Advantage Dental
Oral Health Center

Date (mm/dd/yyyy)

INTAKE FORM (PATIENTS 14 YEARS AND OLDER)

Welcome, and thank you for selecting our dental healthcare team! We strive to provide the best possible dental care. To help us achieve this goal, please fill out these forms as completely as you can, in ink. If you have any questions or need assistance, please feel free to ask us. We would be happy to help!

Last Name	First Name	MI	Suffix (circle one) Sr / Jr / I / II / III	Preferred Name
Gender (check one) ☐ M ☐ F ☐ Choose Not to Disclose ☐ Other _____			Marital Status ☐ Married ☐ Single	
Race/Ethnicity: ☐ White ☐ Black/African American ☐ Hispanic/Latino ☐ Other: _____			☐ Choose not to disclose	
Drivers License # & State	Date of Birth (mm/dd/yyyy)		SSN	
If you require a language interpreter specify language:			Did an interpreter help you with these forms? ☐ YES ☐ NO	
Address	City		State	Zip
Mailing Address (if different)	City		State	Zip
Were you referred to this practice? ☐ YES ☐ NO	If yes, who referred you: _____			
Contact Information: Please provide all phone numbers and email. Email _____ Cell _____ Alternative Phone _____ By providing the contact information above you are consenting to receiving electronic communications from Advantage Dental from DentaQuest about your appointments and treatment.				
Occupation	Employer			
Emergency Contact	Relationship	Home Phone		Cell Phone

Do you have Dental Insurance? ☐ YES ☐ NO **If yes, who is your insurance carrier?**

Primary Carrier	Policy Holder	Group Number	Subscriber I.D.	Policy Holder DOB
Policy Holder SS#_____		Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other		
Secondary Carrier	Policy Holder	Group Number	Subscriber I.D.	Policy Holder DOB / Policy Holder SS#

Primary Care Physician Information

Physician Name	Address	City	Phone Number

If you are completing these forms for the patient, circle your relationship and print your name:

_____

MOTHER FATHER GUARDIAN OTHER

Communication Agreement

Advantage Dental Oral Health Center practices can communicate with me using the contact information provided above. These communications may include voicemail, text, and/or email. You may opt out at any time by responding appropriately to the messages received.

Signature of Patient or Guardian: _____

Date: _____

You can request a copy of our privacy policy at any time. You can always find a copy of this policy at AdvantageDental.com/privacy-policy.

Staff Initial _____

DENTAL AND HEALTH HISTORY

What is the reason for your dental visit today? ☐ EXAMINATION ☐ EMERGENCY ☐ CONSULTATION ☐ PROCEDURE

How would you describe your current dental health? _____

Date of your last dental visit (Month/Year): _____ ☐ EXAM ☐ EMERGENCY ☐ CONSULTATION ☐ PROCEDURE ☐ OTHER _____

Have you had any problems with previous dental treatment? ☐ **YES** ☐ **NO** If yes, please specify**:** _____

Do you have any pain clicking, popping, discomfort, or limited opening in the jaw or jaw joints? ☐ **YES** ☐ **NO** If yes specify: _____

How often do you brush your teeth? ☐ **NEVER** ☐ **SOMETIMES** ☐ **ONCE A DAY** ☐ **TWICE A DAY** ☐ **MORE THAN TWICE A DAY**

How often do you floss your teeth? ☐ **NEVER** ☐ **SOMETIMES** ☐ **ONCE A DAY** ☐ **ONCE A WEEK** ☐ **MORE THAN ONCE A DAY**

Do your gums bleed when you brush or floss? ☐ **NEVER** ☐ **SOMETIMES** ☐ **ALWAYS**

Please state any questions or concerns about dentistry or your dental health: _____

Are you currently experiencing dental pain or discomfort?	YES	NO	Do you have any loose teeth?	YES	NO
Are you unhappy with your smile or the appearance of your teeth?	YES	NO	Do you have headaches, earaches, or neck pains?	YES	NO
Do you want a brighter whiter smile?	YES	NO	Are you worried about losing your teeth?	YES	NO
Do you have problems with eating (trouble chewing, vomiting, etc.)?	YES	NO	Do you clench, brux, or grind your teeth?	YES	NO
Do you have bad breath/ halitosis, metallic taste, or unpleasant taste?	YES	NO	Are your teeth sensitive to cold, hot, sweets or pressure?	YES	NO
Do you have any obstacles to cleaning or caring for your teeth?	YES	NO	Does food or floss catch between your teeth?	YES	NO
Have you ever had a serious injury to your head or mouth	YES	NO	Have you ever had orthodontic (braces) treatments?	YES	NO
Do you have bridges or wear dentures or partials?	YES	NO	Do you have swelling in or around your mouth, face, or neck?	YES	NO

