welcome

The benefits of a happy, healthy smile are immeasurable!
Our goal is to help you reach and maintain maximum oral health.
Please fill out this form completely.
The better we communicate, the better we can care for you.

About You

Today's Date: _____

E-mail: _____

Name: _____
LAST FIRST MI MR MRS MS DR

I prefer to be called: _____ ☐ Male ☐ Female

Birthdate: __/__/__ Age: _____ SS #: _____

Home Address: _____
APT/CONDO #:

_____
CITY STATE ZIP

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Hm #: (____)_____ Cell #: (____)_____

Wk #: (____)_____ Ext: ____ DL #: _____

Employer: _____

Employer's Address: _____

How long there? _____ Occupation: _____

Where & when are best times to reach you? _____

Whom may we Thank for referring you? _____

Other family members seen by us: _____

Previous / Present Dentist: _____ Last Visit Date: _____
(Please Circle)

Spouse Information

His / Her Name: _____

Employer: _____

Wk #: (____)_____ Ext: ____ SS #: _____

Birthdate: __/__/__ Driver's License #: _____

Person Responsible for Account: _____

Wk #: (____)_____ Ext: ___ Hm #: (____)_____

Billing Address: _____

Relation: _____ SS #: _____

Employer: _____ DL #: _____

Insurance Coverage

Primary

Insurance Co. Name: _____

Insurance Co. Address: _____

_____

Insurance Co. Phone #: (____)_____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: __/__/__ Insured's SS #: _____

Insured's Employer: _____

Secondary

Insurance Co. Name: _____

Insurance Co. Address: _____

_____

Insurance Co. Phone #: (____)_____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: __/__/__ Insured's SS #: _____

Insured's Employer: _____

In the event of an emergency, is there someone who lives near you that we should contact?

His / Her Name: _____ Relation: _____

Wk #: (____)_____ Hm #: (____)_____

Medical History

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name: _____

Phone #: (____)_____ Date of last visit: _____

CONTINUED ON BACK

MEDICAL HISTORY *CONTINUED*

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician? ☐ Yes ☐ No
Please explain: _____

Are you taking any prescription / over-the-counter drugs? ☐ Yes ☐ No
Please list each one: _____

Do you smoke or use tobacco in any other form? ☐ Yes ☐ No

Have you ever taken Fosamax or any bisphosphonate? ☐ Yes ☐ No
If so, when? _____

For Women: Are you taking birth control pills? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Week #: _____

Are you nursing? ☐ Yes ☐ No

Have you ever had any of the following diseases or medical problems?

Y	N	Abnormal Bleeding	Y	N	Hepatitis
Y	N	Alcohol / Drug Abuse	Y	N	Herpes / Fever Blisters
Y	N	Anemia	Y	N	High Blood Pressure
Y	N	Arthritis	Y	N	HIV+ / AIDS
Y	N	Artificial Bones / Joints / Valves	Y	N	Hospitalized for Any Reason
Y	N	Asthma	Y	N	Kidney Problems
Y	N	Blood Transfusion	Y	N	Liver Disease
Y	N	Cancer/Chemotherapy	Y	N	Low Blood Pressure
Y	N	Colitis	Y	N	Mitral Valve Prolapse
Y	N	Congenital Heart Defect	Y	N	Pacemaker
Y	N	Diabetes	Y	N	Psychiatric Problems
Y	N	Difficulty Breathing	Y	N	Radiation Treatment
Y	N	Emphysema	Y	N	Rheumatic / Scarlet Fever
Y	N	Epilepsy	Y	N	Seizures
Y	N	Fainting Spells	Y	N	Shingles
Y	N	Frequent Headaches	Y	N	Sickle Cell Disease / Traits
Y	N	Glaucoma	Y	N	Sinus Problems
Y	N	Hay Fever	Y	N	Stroke
Y	N	Heart Attack	Y	N	Thyroid Problems
Y	N	Heart Murmur	Y	N	Tuberculosis (TB)
Y	N	Heart Surgery	Y	N	Ulcers
Y	N	Hemophilia	Y	N	Venereal Disease

Please list any serious medical condition(s) that you have ever had:

_____

_____

Are you allergic to any of the following?

Y	N	Aspirin	Y	N	Erythromycin	Y	N	Metals
Y	N	Codeine	Y	N	Jewelry	Y	N	Penicillin
Y	N	Dental Anesthetics	Y	N	Latex	Y	N	Tetracycline

Please list any other drugs/materials that you are allergic to:

_____

DENTAL HISTORY

Why have you come to the dentist today?

_____

_____

Do you require antibiotics before dental treatment? ☐ Yes ☐ No

Are you currently in pain? ☐ Yes ☐ No

Have you ever had a serious / difficult problem associated with any previous dental work? ☐ Yes ☐ No

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? ☐ Yes ☐ No

Have you been told that you snore or hold your breath while sleeping or wake up gasping for breath? ☐ Yes ☐ No

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Do you like your smile? ☐ Yes ☐ No

Would you like whiter teeth? ☐ Yes ☐ No Fresher breath? ☐ Yes ☐ No

Do your gums ever bleed? ☐ Yes ☐ No

How many times a week do you floss? _____ a day do you brush? _____

Type of bristles? ☐ Soft ☐ Medium ☐ Hard

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

_____
Signature Date

Payment is due in full at the time of treatment unless prior arrangements have been approved.

In the event that a Ashland Dental Arts provider is exposed to your blood or bodily fluids in a manner which may transmit HIV (human immunodeficiency virus) or the hepatitis B or C viruses, you consent to testing of your blood and/or bodily fluids for these infections and to the release of test results to the health care provider who has been exposed. You will be offered the opportunity for face-to-face disclosure of test results and counseling.

