**Alabama Smile Design**
4720 Airport Boulevard Mobile, AL 36608
251.344.4994

Today's date: _____

**First Name: _____ MI: _____ Last Name:_____**

**Date of birth:** _____ **Sex:** __Male __Female **Family Status:** __Single __Married __Child __Other

Social security number: _____ Driver's license number: _____

Email: _____ Nickname:_____

Home address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Employer: _____ Address: _____

**Whom should we contact in an emergency?** *(Please give phone # and relationship to you)*

_____

**Whom may we thank for referring you?** _____

**PREFERENCES** ____No phone calls ____No correspondence ___ No emails

Parent/Guardian Name (if applicable): _____ Phone: _____

## RESPONSIBLE PARTY INFORMATION (if not patient)

Person financially responsible for account: _____ Phone:_____

Relationship to patient: _____ SSN: _____ Date of Birth: _____

Home address: _____

Employer Name: _____ Address: _____ Phone: _____

## DENTAL INSURANCE

Policy Holder's full name:_____

Phone: _____ Date of birth: _____ SSN: _____

Address: _____

Employer's name: _____ Phone: _____

Insurance company name: _____ Phone: _____

Address: _____

Insurance plan name: _____Insurance ID #: _____

Group ID #: _____ Union or local name: _____

## SECONDARY INSURANCE *(If applicable)*

*Secondary* Policyholder's full name: _____

Phone number: _____ Date of birth: _____ SSN: _____

Address: _____

Employer's name: _____ Phone: _____

Insurance company name: _____ Phone: _____

Address: _____

Insurance plan name: _____ Insurance ID #: _____

Group ID #: _____ Union or local name: _____

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## MEDICAL HISTORY

Physician's Name: _____ Phone: _____

Have you had a serious head or neck injury? If yes, please explain:

_____

List any conditions/illnesses for which you are currently being treated:_____

If treated in a hospital or emergency room within the past two years, please describe:_____

_____

## PLEASE CHECK EACH BOX FOR ANY HEALTH CONDITIONS YOU HAVE

**By checking the box it will indicate a "YES" response, leaving blank will indicate a "NO" response.**

| | | | | | |
|---|---|---|---|---|---|
| | ADHD | | Disability (from birth/ acquired since birth) | | Osteoporosis |
| | Anemia | | Ear problems (Hearing impairment, infection) | | Psychiatric/behavior problems |
| | Autism | | Eating or feeding disorder | | Sexually transmitted disease |
| | Auto-immune disease | | Genetic disorder | | Sinus problems (chronic) |
| | Arthritis (osteo, rheumatoid, lupus, fibromyalgia) | | Heart problems | | Seizure disorder (epilepsy) |
| | Adrenal gland disorder | | Hepatitis/liver problems | | Sleep apnea |
| | Bleeding disorder | | HIV/AIDS | | Stomach/gastrointestinal disorder |
| | Blood pressure problems | | Hormone problem (ex. menstrual, sex, puberty) | | Transplant - organ or stem cell |
| | Brain/nerve disorder (ex. MR, Alzh, MS,CP) | | Joint replacement with a prosthesis | | Tuberculosis |
| | Cancer | | Kidney/bladder disorder | | Thyroid gland disorder |
| | Diabetes | | Lung (ex. asthma, emphysema, cystic fibrosis) | | Vision problems (blindness, Glaucoma) |

If there are any other medical conditions we should be aware of, please describe:_____

_____

**Allergy to medication or other sensitivities:**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | Dental restorative materials | | Food allergies | | Seasonal of environmental | | Medication Allergy |

Are you allergic to any of these medications: __ Penicillin __ Iodine Dye __ Codeine __ Latex __ Sulfa __ Aspirin

Please list any other allergies: _____

Please list any previous surgeries you have had with dates:_____

_____

Do you consume alcohol? ___None ___Social use ___More than social use

Do you use street drugs? ___None ___Marijuana ___Cocaine ___Methamphetamine ___Heroin ___Other

Do you use tobacco products? _____None _____Cigarette _____Cigar _____Smokeless _____Pipe

