AVANT DENTISTRY

Patient Name: _____ Date:_____
Last, First MI (Preferred Name)

Email: _____ (*for appointment reminders and helpful dental facts*)

Gender:_____ Marital Status: _____ Birth Date: _____ S.S #:_____

Phone (Home): _____ (Cell): _____ (Work): _____ Ext: _____
Which number would you prefer we call: (please circle) Home Cell Work Best time to call: _____

Confirm Appointment by Text (# to send text): _____

Address: _____
Street Apartment #

_____
City State Zip Code

Health Information

Date of Last Dental Visit: _____ Reason for today's visit: _____

Have you ever had any of the following? Please check those that apply:

- ☐ Acid Reflux/GERD
- ☐ Allergies _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Pregnancy
  Due date:_____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy
- ☐ Smoking / Tobacco use
  __#packs/day? __Years?
- ☐ Recreational drugs
  Type: _____
- ☐ Alcohol Use
  How often?_____

OTHER:
- ☐ _____

Please list any current medications: _____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient, friend ☐ Another patient, relative

☐ Google ☐ Yelp ☐ Facebook ☐ Website ☐ Insurance company ☐ Blog ☐ Other _____

Name of person or office referring you to our practice: _____

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address_____
Street City, State Zip Code Phone

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Release of Information

In accordance to the HIPAA Privacy Act, please note that for all patients over the age of 18, we are unable to release any information (including but not limited to treatment plan, treatment history, appointment dates, financial information, insurance information, etc.) to anyone (including family members, policy holders, etc.) unless given written authorization. Please list the name(s) of the person(s) you allow us to share your information. If none, please write "none."

Name	Relationship to patient	Phone number

Consent for Services

Consent for Services:

1. I hereby authorize the doctor or designated staff to take x-rays, study models, photographs and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis.

2. Upon such diagnoses, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to be responsible for payment of all services on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1/2% late charge (18% APR) may be added to my account.

4. I hereby give Dr. Yu the absolute right and permission to use my photographs/ slides for educational or promotional purposes. The undersigned completely and forever releases any right to present or future compensation in connection with the use of said photographs/slides.

Cancellation Policy

We, at Avant Dentistry, kindly request 48-hour notice for appointment cancellations. We never double-book our appointment slots—this allows us to give you the attention and the highest quality of care on which we pride ourselves. We reserve the right to assess a fee, up to 25% of the estimated treatment cost, on your account. While we understand that unforeseen circumstances may occur, we ask that you please respect the time that we have reserved exclusively for you.

I have read the above conditions (1 through 4) of treatment and policies, and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party

Acknowledgement of Receipt of HIPAA Notice of Privacy Practices

I acknowledge that I have reviewed/received a copy of Avant Dentistry's HIPAA Notice of Privacy Practices. If I lose my copy, I am aware that I can request a new copy at any time.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian