Welcome to

ArborDENTAL

1 About You:

Legal Name: _____
Name you like to be called: _____
Birth Date: _____
Full SSN:_____
□ Male □ Female
Address: _____
City_____State_____Zip_____
Home Phone: _____
Cell Phone: _____
Work Phone: _____
Email Address: _____
Employer: _____
Employer Address: _____
_____
Status: □ Minor □ Single □ Married □ Student
HOW DID YOU HEAR ABOUT US?_____

2 In Case of Emergency

Name: _____
Relation: _____
Home #: _____
Work #: _____
Medical Dr.'s #: _____
Medical Dr. Name: _____
Preferred Pharmacy: _____

If Minor Only:

Mom's Name: _____
DOB _____ SSN _____
Dad's Name: _____
DOB _____ SSN _____

3 Insurance Information (Primary)

Insurance company name: _____ Phone #: _____
Policy Holder's Name: _____ SSN/ID#: _____
Date of Birth: _____ Group #: _____
Insured's Employer: _____ Relationship: _____

4 Dental Information:

Reason for your visit today: Exam Emergency Consultation
Are you in pain? Yes or No

When was your last dental visit?

Do you have: _____

- O Discomfort, clicking or popping
- O Red, swollen, or bleeding gums
- O Sensitive teeth or gums
- O Blisters/sores in/around mouth
- O Broken chipped teeth
- O Bad breath
- O Lost/broken fillings
- O Stained teeth
- O Teeth grinding
- O Ringing in ears
- O Locking jaw
- O Other _____

Would you like to discuss how to improve the appearance of your teeth? Yes or No

Do you use tobacco? Yes or No

Are you interested in tooth whitening? Yes or No

5 Health History:

Have you ever had any radiation treatment? Yes or No

Have you ever taken any bisphosphonates orally or through IV, Inculding: alendronate (fosamax), clodranate (ostac, bonefos), etidronate (didronel), ibandronate (boniva), pamidronate (actonel), Tiludronate (skelid), zoledronic acid (zometa) Yes or No

Are you taking:

- O Nerve pills or stimulants
- O Pain pills, tranquilizers, or muscle relaxers
- O Birth control pills
- O blood thinners
- O insulin
- O If taking no medications please mark here

List any medications you are taking: _____

List any surgeries you have had: _____

Indicate all that applies to you:

- O Allergies_____
- O Anemia
- O Arthritis
- O Artificial Joints
- O Asthma
- O Blood disease
- O Cancer
- O Codeine Allergy
- O Diabetes
- O Head injuries
- O Heart Disease
- O Heart Murmur
- O Hepatitis
- O High blood pressure
- O HIV
- O Kidney/Liver Disease
- O Mental/Nervous Disorder
- O Penicillin allergy
- O Epilepsy
- O Pregnancy due date _____
- O Radiation Treatment
- O Respiratory problems
- O Rheumatism
- O Sinus problems
- O Stomach Problems
- O Tuberculosis
- O Tumors or ulcers
- **O None of the above**

6 HIPAA

Purpose of consent: By signing this form you will consent to our use and disclosure of protected health information (PHI) to carry out treatment, payment activities, and healthcare operations. You've read our Notice of Privacy Practices which accompanies the Consent, and have full opportunity to consider it's contents. I understand that by signing this Consent form, I am giving my consent to your use and disclosure of my PHI to carry out treatment, payment activities, and healthcare operations.

Signature: _____ **Date:** _____

7 Informed Consent

The dental treatment necessary to my existing oral condition(s) has been explained to me and my questions have been answered fully. I hereby authorize Associates or Assistants associated with Brian S Glazier, DDS, P.C. "Arbor Dental" to perform those procedures, including surgery, x-rays, and other diagnostic aids as may be deemed necessary or advisable to my dental treatment. This includes administration of anesthetic, sedative, analgesic, therapeutic/pharmaceutical agents: including those related to restorative, palliative or surgical treatment. I do voluntarily assume the possible risk with these procedures. I've read all the information on this sheet and all answers have been completed. I certify this information is true and correct to the best of my knowledge. I'll inform Brian S Glazier, DDS, P.C. "Arbor Dental" of any change in my medical status.

Signature: _____

Date: _____

8 Payment Policy

Although I may have insurance, Brian S Glazier, DDS, P.C. "Arbor Dental" may bill that insurance AS A COURTESY TO ME, but ultimately, the balance is my responsibility to pay regardless of what the insurance may or may not pay. Payment is due at the time of service. A pre– and post-judgment finance charge of 2% per month on all unpaid balances will be assessed on all accounts exceeding 30 days from the date of service. If payment is not fully tendered, I acknowledge and agree that Brian S Glazier, DDS, P.C. "Arbor Dental" may turn this account to collections, which may include a third party collection company/Attorney. Initial commission of no less than 40% of the entire balance may be assessed to my account by any collection agency or attorney retained for this matter. To the extent necessary to determine liability for payment and obtain reimbursement, I authorize disclosure of my dental records. The highest collection cost allowed by law will be assessed for any returned check. A cancellation fee of $25 may be assessed if giving less than 24 hours notice for appointments.

Notice payment is due at the time of service unless alternative arrangements have been made in advance

Signature: _____

Date: _____