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For children – Are immunizations up to date? ___Yes ___No ___Uncertain ___ Delayed immunization schedule

For women – Are you pregnant or think you may be pregnant? ___ Yes ___ No

Are you taking birth control pills? ___ Yes ___ No

Are you nursing? ___ Yes ___ No

Preferred pharmacy name and telephone number:

_____

**Do you take prescribed or over-the-counter medications on a regular basis?** _____No ____Yes.

***If yes, please list:***_____

_____

Please list any Herbals/other remedies you take:_____

Please list any vitamins you take:_____

Do you take the blood thinning medication Coumadin? _____No _____Yes

Do you take any of these anticoagulants? __Aspirin __Plavix __Eliquis ___Xarelto ___ Pradaxa

Do you take Steroid Medication? ___No ___Yes

Do you take drugs with suppress the immune system? ___ No ___ Yes

Have you ever taken Bisphosphonates for osteoporosis or for chemotherapy for multiple myeloma? ___ No ___ Yes

☐ I affirm that the information provided in these forms are true and correct to the best of my knowledge. I certify that I understand the importance of a truthful health history and that my dentist and his/her staff will rely on the information provided for treating me. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may make in the completion of these forms.

**SIGNATURE**

_____

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# DENTAL HISTORY

How can we help you today? _____

Do you have any tooth or oral pain? ___No ___Yes *If yes, where is the pain?*_____

Are you taking pain medication for oral pain? ___ No ___ Yes ___Uncertain

*If yes, what pain medication?* _____

Are you currently taking any antibiotics for oral infection? ___ No ___ Yes ___Uncertain

*If yes, which antibiotic?*_____

**Please Check any which may apply:**

Bad breath Broken fillings Broken teeth Gum problems Smile/cosmetic issues
Bite problems Chewing problems Cavity problems Missing teeth Old fillings which should be evaluated

How often do you see a dentist for routine care?

| | | | | | |
|---|---|---|---|---|---|
| Annually | Twice a year | 3-4 times a year | Only for pain | Seldom | Never |

How many cavities have you had recently?: _____
When was your last dental treatment? _____

What was done at that visit?

| | | | |
|---|---|---|---|
| Cleaning | Denture/Partial | Extraction | Root canal |
| Filling/Crown/Bridge | Evaluation | Gum treatment | Uncertain |

When were your last dental x-rays taken? _____

Have you lost any teeth besides your baby teeth? _____No _____Yes

*Please check below the reason for loss if applicable:*

| | | |
|---|---|---|
| Wisdom teeth extracted | Extracted because of gum problem | From an accident |
| Extracted because of decay | For orthodontic care | Reason not listed |

How is your family's dental health?

| | | |
|---|---|---|
| Most have good teeth | History of dentures | History of tooth loss |
| Most have bad teeth | History of gum disease | Uncertain |

What are you brushing habits?

| | | | | | |
|---|---|---|---|---|---|
| Once per day | Twice per day | Three times per day | Seldom | Never | Not applicable |

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How many times per day do you eat/drink items with sugar? __Less than 3 __More than 3 __ More than 5 __None

Do you floss your teeth? __Daily __Weekly __Occasionally __ Seldom __Never __ N/A

Does your mouth feel dry most of the time? __ No __ Yes __ N/A

If so, is your dry mouth a new experience? __ No __ Yes __ N/A

Have you experienced any alteration in your taste perception? ___No ___Yes

Are there physical or mental limitations preventing oral hygiene? ___No __Yes

Does food get stuck between your teeth? __No __Yes, a few places __Yes, in many places __ N/A

Do your gums ever bleed when brushing your teeth? __No __Occasionally __Yes __ N/A

Are you concerned about receding gums? __ No __ *Yes If yes, were?*_____

Do you have partials or dentures? __No __Yes | *If you do have them, do they work well?* __Yes __Not well __No

Are your teeth very sensitive to hot or cold? __ No __Yes __ Sometimes __ N/A

Do you have any aches or pains in your jaws or ears? __No __Yes

Do you have any jaw clicking or popping? __No __Yes

Are you aware of any habit of grinding or clenching? __No __Yes

Are you interested in replacing lost teeth? __No __Yes __Uncertain

Do you like your smile? __Yes __No __Would like whiter teeth __Would like to talk about smile __Uncertain

