

Thank you for selecting our dental health care team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us -- we will be happy to help.

Patient Information (CONFIDENTIAL)		ID/SS#			
Name		Birthdate/	/		
Address	City	State	Zip Code		
Home ()Cell(	)	Email			
SingleMarriedSpouse or Par	rent/Guardian's Na	me			
Person to Contact in Case of Emergency	Phone ()				
Physician Name	Phone#	Last Phy	sical//		
Insurance Information					
Name of Insured		Relationship to Patient			
	Policy ID# 				
Employer	nis comp_				
Responsible Party					
		DOI	o / /		
Name of Person Responsible for this Account					
Relationship to Patient					
Address					
Home ()Work (	)	Employer (	)		
I understand this is a courtesy, Allred Family Den insurance benefits (otherwise payable to me) dire of services rendered and also responsible for pay does not cover.	ectly to this office. I	also understand that I am	responsible for payment bles that my insurance		
Signature		שמוכ /	1		

Patient Name:				Date of Birth:	
Are you under physician's car	e now?	o YES	o NO	If yes,	
Have you ever been hospitalize	zed/had major operat	tion? O YES o	ON C	If yes,	
Have you ever had a serious h	nead/neck injury?	o YES	o NO	If yes,	
Are you taking any medicatio	ns, pills, or drugs? (V	Ve need a list	of <u>ALL</u>	medications befor	e we can get you back)
o YES o NO If yes,					
Do you take, or have you tak	en, Phen-Fen or Redu	ux? o YES	o NO	If yes,	
Have you ever taken Fosamax other medication containing b		any o YES	o NO	If yes,	
Are you on a special diet?		o YES	o NO		
Do you use tobacco?		o YES	o NO		
Do you use controlled substan	nces?	o YES	o NO	If yes,	
Women: Are you: O Pre	gnant o	Nursing	0	Taking oral contra	oceptives
•			•	ilic o Metal	
Do you have, or have you had o AIDS/HIV o Alzheimer's Disease o Anaphylaxis o Anemia o Angina o Arthritis/Gout o Artificial Heart Valve o Artificial Joint o Asthma o Blood Disease o Blood Transfusion o Breathing Problems o Bruise Easily o Cancer o Chemotherapy o Chest Pains o Cold Sores/Fever Blisters o Congenital Heart Disorder o Convulsions o Yellow Jaundice	d, any of the followin	sine sine sing Dizziness ea ches	o Hepa o Hepa o Hepa o High o Hive o Hypa o Kidn o Leuk o Liver o Low o Lung o Mitr o Oste o Pain o Para	Blood Pressure Cholesterol s or Rash oglycemia gular Heartbeat ey Problems	-
To the best of my knowledge, the qu dangerous to my (or patient's) healt					roviding incorrect information can be I status.

Signature of patient, parent or guardian: \_\_\_\_\_\_ Date: \_\_\_\_\_



# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

\*You may refuse to sign this acknowledgment\* \_\_\_\_\_, have received a copy of this office's Notice of Privacy Practices. \*Date \*Signature \*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: o Individual refused to sign o Communication barriers prohibited obtaining the acknowledgment An emergency prevented us from obtaining acknowledgement Other (Please specify) List any individuals you allow us to disclose personal/health information with (including but not limited to diagnoses, labs, prognosis, treatment, billing, personal contact information, and all conditions) NAME/DOB **CONTACT PHONE NUMBER RELATIONSHIP TO PATIENT** 



#### MISSED AND LATE APPOINTMENT POLICY

At Allred Family Dentistry, when you make an appointment, a specific amount of time is reserved especially for you. Many offices will double or even triple book appointments to prevent from being financially damaged as a result of a missed appointments. However, overbooking appointments does not allow us to give the care and attention needed to provide quality dentistry and for this reason, we choose not to do this. We trust that you, as our patient, will respect the time our doctors have reserved to see you.

**Cancel or change your appointment:** If for any reason you must cancel/change your appointment, it is important that you give our office at least 48hrs notice. This gives us the opportunity to offer that spot to someone else and allows us to better serve other patients in need of dental work. Our doctors' times are highly requested, and we want to make sure that our patients don't have to wait for months to be treated.

**Late arrival:** When we reserve time for you, we require all that time to provide you with the best quality work possible. When you are late, it decreases our ability to accomplish this. If you arrive late, your appointment may be rescheduled.

**Missed appointment:** After a missed appointment, foryou to schedule a future appointment, a \$50.00 deposit must be made. When you arrive to your scheduled appointment, this will be credited back to you. If the second appointment is failed, the deposit is non-refundable.

### **FINANCIAL POLICIES**

# ALL PAYMENT IS DUE AT TIME OF SERVICE

Payment is required at the time services are rendered. This includes applicable coinsurance, copayments, deductibles and past due balances. We accept Cash, VISA, MasterCard, Discover, American Express and CareCredit. **WE DO NOT ACCEPT CHECKS**. We use a collection agency to pursue accounts with past due balances of 90 days or more.

**INSURANCE:** We bill insurance as a courtesy to you. **WE ARE ONLY IN NETWORK WITH CIGNA PPO, METLIFE PPO, DELTA DENTAL PPO, & GUARDIAN PPO**. Benefits and eligibility will be confirmed prior to any procedure. An estimate will be given to you for all procedures. This is only an estimate and not a guarantee of coverage. Changes to your treatment during your procedure may alter the cost of your care. Because this is an estimate, after your claim is paid by the insurance company, you may receive a bill or refund from us. It is your responsibility to know your coverage.

You are responsible for any portion not covered by your insurance.

Please sign below to indicate that you have read and agree to the above policies.

\*Signature \*Date



# **Patient Screening Form**

## Patient Name:

	PRE-APPOINTMENT	IN-OFFICE
	Date:	Date:
Do you/they have fever or have you/they felt hot or feverish recently (14-21 days)?	☐ Yes ☐ No	☐ Yes ☐ No
Are you/they having shortness of breath or other difficulties breathing?	☐ Yes ☐ No	☐ Yes ☐ No
Do you/they have a cough?	☐ Yes ☐ No	☐ Yes ☐ No
Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	☐ Yes ☐ No	☐ Yes ☐ No
Have you/they experienced recent loss of taste or smell?	☐ Yes ☐ No	☐ Yes ☐ No
Are you/they in contact with any confirmed COVID-19 positive patients?  Patients who are well but who have a sick family member at home with COVID-19 should consider postponing elective treatment.	☐ Yes ☐ No	☐ Yes ☐ No
Is your/their age over 60?	☐ Yes ☐ No	☐ Yes ☐ No
Do you/they have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	☐ Yes ☐ No	☐ Yes ☐ No
Have you/they traveled in the past 14 days to any regions affected by COVID-19? (as relevant to your location)	☐ Yes ☐ No	☐ Yes ☐ No

Positive responses to any of these would likely indicate a deeper discussion with the dentist before proceeding with elective dental treatment.

• For testing, see the list of <u>State and Territorial Health Department Websites</u> for your specific area's information.