



PATIENT INFORMATION

CONFIDENTIAL	
Name (Last) _____ (First) _____	
Birthdate ____/____/____ Email _____	
Home Phone _____ Mobile Phone _____ Work Phone _____	
Address _____ City _____ State ____ Zip code ____	
Check Appropriate Box below :	
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Minor <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	
Whom may we thank for referring you? <input type="checkbox"/> Primary Dentist <input type="checkbox"/> Friend <input type="checkbox"/> Family Website: <input type="checkbox"/> cliffsoralsurgery.com <input type="checkbox"/> alpineimplant.com	
Referral Name _____	
*If someone referred you here, please write down their name so we can thank them.	
EMERGENCY INFOMATION	
Name (Last) _____ (First) _____ Work Phone _____	
Relationship to Patient _____ Mobile Phone _____	
DENTAL INSURANCE INFORMATION	
*Insurance Plan : <input type="checkbox"/> Regular <input type="checkbox"/> PPO <input type="checkbox"/> HMO <input type="checkbox"/> Medicaid	
*Your relationship to subscriber : <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent	
Subscriber Name _____ Subscriber ID # _____	
Social Security # ____-____-____ Birthdate ____/____/____ Relationship to Patient _____	
Insurance Company _____ Group # _____	
Insurance Company's Address _____ Phone # _____	
City _____ State _____ Zip Code _____	
DO YOU HAVE ANY ADDITIONAL INSURANCE? <input type="checkbox"/> Y <input type="checkbox"/> N	

BY SIGNING BELOW I CERTIFY THE INFORMATION PROVIDED IS ACCURATE AND WILL BE RELIED UPON FOR PROVIDING DENTAL SERVICES. AS A CONDITION OF TREATMENT BY THIS OFFICE, I UNDERSTAND FULL PAYMENT IS DUE AT THE TIME OF SERVICE. WHEN I RECEIVE THE INSURANCE PAYMENT, I WILL RETURN THE INSURANCE CHECK TO DR.LEE'S OFFICE AS SOON AS POSSIBLE WITH MY SIGNATURE ON THE BACK OF THE CHECK.

Today's Date ____/____/____

SIGNATURE OF PATIENT OR PARENT IF MINOR



PATIENT HEALTH HISTORY

DENTAL HISTORY	
Previous Dentist Name _____	Phone _____
Last Dental Visit (MM/YY) _____	
Please check or write all that apply below :	
<input type="checkbox"/> Pain when chewing	<input type="checkbox"/> Swollen / bleeding Gums Sensitivity of Teeth : <input type="checkbox"/> Cold / <input type="checkbox"/> Hot / <input type="checkbox"/> Pressure
<input type="checkbox"/> Painful / Broken Fillings	<input type="checkbox"/> Dry Mouth <input type="checkbox"/> Bad Breath
<input type="checkbox"/> Jaw Clicking / Popping	<input type="checkbox"/> Teeth Grinding while sleeping
<input type="checkbox"/> Sores, Growths, Lesions in mouth	<input type="checkbox"/> Other _____
Current Pain Level (1-10) _____	Your Dental Issue _____
Frequency of Teeth brushing ____ / Flossing ____ / Mouthwash ____ / Cleaning ____ / Check up _____	
MEDICAL HISTORY	
Physician Name _____ Phone _____	
Are you under the medical treatment now? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Current Medication : _____	
Allergies to <input type="checkbox"/> Anesthetics / <input type="checkbox"/> Penicillin / <input type="checkbox"/> other Antibiotics <input type="checkbox"/> Others _____	
Allergies to any medicines? _____	
Do you need Antibiotics coverage before dental treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Check Appropriate Box below :	
History of <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Heart Murmur <input type="checkbox"/> Heart Disease : <input type="checkbox"/> Chest Pain <input type="checkbox"/> Cardiac Pace Maker <input type="checkbox"/> Stroke	
<input type="checkbox"/> Cancer, Type _____, Medication _____	
<input type="checkbox"/> Asthma <input type="checkbox"/> Emphysema <input type="checkbox"/> Respiratory Problems	
<input type="checkbox"/> Diabetes <input type="checkbox"/> Thyroid <input type="checkbox"/> Long Term Steroid Treatment, Medication _____	
<input type="checkbox"/> Osteoporosis <input type="checkbox"/> Joint Replacement <input type="checkbox"/> Arthritis, Medication. _____	
<input type="checkbox"/> Bleeding Disorder, Any medication which may affect bleeding _____	
Any other Any Contagious Disease : <input type="checkbox"/> HIV <input type="checkbox"/> Hepatitis, Type _____ Any other Diseases? _____	
WOMEN ONLY Are you :	
Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Number of weeks/months _____
Nursing? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Taking birth control pills or hormonal replacement? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK

I verify that the above information is factual and true to the best of my knowledge. I authorize to the dentist to employ the X- Rays, Photographs, Anesthetics Medicines, Surgeries, and other equipment or aids as he/she deems necessary in order to provide the proper dental care. I understand that payment, proof of insurance, self pay and / or copay is due at the time of service.

Today's Date ____ / ____ / ____

SIGNATURE OF PATIENT OR PARENT IF MINOR



ADVANCED DENTAL SPECIALTY GROUP

Financial Responsibility Agreement

Patient Name (Print): _____ Date of Birth: _____

We are pleased to assist you with any dental insurance. If you have dental insurance, please be aware that insurance quotes are an ESTIMATE only. Coverage may be different if your deductible has not been met, annual maximum has been met, or if your coverage table is lower than average.

Patient Financial Responsibilities are:

- The patient (or patient's parent or guardian, if under the age of 18) is fully responsible for payment of care regardless of if you have insurance or not.
- As a courtesy to you, we will bill your insurance company for services rendered.
- Some procedures or treatments may not be covered by your insurance plan. Patients are responsible for the payment of all services rendered in this office, with or without insurance.
- Any remaining balance left after the insurance has paid their portion is the responsibility of the patient or their guardian if the patient is a minor.
- Copay and deductibles are due at time of service.
- I am responsible for providing a copy of my current insurance card to Dr. Lee's Office. If my current insurance is incorrect it is my responsibility to provide that information the day of service. If I fail to provide my insurance information on the day services are rendered I understand that I must PAY IN FULL the same day that services are rendered. INITIAL HERE _____

I acknowledge that I am fully responsible for payment for all treatment I receive in this office. I understand my insurance carrier may deny part of, or not cover, my claim for these services. I understand that providing Dr. Alexander Lee DDS with my insurance information is my responsibility. I understand that my insurance is a contract between myself and my insurance carrier and Advanced Dental Specialty Group has no part in this contract. I understand the terms of this form and accept full financial responsibility with or without the use of dental insurance.

Patient or Guardian Signature: _____ Date: _____