

# 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)

## 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: \_\_\_\_\_

## SPOUSE INFORMATION

His / Her Name: \_\_\_\_\_

Employer: \_\_\_\_\_

Wk #: (\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_ SS #: \_\_\_\_\_

Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Driver's License #: \_\_\_\_\_

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

His / Her Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Wk #: (\_\_\_\_) \_\_\_\_\_ Hm #: (\_\_\_\_) \_\_\_\_\_

Person Responsible for Account: \_\_\_\_\_

Wk #: (\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_ Hm #: (\_\_\_\_) \_\_\_\_\_

Billing Address: \_\_\_\_\_

Relation: \_\_\_\_\_ SS #: \_\_\_\_\_

Employer: \_\_\_\_\_ DL #: \_\_\_\_\_

## 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 <sup>+</sup> / 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: \_\_\_\_\_

***\*\*Please Note – if you require a pre-medication for your dental appointment, we require written documentation from your doctor stating your medication protocol before your appointment\*\****

[illegible]

# Ashland Dental Arts

Welcome!

All of us at Ashland Dental Arts are committed to providing you and your family with quality dental care at 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 prior to any appointments. We will contact your benefits provider to verify dental coverage and request a breakdown of your dental benefits. **If your dental insurance information is unable to be verified, you will be expected to pay in full at the time of service.**

While we will do our best to explain your dental coverage to you, it is ultimately your responsibility to know your dental benefits. It is also your responsibility to keep up with your remaining dental insurance benefits; we will help you with this to the best of our ability. **Your co-insurance (co-pay) and/or deductible is due at the time of service.** We will file claims and accept payments from your benefit provider on your behalf. If your claim is denied, we will file one (1) appeal on your behalf. If the appeal is denied, it is your responsibility to pay the full balance and contact your dental insurance company to provide the reason for denial.

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

If overpayment of services occurs, Dr. Drees will issue a refund check within fourteen (14) business days of the request being approved. If your original payment method was via credit/debit card, card processing fees will be deducted from the refunded amount. All refund checks require in-person pick-up.

## Please read the following carefully and sign where indicated:

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

I have read and understand the above mentioned policies.

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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 a minimum 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 ***less than 48 hours in advance*** may or may not be considered a broken appointment; it will be at Dr. Drees' discretion.

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

Ashland Dental Arts does not accept appointment cancellations via text or email - patients must contact the office via phone.

Broken appointment fees are not payable by insurance companies and all fees must be paid prior to scheduling another appointment.

## **Failure to give 48 hours 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 the following fees:
  - \$50 for a hygiene appointment (cleaning and check-up)
  - \$75 per hour for a restorative appointment (treatment)

Please be aware that if you are more than 15 minutes late to your appointment, it will be considered a broken appointment and your appointment will need to be rescheduled.

Our number one concern is our patient's dental health. Providing services in a timely manner is critical to accomplish that goal. The appointment you schedule 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. I consent to the terms listed above.

---

Signature

Print Name

Date

**Ashland Dental Arts**  
**HIPAA Consent and Release Form**

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this consent by requesting a copy from the front desk. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and healthcare operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information (PHI) may be disclosed or used for treatment, payment, filing of insurance claims or health care operations.
- Protected health information (PHI) may be disclosed to third parties and affiliates that perform services for Ashland Dental Arts. These parties are required by law to sign a Business Associate Agreement (BAA) agreeing to protect the confidentiality of your PHI.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this notice.
- The Practice reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the use of their information, but the Practice does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon execution of this Consent.

☐ YES ☐ NO

Do you give permission for Ashland Dental Arts to leave, as thorough of a message as needed, on your voicemail/answering machine. This includes, but is not limited to, appointment(s), treatment scheduled, documents to be signed, financial and collection concerns, and pre- or post-treatment directions.

☐ YES ☐ NO

Do you give permission to discuss your medical information with anyone else? If yes:

Name:	Telephone:	Full or Partial Access?*
		<input type="checkbox"/> Full <input type="checkbox"/> Partial
		<input type="checkbox"/> Full <input type="checkbox"/> Partial
		<input type="checkbox"/> Full <input type="checkbox"/> Partial

*\*If selecting partial access, list which parts of your chart: ex. financial, treatment, health history, etc.*

Pharmacy Name and Number: \_\_\_\_\_

\_\_\_\_\_  
*Patient's Name (Printed)*

\_\_\_\_\_  
*Date of Birth*

\_\_\_\_\_  
*Signature (Patient or Legal Guardian)*

\_\_\_\_\_  
*Date*

☐ Patient refused to sign HIPAA consent. Patient has the right to refuse. USPS or patient pick-up will be used for PHI transfer.

Office Staff Signature: \_\_\_\_\_ Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_

Witnessed Staff Signature: \_\_\_\_\_ Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_

## **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: \_\_\_\_\_