ASHVILLE DENTAL CENTER

PATIENT INFORMATION

Patient Name:____

Male Female Marital Status: Single Married Child

Social Security #:_________/______/_________ Date of Birth:______/_____/______ Age: __________

Home # (____) ________-___________ Work # (____) ________-_________ Cell # (______) _______-____________

Driver's License#:______________________Email Address:____

Street Address: ____City, State,Zip:______________________________

If you're completing this form for someone else what is your relationship to that person?

Your name:________________________________ Relationship: ___________________________

Emergency Contact:____________________________Relation:___________________Phone #: (______) _______________

HEALTH INFORMATION

Do you have or have you ever had any of the following? Please circle all that apply. If none, please circle NONE.

None
AIDS/HIV
Allergies
Aortic Valve Reg.
Anemia
Arthritis
Artificial Joints
Asthma
Blood Transfusion
Birth Control
Cancer
Codeine ALLERGY
Diabetes

Dizziness
Alcohol/Drug Add.
Epilepsy
Fainting
Fever Blisters
Glaucoma
Head Injuries
Heart Disease
Heart Murmur
Heart Stents
High Blood Pressure
Jaundice
Kidney Disease

Latex ALLERGY
Liver Disease
Mitral Valve Prolapse
Mouth Ulcers
Nervous Disorders
Pacemaker
Penicillin ALLERGY
Radiation Treatment
Respiratory Problems
Rheumatic Fever
Sexually Transmitted Disease
Hepatitis A B C

Stomach Ulcers
Stroke
Sulfa ALLERGY
Tuberculosis
Ulcers
Using Blood Thinner
Using Methadone
Viagra Type Med.
Other: _____________

Do you need to pre-medicate for any medical reasons? **YES** **NO**

Do you have any health problems not listed above or that need further clarification? YES NO

Have you been admitted to a hospital or needed emergency care during the past five years? YES NO

If yes, please explain: ____

Are you under the care of a physician now? YES NO

Explain: ____

Name of Physician ______________________________________ Phone___________________________

PLEASE SIGN: ____ DATE: ______________________

DENTAL HISTORY

Date of your LAST Dental Visit: ____/_____/______ Reason for TODAY'S visit: ___________________________

Have you ever had complications following a dental procedure?	YES ____ NO_____
Do your gums bleed when you brush or floss?	YES ____ NO ____
Are your teeth sensitive to hot / cold / sweets / pressure?	YES ____ NO ____
Do you have dry mouth?	YES ____ NO ____
Do you have / wear a denture or partial?	YES ____ NO ____
Have you had any periodontal (gum) treatments?	YES ____ NO ____
Do you use tobacco (smoke, snuff, and chew)?	YES ____ NO ____

**********************LIST ALL MEDICATIONS ********************

____ ____

____ ____

____ ____

____ ____

____ ____

____ ____

____ ____

____ ____

WOMEN ONLY: Are you pregnant: YES NO

If YES when is due date: _____/_______/________

Are you nursing: YES NO ?

PLEASE SIGN: ________________________________Date: _________________

Ashville Dental Center

Joseph Labbe DMD. 120 6th Ave, Ashville, AL 35953 | 205-594-5171 | ashvillesmiles@gmail.com

Financial Policy

Patients without Insurance:

Payment is due at the time of service. We do not have payment plans. We only expect payment for the services that are provided at the appointment date.

Patients with Insurance:

Copayments and deductibles are due at the time of service. Treatment plan amounts are only an estimation of what insurance will cover according to your individual coverage. If your insurance fails to pay within 60 days of service, you are responsible for the full amount due.

All accounts that are delinquent after 90 days will be turned over to small claims court for collections.

I have read the financial agreement in its entirety and agree to the conditions above

Patient Name: ___________________________

☺Patient Signature:____________________________Date: __________________

Ashville Dental Center

Joseph Labbe DMD 120 6th Ave, Ashville, AL 35953 | 205-594-5171 | ashvillesmiles@gmail.com

Broken Appointment Policy

In order to ensure proper treatment time, and to have available appointments for every patient, it is very important that all patients keep their appointments as scheduled. If you are unable to keep your scheduled appointment time, please call our office to reschedule. We require at a 24 hour notice or the appointment will be counted as a broken appointment. Patients who are 15 minutes late or more for their appointment will be rescheduled and it will be counted as a broken appointment.

As of November 1, 2014, our office will allow 2 broken appointments per patient. A third broken appointment will result in patient dismissal from the practice.

Thank You,

Joseph Labbe DMD

Signature: ______________________________ Date: ___________________

EMPLOYMENT INFORMTAION

Employer Name: ________________________________ Phone #:____________________________

Street Address: ______________________________________ City, State, And Zip: ________________________

Insurance Information

Primary:

Insurance Carrier: _____________________________________ Is Insured a patient? **Yes** **No**

Name of Insured: ____________________________________ Group #__________________

Insured Address (If different from patient)

Street Address: ____ City, State, Zip: _____________________

Insured Social Security #: _____-____-______ Member Id: _______________________________

Insured Employer: _______________________________ Insured D.O.B. _________________________

Patient Relationship to Insured: **Self** **Spouse** **Child** **Other**: ______________

Secondary:

Insurance Carrier: _____________________________________ Is Insured a patient? Yes No

Name of Insured: ____________________________________ Group #__________________

Insured Address (If different from patient)

Street Address: ____ City, State, Zip: _____________________

Insured Social Security #: _____-____-______ Member Id: _______________________________

Insured Employer: _______________________________ Insured D.O.B. __________________________

Patient Relationship to Insured: Self Spouse Child Other: ______________

I certify that I have read and understand the above and that the information provided on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff rely on this information when treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. 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 have made in the completion of this form.

Signature of Patient or Legal Guardian: ____

Date: _______________________

PATIENT HIPPA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that by signing this consent I authorize you to use and disclose my protected Health information to carry out:

♦Treatment (including direct or indirect treatment by other healthcare providers involved in my Treatment)

♦Obtaining payment from third party payers (e.g. my insurance company)
♦The day to day healthcare operations of your practice

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health Information, and my rights under HIPPA. I understand that you reserve the right to change terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information Is used and disclosed to carry out treatment, payment, and healthcare operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with restrictions.

ADA Guide for Compliance with "The New Red Flags Rule for Protection of Identity Theft And Detection Response Program" are in place.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Print Patient Name: ____

Signature: ____Date:______________________

Please list Name and Relationships of person(s) with permission other than parent/legal guardian to accompany patient to appointments. The person(s) listed can make decisions about treatment administered at this visit or any future visits, can also make changes to appointments and will be responsible for any co-payments due at the time of appointment.

Name/Relationship: _____________________________ _____________________________

_____________________________ _____________________________

_____________________________ _____________________________

Office Personal: ___________________________________ Date: ____________________