Provide details to all YES answers here:

Do you have, or have you had any of the following? (Circle yes or no for each) For each yes, provide details below where indicated

Acid Reflux/GERD	YES NO	Cortisone Medicine	YES NO	Heart Pacemaker	YES NO	Psychiatric Care	YES NO
AIDS/HIV Positive	YES NO	Depression	YES NO	Heart Trouble/Disease	YES NO	Radiation Treatment	YES NO
Alzheimer's Disease	YES NO	Developmental Disorder	YES NO	Hemophilia	YES NO	Recent Weight Loss	YES NO
Anaphylaxis	YES NO	Diabetes	YES NO	Hepatitis A	YES NO	Renal Dialysis	YES NO
Anemia	YES NO	Drug Addiction	YES NO	Hepatitis B or C	YES NO	Rheumatic Fever	YES NO
Angina/Chest Pain	YES NO	Easily Winded/Shortness of Breath	YES NO	Herpes	YES NO	Rheumatism	YES NO
Arthritis/Gout	YES NO	Eating Disorder	YES NO	High Blood Pressure	YES NO	Scarlet Fever	YES NO
Artificial Heart Valve	YES NO	Emphysema	YES NO	Human Papillomavirus (HPV)	YES NO	Sexually Transmitted Disease	YES NO
Artificial Joint	YES NO	Epilepsy or Seizures/Convulsions	YES NO	Hypoglycemia	YES NO	Shingles	YES NO
Asthma	YES NO	Excessive Bleeding	YES NO	Irregular Heartbeat	YES NO	Sickle Cell Disease	YES NO
Blood Transfusion	YES NO	Excessive Thirst	YES NO	Kidney Problems	YES NO	Sinus Trouble	YES NO
Bruise Easily	YES NO	Fainting spells/Dizziness	YES NO	Leukemia	YES NO	Stomach/Intestinal Disease	YES NO
Cancer	YES NO	Frequent Cough	YES NO	Liver Disease	YES NO	Stroke	YES NO
Chemotherapy	YES NO	Frequent Diarrhea	YES NO	Low Blood Pressure	YES NO	Thyroid Disease	YES NO
Circulatory Problems	YES NO	Frequent Headaches	YES NO	Lung Disease	YES NO	Tuberculosis	YES NO
Cold Sores/Fever Blisters	YES NO	Glaucoma	YES NO	Mitral Valve Prolapse	YES NO	Tumor or Growths	YES NO
Congenital Heart Disorder	YES NO	Heart Attack/Heart Failure	YES NO	Osteoporosis	YES NO	Yellow Jaundice	YES NO
COPD	YES NO	Heart Murmur	YES NO	Parathyroid Disease	YES NO	Ulcers	YES NO

Provide details to all YES answers here:

If you have TB, is it active? ☐ **YES** ☐ **NO** If yes, what medication are you on: _____

Are you taking, have you recently taken (within the last month), or are you supposed to be taking any medications? ☐ YES ☐ NO
(Prescription, over the counter, diet supplements, vitamins, natural, or herbal)

If yes, please specify medication(s), dosage, and frequency (If you take more than 4 medications, please provide us with a written list of all medications)

Medication Prescription or Over the Counter	**Dosage/Frequency**	**Supplements** Diet supplements, vitamins (natural or herbal)	**Dosage/Frequency**

PLEASE CIRCLE YOUR RESPONSES YES or NO TO INDICATE IF YOU HAVE OR HAVE NOT HAD ANY OF THE FOLLOWING DISEASES OR PROBLEMS

Are you now, or have you been in the past year, under the care of a physician? ☐ YES ☐ NO