Have you ever had trouble with a previous dental treatment? _____No _____Yes

If yes, please describe: _____

Have you ever had root canal treatment? _____No _____Yes _____Uncertain

Have you ever had Periodontal (gum) treatment? _____No _____Yes _____Uncertain

**Please check any of the following that describe you.**

__Dental Care does not frighten me __A relaxation pill helps me with dental care __I am frightened of dental care

__I have extreme dental phobia__Nitrous Oxide (laughing gas) helps me tolerate dental care

**Do you have other problems you would like to tell us about which have not been identified?**

_____

_____

## SIGNATURE

_____

If you are completing this form for another person, please tell us your relationship: _____

If you are completing this for the patient, are you the legal guardian? ___Yes ___No

Your name *(if you are not the patient*):_____ Phone: _____

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## CONSENT FOR SERVICES

As a condition of your treatment by Alabama Smile Design, financial arrangements must be made in advance. Please understand that payment of your bill is considered part of your treatment. The practice depends on reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of the patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patients account. However, Alabama Smile Design cannot render services on the assumption that our charges will be paid by an insurance company. It is up to you to know your insurance benefits. Our responsibility is to provide you with treatment that best meets your needs, not try to match your care to your insurance plans limitations.

A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 30 days, unless previously written financial arrangements are satisfied. A 3.5% fee will be added to all credit card use. A service charge of $35 will be applied for all returned checks. You are responsible and agree to pay all cost of collecting or attempting to collect, including attorney fees and court costs.

I understand that the fee estimate listed for dental care can only be extended for a period of 6 months from the date of the patient examination.

We do require a notice of 48 hours to cancel an appointment. If no notice is given, you will be charged $40.00. Please help us service you better by keeping those scheduled appointments.

I have read the above conditions of treatment and payment and agree to their content.

**SIGNATURE** **DATE**

_____ _____

**SIGNATURE OF GUARANTOR OF PAYMENT/ RESPONSIBLE PARTY** **DATE**

_____ _____

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## NON-COVERED SERVICES POLICY

As your dentist, I want to provide you with your choice in dental services. There may be certain services that I feel are necessary for the treatment of your condition and maintenance of good health that are not covered by your insurance company or that are covered at a lower fee from the procedure performed (also called downgrading). You are expected to pay the fee schedule difference for that service(s) or pay for those service(s) in full. Any fee from the lab above the PPO or insurance plan fee schedule will be your responsibility.

In addition, procedures that are considered cosmetic are not covered by your contract and you will be responsible for payment in full. We can only estimate what your insurance will pay and they always give a disclaimer when calling for information that benefits and payment are not guaranteed until a claim is received and processed.

Rest assured that only services necessary and appropriate for your treatment and care will be performed. If you have any questions, someone in our office will be happy to assist you. Thank you for your understanding and we appreciate you choosing ASD for all of your dental needs.

I have read your policy and agree, as indicated by my signature below, to pay for the services that are not covered or for which payment is not allowed by my insurance company.

**SIGNATURE** **DATE**

_____ _____

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# ADA COVID SCREENING

Regular dental appointments are an important part of taking care of your overall health. Your health and safety is, and has always been, our top priority. Please complete the form below prior to arrival. Thank you!

**First Name: _____ MI: _____ Last Name:_____**

Do you have a fever or have you felt feverish recently (14-21 days)? __YES __NO

Are you having shortness of breath or difficulties breathing? __YES __NO

Do you have a cough? __YES __NO

Do you have any flu like symptoms - headache, fatigue, gastrointestinal upset? __YES __NO

Have you experienced recent loss of taste or smell? __YES __NO

Are you over the age of 60? __YES __NO

Do you have heart disease, lung disease, kidney disease, diabetes or any auto immune disorders? __YES __NO

Have you traveled in the past 14 days? __YES __NO

Have you been in contact with confirmed COVID patients? __YES __NO

**SIGNATURE** **DATE**

_____ _____