_____
Signature Date

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the patient named herein. Initials: _____ Date: _____

MEDICAL HISTORY UPDATE

1. Date: _____ Comments: _____ Signature: _____
2. Date: _____ Comments: _____ Signature: _____
3. Date: _____ Comments: _____ Signature: _____
4. Date: _____ Comments: _____ Signature: _____
5. Date: _____ Comments: _____ Signature: _____

Current Medication Record

Name: _____ *Date of Birth:* _____

Date:	Medication:	Stop Date:

Ashland Dental Arts

Welcome!

All of us at Ashland Dental Arts are committed to providing you and your family with quality dental care with reasonable fees. We feel a clear understanding of your responsibilities is essential to the well being of our relationship. If you should have any questions, please feel free to ask.

Financial Policy:

Payment, in full, is due at the time of service. For your convenience, we accept cash, personal checks, debit cards, Amex, Discover, Mastercard, Visa and CareCredit.

Patients with Dental Insurance:

Patients are expected to provide current dental insurance information before any appointments. If insurance information is unable to be verified, patient will be expected to pay in full at the time of service. We will contact your benefits provider to verify dental coverage and request a breakdown of your dental benefits.

We will do our best to explain your coverage to you. Your co-insurance (co-pay) is due at the time of service. We will file claims and accept payments from your benefit provider on your behalf. Claims that are denied twice will become your responsibility. It is also the patient's responsibility to keep up with the insurance benefits remaining; we will help you with this to the best of our ability.

Returned checks are subject to a $40 returned check fee.

Please read the following carefully and sign where indicated:

If my account is turned over to an attorney for collections, I understand that I will be responsible for any additional fees added to my account, including, but not limited to, billing and service charges, legal fees and court costs.

I have read and understand the above mentioned policies.

Signature Print Name Date

Cancellation and Broken Appointment Policy

We understand that illness, emergencies, flat tires and bad weather do occur. We ask our patients to give us 48 hours notice, whenever possible, if they cannot keep an appointment. This allows us time to fill our schedule with other patients who may be waiting.

Policy and Fees:

Cancellation or rescheduling of an appointment with ***48 hours or more*** notice – ***no charge***

Cancellation or rescheduling of an appointment ***less than 48 hours in advanced*** may or may not be considered a broken appointment; it will be at our discretion.

If a patient no shows for an appointment- an automatic broken appointment fee will apply.

Failure to give 24 hour advance notice:

- We allow for one (1) broken appointment within a 12 month period
- Any additional broken appointments within a 12 month period will be charged a fee
    - $50 for a hygiene appointment (cleaning and check-up)
    - $75 for a doctor's appointment scheduled for an hour or less, each additional hour incurs an additional fee of $50

Definition of "Broken Appointment": A broken appointment is when you

- Cancel or reschedule an appointment with ***less than 48 hours notice***
- Do not show up for the scheduled appointment

Our number one concern is our patient's dental health. Providing services in a timely manner is critical to accomplish that goal. Our other goal is to keep the cost of dental services. As economical as possible. The appointment you schedule for treatment is reserved for you and your treatment only. When you fail to keep your appointment without providing us adequate notice, this adds to the overall cost of care, as trained professionals and dental facilities are not being utilized.

We appreciate your understanding and consideration regarding our appointment policy and if you have any questions or concerns, never hesitate to ask us at Ashland Dental Arts.

I have read and understand the above mentioned policy.

Signature Print Name Date

Ashland Dental Arts
HIPAA Consent and Release Form

Name: _____ Date of Birth: _____

Our notice of Privacy Practices provides information about how we may use and disclose your protected health information. It contains a section on Patient Rights outlining your rights under the law. You have a right to view our Notice before signing this consent. The terms of our Notice may change. If so, you may obtain a copy by contacting our office.

You have a right to request that we restrict how your protected health information is used or disclosed for treatment, payment and healthcare operations. We are not required to agree to such restriction but if we agree, we will honor that agreement.

By signing this form, you agree to our use and disclosure of your protected health information for treatment, payment and healthcare operations. You have a right to revoke this consent, in writing signed by you. Such a revocation will not affect any disclosures already made in reliance upon your prior consent. This form is provided to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient (or responsible party) understands that:

- Protected health information may be disclosed for purposes of treatment, payment and healthcare operations, or for other purposes permitted or required by law.
- The office has a Notice of Privacy Practices and the patient has the opportunity to review the Notice.
- The office reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the use of their information but the office does not have to agree to the restrictions.
- The patient has the right to revoke this consent in writing and all future disclosures will then cease.

_____

Signature (Patient or Responsible Party) *Date* [ ]self [ ]resp. party

Do you give permission to discuss your medical information with anyone else? [ ] YES [ ] NO If yes:

Name:	Relationship:	Telephone:

May we leave personal medical information on your voicemail/answering machine? [ ] YES [ ] NO
If yes, please provide the number we may use to leave the information: _____

Pharmacy Name: _____

Pharmacy Address: _____

Pharmacy Phone Number: _____

Release of Dental Records to Ashland Dental Arts

Gretchen S. Drees, D.D.S.
Ashland Dental Arts
100 Arbor Oak Drive
Suite 101
Ashland, VA 23005
(804) 798-7388
Fax: (804) 798-0859
info@ashlanddentalarts.net

TO:

_____

Doctor

_____

_____

Address

_____

Phone Number

I, _____, authorize the release of my dental records and x-rays to Ashland Dental Arts.

_____

Signature *Date*

Date of Birth or Social Security #: _____

Address: _____

Phone Number: _____