If yes, what is/are the condition(s) being treated? _____

Have you had an organ transplant? If yes, please specify: ☐ YES ☐ NO

☐ HEART ☐ KIDNEY ☐ LIVER ☐ LUNG ☐ OTHER (SPECIFY): _____

Have you had an orthopedic total joint (e.g., hip, knee, elbow, finger) replacement? ☐ YES ☐ NO

If yes, what joint was replaced? _____ If yes, when (Month/Year)? _____

Have you ever had any radiation therapy or chemotherapy for a growth, tumor, or other condition? ☐ YES ☐ NO

If yes please specify: _____

In the last 2 years, have you taken or are you now taking steroids (e.g. cortisone)? ☐ YES ☐ NO

If yes please specify: _____

Have you taken, are you taking, or are you scheduled to begin taking: Oral bisphosphonates? ☐ YES ☐ NO
(Alendronate (Fosamax, Fosamax Plus D), Etidronate (Didronel), Ibandronate (Boniva), Risedronate (Actonel), Tiludronate (Skelid)?

If yes, what drug, dose, and frequency? _____

Have you taken, are you taking, or are you scheduled to begin taking intravenous bisphosphonates?:
Clodronate (Bonefos), Pamidronate (Aredia), or Zoledronic Acid (Reclast, Zometa)? ☐ YES ☐ NO

What drug, dose and frequency? _____ What for? _____ When was last dose? _____

Do you normally take an antibiotic prior to dental treatment? ☐ YES ☐ NO

TOBACCO

Do you use or have you used tobacco (smoking, snuff, chew, bidis)? ☐ NEVER ☐ PAST ☐ CURRENTLY

How interested are you in stopping? ☐ VERY ☐ SOMEWHAT ☐ NOT INTERESTED

DRUGS/ALCOHOL

Do you use recreational drugs or prescription medication for non-medical reasons? ☐ YES ☐ NO

Do you use alcohol on a regular basis? ☐ YES ☐ NO

ALLERGIES

Are you allergic to any medications, metal, latex or certain materials? ☐ YES ☐ NO If so what are they? _____

DIABETIC PATIENTS

Diabetic Patients (please answer): When was your last A1C (blood sugar test)? _____ What was the number? _____

WOMEN ONLY

Are you pregnant? ☐ YES ☐ NO If yes, number of weeks: _____ Are you nursing? ☐ YES ☐ NO Are you trying to become pregnant? ☐ YES ☐ NO

OTHER

Are there any other health conditions that you would like to make us aware of to improve our delivery of care and better meet your oral health care needs?

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient or Guardian: _____ **Date:** _____

OFFICE USE

Blood Pressure: _____ /_____ Pulse: _____ Height: _____ Weight: _____ Temp: _____ Date: _____

HEALTH HISTORY REVIEWED BY _____
PROVIDER'S SIGNATURE **DATE**

AUTHORIZATION TO ACCOMPANY A MINOR

To be completed by the patients authorized representative.

We understand the conflict of work schedules and appointments, but we require all children under the age of 14 years to be accompanied by a RESPONSIBLE PARTY or your child will not be treated. This person must be at least 19 years old and must remain on the premises at all times during treatment.

I affirm that I am the parent or legal guardian for the minor child/children named below:

Child	Date of birth
Child	Date of birth
Child	Date of birth

If I am unable to accompany my child, I give permission for the individuals named below to escort my child for dental treatments:

Name	Relationship
Name	Relationship
Name	Relationship

For a child/children 14 and over, please check one:

- ☐ Since my child/children is/are 14 or over, I also give permission for him/her/them to present for treatment unaccompanied by an adult.
- ☐ Although my child is/are 14 or over, I wish to be present for all treatments performed.

I certify that I have read and fully understand the above statements and confirm the contents of this form.

Signature of Legal Guardian/Custodial Parent	Date
Print Full Name of Legal Guardian/Custodial Parent	Relationship to Minor(s)

Advantage Dental
From DentaQuest

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES AND NON-DISCRIMINATION NOTICE

Patient Name: _____

* You May Refuse to Sign This Acknowedgement*

I, _____, have been offered a copy of this office's Notice of Privacy Practices and Non-Discrimination Notice.

