tumors or Growths					Ulcers					Venereal Disease					Yellow Jaundice
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Have you ever had any serious illnesses not listed? Yes No If yes, please explain _____

WOMEN

Are you pregnant? Yes No Due Date _____ Are you nursing? Yes No Birth control pills? Yes No

MEDICATIONS

Please list any medications you are currently taking _____

ALLERGIES

None Aspirin Barbiturates Codeine Iodine Latex Local Anesthetic Penicillin Sulfa Other

Have you ever been hospitalized or had any surgeries? Yes No If yes, please explain with reason and dates _____

Physician _____ Phone _____ Last Appointment _____

To the best of my knowledge, all of the preceding answers are true and correct. I will not hold this office responsible for errors or omissions that I may have made in the completion of this form. If my health history changes, I will notify this office at my next dental appointment.

Signature of Patient, Parent, or Guardian _____ Date _____



PATIENT NAME _____

Please initial that you have read and understand each section.

_____ **Financial Policy**

I have received the Albany Dental Group Financial and Insurance Policy that outlines my financial responsibility toward care rendered by the doctors at Albany Dental Group. I understand that the guarantor on the account will be responsible. If my child has an appointment the guarantor on the account will be responsible for payment at the time services are rendered.

_____ **Appointment Cancellation or No-Show Policy**

I take full responsibility for the cancellation/rescheduling of any needed appointments. A specific amount of time is reserved especially for you and we strongly encourage all patients to keep their appointments. If you must change your appointment, WE REQUIRE AT LEAST A 24 HOUR NOTICE PRIOR TO YOUR APPOINTMENT TIME to avoid a \$45 cancellation fee. Many patients are waiting months in advance for appointments, please respect our schedule and our other patients by giving us time to fill your reserved spot with another patient in need of care. Albany Dental Group reserves the right to dismiss the patient from the practice after 3 missed or late cancelled appointments.

_____ **Medical/Dental Release Statements**

I give my consent for the doctors of Albany Dental Group to complete a thorough examination on myself or the patient named above including any needed diagnostic radiographs. To the best of my knowledge the information I have provided is accurate and I understand that it will be held in the strictest of confidence and in accordance to all federal and state HIPAA regulations. Further more, I understand that it is my responsibility to inform Albany Dental Group of any future changes to my or my child's medical history status. I also hereby grant the doctors and staff of Albany Dental Group permission to perform future treatment(s) as deemed appropriate. I understand that all necessary treatment will be explained prior to commencement and that I am responsible for payment in full at the time services are rendered, unless prior arrangements have been approved.

_____ **Insurance Claim Release & Financial Responsibility Statement**

To precipitate the filing of this and all future dental insurance claims, I do hereby authorize the release of confidential information to my dental insurance company. I am aware that Albany Dental Group will be providing an estimate of the insurance coverage prior to initiating any future treatment and that I am legally responsible for any portions not paid by this policy. I understand that additional out-of-pocket expenses may be accrued should estimates provided by my insurance company be inaccurate or should procedures change during the course of the treatment. Furthermore, I am aware of my financial responsibility should my insurance policy fail to pay, for any reason, within 45 days of receiving such treatment.

_____ **Authorization for Direct Payment**

I hereby authorize payment of insurance benefits directly to Albany Dental Group or the dentist that performs my treatment. Furthermore, in the event of payment default for services previously rendered, I also agree to pay all reasonable collection and/or legal fees incurred in an attempt to collect on this amount.

_____ **Notice of Privacy Practices, Health Insurance Portability & Accountability Act of 1996**

I have read the form entitled, "Notice of Privacy Practices," and understand its contents concerning the privacy of my confidential health care information. I do hereby provide consent for the standard use of such information and understand that these provisions prohibit Albany Dental Group from selling or transferring this information to any unauthorized locations without my prior approval. I have reviewed this information and all questions have been answered to my satisfaction.

I have read and understand the above policies.



PATIENT NAME _____

FINANCIAL POLICY AND INSURANCE INFORMATION

Methods of Payment

For your convenience we accept cash, check, and all major credit cards (Visa, MasterCard, American Express and Discover). We gladly offer and accept payment plans through CareCredit for dental treatment.

As we strive to be one of Albany's leading providers for family dental care, we work to assist patients in taking an active role in their dental health. Because we value our relationship with you and believe that the best relationships are based upon understanding, we offer these clarifications on methods of payment & insurance reimbursement.

At each visit, we will request a copy of your dental insurance information to allow us to file your claim. Please remember to bring all dental insurance information/insurance card(s) to each appointment. Please contact Albany Dental Group immediately after making any changes to your dental coverage, so we can keep our records current and to provide expeditious reimbursement of your benefits.

If any treatment needs are discovered during your or your child's exam, we will provide you with a cost estimate indicating our total fee, what we anticipate your insurance coverage to be, and your ESTIMATED out-of-pocket portion for the treatment plan. We will discuss all treatment options and costs before beginning any further treatment. We know that dental insurance can be confusing so feel free to contact us with insurance or payment questions.

Dental Insurance

We are dedicated to providing all our patients with the best treatment available and base all our treatment recommendations on what will be best for you or your child and not what your insurance company does or doesn't pay. Please note the following in regards to your dental insurance coverage:

1. We must emphasize that as a health care provider, our relationship is with you and not your dental insurance company. Your dental insurance is a contract between you, your employer and the insurance company. Most plans routinely pay between 50-75% of the average total fee for a given procedure. This percentage is pre-determined by the plan your employer has purchased.
2. As a courtesy, we will be happy to file for your insurance benefits. Because your dental insurance plan is a contract between you, your employer, and the insurance company, many carriers will not reimburse our office. **In this instance, you will be responsible for the full cost of each visit at the time services are provided and your insurance company will send you the reimbursement check directly.**
3. **Any amount not covered by your insurance company is payable at the time services are rendered.** These fees may include deductibles, co-payments or certain procedures not covered by your insurance policy. Unfortunately, some of the services that we may recommend for your child may not be covered by your specific dental insurance. Our primary goal is to treat you and your child using the best possible materials, supplies, medications and environment.
4. We allow a maximum of 45 days for your insurance company to clear account balances. **Any unpaid portions will be due in full, by you, after this period.** If you have not paid your balance within 60 days of the date treatment was rendered, a finance charge of 1.5% will be added to your account each month until paid. Should your insurance company submit payment after this time, we will be glad to reimburse you. This is rare but is important that you recognize that your insurance is a legal contract between you and your insurance company. Our office is not, and cannot be part of that legal contract. Ultimately you are responsible for all charges incurred in our office.
5. Our office does not determine your dental benefits. Your employer chooses your particular policy. If you are unhappy with it's coverage, this should be mentioned to your employer's benefits coordinator. Only your employer can adjust benefits.

Prior to completing any treatment, we will provide you with a cost estimate indicating our total fee, what we anticipate your insurance coverage to be, and your estimated out-of-pocket portion (estimated patient portion or EPP). Please remember, this is only an estimate based upon generalized information provided by your dental insurance company. An additional billing or possibly a refund may be subsequently required should information provided be inaccurate.

We will always do our best to maximize the insurance benefits that you are eligible to receive and we appreciate your prompt settlement of any charges that may be incurred during the treatment process. We look forward to years of close association with you, as we work together to maintain your oral health!