_____ _____

Please Print Name Relationship to Patient

_____ _____

Signature Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices and Non-Discrimination Notice, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communications barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (please specify)

_____

_____

_____

PATIENT FINANCIAL POLICY

Our goal is to provide you and your family with optimal dental care, and to be a place where patients feel welcomed and valued. Our office strives to provide the highest quality dental care at affordable prices. Our dentist will diagnose treatment based on your dental health and not your insurance coverage. We encourage you to ask questions and to be involved in treatment decision, while we help educate you about your oral health and the importance of prevention.

Kindly remember, you are fully responsible for all fees charged by this office regardless of your insurance coverage.

The purpose of this policy is to eliminate confusion or misunderstandings concerning financial arrangements offered by our office. If you have dental insurance, your portion of the fee is due at the time of service. As a courtesy, this office will file your insurance claim, but we do not guarantee any benefit. Accordingly, to the extent permitted by law, you consent to Advantage Dental Oral Health Center (or its designee's) use and disclosure of your Protected Health Information to carry out payment activities in connection with your insurance claim. This information will be used exclusively for the purpose of evaluating and administering claims for benefits. You further authorize and direct payment to Advantage Dental Oral Health Center of the dental benefits otherwise payable to you. Please understand that the amount to be paid by insurance depends on the benefits of your particular plan. If you have any questions about the amount your plan will pay or the treatments your plan will cover, you should refer these questions to your insurance company. Additionally, there may be a deductible, a co-insurance factor, and/or a yearly maximum to be considered.

1. For our Medicaid patients, Medicaid will be billed for covered services. In the event a service is not covered by Medicaid, you will be informed prior to the service being performed.

2. Payment at the time of service is expected, including the estimated portion of the amount that insurance does notcover. Our office accepts the following payment methods: Cash, Check, Major Credit Cards, and certain third-party financing options (for those who qualify). We do not offer in house payment plans.

3. A statement for services rendered will be mailed to you on a monthly basis. Receipt of payment is expected within 30 days of the billing date on the statement. Payment should be mailed with the specified portion of the statement to establish the proper crediting of the account. If your insurance company hasn't made payment on a claim after 30 days, please contact your insurance company directly.

4. You may choose to pay the amounts due on your statement by phone using an acceptable form of payment. In the event you choose this payment option, we may securely store your payment information for future payments to be made at your direction.

5. Your account is considered delinquent if payment is not received within 30 days of the billing date on the statement. If payment is not received, a late charge of 1½% per month ($1.00 minimum) may be assessed and will appear on the next statement. The annual percentage rate shall be the lesser of 18% or the highest rate allowed under state law.

6. For any check that is returned for any reason, the original amount of the returned item plus a $35.00 charge will be billed to your account. If a check is returned, we may not accept payments by check from you in the future.

7. If you are the parent or legal guardian of a patient that receives treatment when you are not present (either accompanied by an authorized person or unaccompanied), you agree to pay for any services/treatments performed in your absence.

You understand and agree that if you fail to make timely payments, you will be responsible for all costs of collection monies owed, including court costs, collection agency fees, and attorney fees.

By signing below, you acknowledge you have read and understand the financial policy of Advantage Dental Oral Health Center and agree to all the terms described in it.

Signature of Patient (or Person Authorized to Sign for Patient) _____ Print Name _____

Relationship to Patient _____ Date _____

CONSENT TO DENTAL PROCEDURES

Patient: _____ Age: _____ Date: _____

I, the undersigned, for myself or another person for whom I have authority to sign, hereby consent to dental care and treatment while such care and treatment is provided through Advantage Dental Oral Health Center. This consent includes my consent for all treatment performed by a Advantage Dental Oral Health Center dentist and any other dental care provider or other designees under the supervision of the dentist, as deemed reasonable and necessary.

I understand that any current or future treatment may include, but is not limited to examinations, oral prophylaxis(cleanings), fluoride treatments, sealants, restorations (amalgam or composite fillings, crowns and bridges), periodontal (gum) treatments, endodontic (root canal) treatments, extractions, and the use of anesthetics. Such current or future treatment may involve the use of secure electronic communications and technologies to deliver virtual dental health and education services on a remote basis rather than in a traditional dental office setting. Dental treatment is not without potential complications, which may include (but are not limited to) pain, infection, swelling, bleeding, bruising, delayed healing, sinus complications, allergic reactions, stiffness, discomfort and decreased range of motion in the jaw joint(s), loosening of teeth or restoration in teeth, injury to other tissues and need for additional treatment outside scope of treating dentist. I understand topical anesthesia, local anesthesia and/or nitrous oxide inhalation anesthesia may be used if needed during treatment and I consent for their use in my care and that the use of anesthetics may carry a small risk for swelling, bruising, allergic reaction, changes in pain perception, prolonged or in extremely rare instances permanent numbness. I further understand that in the course of any treatment, it may be necessary to modify the intended treatment because of conditions discovered during the ordinary course of dental care and treatment. I further understand and acknowledge that my dental treatment may result in an increased risk of exposure to certain viruses and other pathogens present in the community at the time of my visit (including but not limited to the novel coronavirus/COVID-19, flu, cold virus, etc.). It is possible for such pathogens to be transmitted through respiratory droplets or fine water spray (aerosols) that may be present in a dental practice. I understand that these risks can be mitigated through the dental practice's infection control protocols and other preventative measures designed to reduce the potential for infection, but that these risks cannot be completely eliminated.

I understand that I have the right to discuss and ask questions of any current or future treatment and the purpose, potential risks and benefits of such treatment, as well as any alternative treatments, in order to make an informed decision regarding my care. I further understand that I have the right to refuse treatment and accept any potential consequences of refusing treatment and that I have the right at any time to discontinue treatment.

By signing below, I am indicating that (1) I intend that this consent continue in nature even after a specific diagnosis has been made and treatment recommended; and (2) I consent to treatment at this office or any other Advantage Dental Oral Health Center office. The consent will remain fully effective until it is revoked in writing.

Signed Consent

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____ [ ] Patient under 18 years of age _____

Signature of Patient or Legal Guardian Date

_____ _____

Printed Name of Patient or Legal Guardian Relationship to Patient

I hereby give my consent to treat the minor child/children below, who is/are under the legal age of eighteen years of age, to receive dental care and/or treatment from a Advantage Dental Oral Health Center dentist. Any care and/or treatment deemed reasonable and necessary may be provided with or without my presence:

_____ _____

Child Date of birth

_____ _____

Child Date of birth

_____ _____

Child Date of birth

RIGHTS AND RESPONSIBILITIES

The patient shall have the following rights:

- To be treated with dignity and respect
- To be treated by providers the same as other people seeking health care benefits
- To have a friend, family member, or advocate present during consultations and at other times as needed for help with treatment decisions
- To be actively involved in decisions about his/her treatment plan
- To be given information about his/her condition and covered and non-covered services to make an informed decision about treatment(s) options
- To consent to treatment or refuse services, and be told the consequences of that decision, except for court ordered services
- To receive written materials describing rights, responsibilities, benefits available, how to access services, and what to do in an emergency
- To have written materials explained in a manner that is understandable
- To receive necessary and reasonable services to treat the condition
- To receive services that meet generally accepted standards of practice and are medically appropriate
- To receive covered preventive services
- To receive a referral to specialty providers for medically appropriate covered services
- To have a clinical record containing documents about conditions, services received, and referrals made
- To have access to one's own clinical record, unless restricted bylaw
- To transfer a copy of his/her clinical record to another provider
- To receive a notice of an appointment cancellation in a timely manner
- To receive a copy of this practices notice of privacy policy

The patient has the following responsibilities:

- To treat the providers and clinic's staff with respect
- To be on time for appointments made with providers and to call in advance to cancel if unable to keep the appointment or if he/she expects to be late
- To seek periodic health exams and preventive services from his/her dentist
- To use his/her dentist for diagnostic and other care except in an Emergency
- To obtain a referral to a specialist from the dentist before seeking care from a specialist unless self-referral to the specialist is allowed
- To use emergency services appropriately
- To give accurate information for inclusion in the clinical record
- To help the provider or clinic obtain clinical records from other providers which may include signing an authorization for release of information
- To ask questions about conditions, treatments and other issues related to his/her care that is not understood
- To use information to make informed decisions about treatment before it is given
- To help in the creation of a treatment plan with the provider
- To follow prescribed agreed upon treatment plans
- To provide the office with any information regarding insurance benefits
- To provide the office with information about address changes, phone number changes, insurance benefit changes
- To pay for non-Covered Services
- To bring issues or complaints to the staff
- To sign an authorization for release of medical information so that the provider can get information which may be needed to respond to a complaint or issue
- To abide by office policies and procedures