

Patient Information

Patient Name: _____ Birth Date: _____
Last First

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

Social Security: _____ Email Address: _____

Phone (Home): _____ (Work): _____ (Cell): _____

Address: _____

Street Apartment # City Zip Code

Employer Name: _____ Occupation: _____

Whom may we thank for referring you to our practice? _____

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

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

- | | | | |
|--|--|---|---|
| ☐ AIDS | ☐ Excessive Bleeding | ☐ Liver Disease | ☐ Thyroid Problem |
| ☐ Allergies _____ | ☐ Fainting | ☐ Mental Disorders | ☐ Tuberculosis |
| ☐ _____ | ☐ Glaucoma | ☐ Nervous Disorders | ☐ Tumors |
| ☐ Anemia | ☐ Growths | ☐ Pacemaker | ☐ Ulcers |
| ☐ Arthritis | ☐ Hay Fever | ☐ Pregnancy | ☐ Venereal Disease |
| ☐ Artificial Joints | ☐ Head Injuries | Due date: _____ | ☐ Codeine Allergy |
| ☐ Asthma | ☐ Heart Disease | ☐ Radiation Treatment | ☐ Penicillin Allergy |
| ☐ Blood Disease | ☐ Heart Murmur | ☐ Respiratory Problems | ☐ Latex Allergy |
| ☐ Cancer | ☐ Hepatitis | ☐ Rheumatic Fever | OTHER: _____ |
| ☐ Depression | ☐ High Blood Pressure | ☐ Rheumatism | _____ |
| ☐ Diabetes | ☐ HIV | ☐ Sinus Problems | _____ |
| ☐ Dizziness | ☐ Jaundice | ☐ Stomach Problems | |
| ☐ Epilepsy | ☐ Kidney Disease | ☐ Stroke | |

List medications Prescription & Non-Prescription : _____

Do you have any problems related to snoring and TMJ? If yes, please explain:

Are you now under the care of a physician? If yes, please explain:

Name of Physician: _____ Phone: _____

Do you have any health problems that need further clarification? Yes No If yes, explain:

Have you ever had any complications following dental treatment? Yes No If yes, please explain:

Emergency Contact: _____ Phone: _____

To the best of my knowledge, all 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.

X _____

Signature of Patient / Responsible Party

Date: _____



Responsible Party Information

☐ Same as patient

Name: _____ Social Security: _____
Last First

Birth Date: _____

Phone - Home: _____ Work: _____ Other: _____

Insurance Claim Information

To process insurance claims on your behalf, we require the subscriber's Social Security number. **Without this information, full payment may be requested at the time of service, and we will assist you with the necessary documentation to submit to your insurance for reimbursement.**

Subscriber Name: _____ Social Security: _____ Birth Date: _____
Last First

Financial Policy

Thank you for choosing us as your dental care provider. We are committed to the success of your oral health.

We ask that you realize that we don't work for insurance companies, but we do work 100% for our patient.

Most insurance companies provide great benefits for our patients and we're going to do everything we can to maximize your benefits.

So please understand that the fees that we charge and the treatment that we're going to recommend

is specifically designed for your individual needs and never based on your insurance coverage.

Payment, Insurance, and Treatment Acceptance Policy

Your co-payment and deductible are due at the time of service. We accept cash, check, Visa, MasterCard, American Express, Discover, and CareCredit. For extensive treatment plans, flexible payment options are available but must be arranged prior to treatment. **Appointments lasting one hour or longer require a one-third deposit to reserve the appointment time. Returned checks are subject to a \$45 fee.**

We are happy to assist with filing dental insurance claims as a courtesy to our patients. However, it is your responsibility to inform us of any changes to your insurance coverage. **Co-payments are estimates only** and not a guarantee of payment or coverage. The patient is ultimately responsible for all charges incurred, including any deductible, copayment, coinsurance, non-covered services, denied claims, downgrades, frequency limitations, waiting periods, or any remaining balance not paid by the insurance company. Due to high patient volume, we are unable to make frequent calls to insurance carriers on your behalf. Please note that some plans provide alternative benefits for composite (white) fillings and all-ceramic posterior crowns, which may result in higher out-of-pocket costs than initially estimated. Additional services such as desensitizers and antimicrobial irrigation used during treatment are not typically covered by insurance and may be billed separately.

Before permanent cementation or insertion of crowns, bridges, veneers, dentures, or partial dentures, I have had the opportunity to review and approve the shade, shape, size, fit, and overall appearance. By authorizing final insertion, I acknowledge acceptance of the restoration and understand that any future changes may require additional treatment, appointments, and fees.

I understand that during treatment, it may be necessary to change and/or add procedures because of conditions found while working on the teeth that were not discovered during the examination. Upon my consent, I will give my permission to the dentist to make any/all changes and additions as necessary.

X _____

Date: _____

Signature of Patient / Responsible Party



Missed and Cancelled Appointments

Please consider your calendar carefully when scheduling an appointment. We require **48 hours'** notice to change or cancel your appointments. There may be a \$75 fee per hour for all missed, cancelled, or changed appointments.

Collection Accounts

Please note that if your account remains unpaid for a period of 30 days, interest at 1.5% will be applied per month and a one-time charge of **\$45 for delay and unpaid balances**. If your account is sent to collections, you will be responsible for **all costs** involved with the collections process, which includes all court costs, attorney fees and finance charges. Your signature below indicates that you have read and agreed to our financial policy. Thank you for being a valued patient.

Your First Visit

Your first visit is focused on getting to know you, your dental concerns, and your oral health needs. If you do not have recent dental records or X-rays, we will take a full set of digital X-rays, photos, and a wellness scan. Your visit includes a comprehensive exam, oral cancer screening, and professional cleaning using the method best suited to your needs. Fluoride treatment may also be recommended. After reviewing your findings, we will discuss a personalized treatment plan, including recommended care, estimated costs, and insurance coverage.

Photo & Social media Authorization

☐ **I AGREE** to allow Avin dental Care to photograph or record me (or my child) and use the images/videos for practice marketing, including social media, website, and advertising.

☐ **I DO NOT AGREE**

Authorization to Release Information

I authorize Avin dental Care to release my dental/health information to the person (s) listed below, as requested by me.

Name: _____ Relationship: _____ Phone: _____

☐ **I authorize** ☐ **I do not authorize**

Patient Communication Consent

I consent to receiving communications from Avin Dental Care via text message, email, and phone calls, including automated messages. I understand these messages may include reminders for appointments, pending treatments, care coordination, and occasional practice promotions.

I understand: Standard message and data rates may apply. I may opt out at any time by contacting the office.

Notice of Privacy Practices Acknowledgement

I acknowledge that I have been provided with **Avin Dental Care's Notice of Privacy Practices**. I understand that the Notice describes how my protected health information may be used and disclosed, my privacy rights, and Avin Dental Care's legal responsibilities regarding my health information.

I understand that I may request a paper or electronic copy of the Notice of Privacy Practices at any time.

My signature below acknowledges receipt or offer of the Notice of Privacy Practices. **It does not constitute an authorization for any use or disclosure of my health information beyond what is permitted by law.**

X _____

Date: _____

Signature of Patient / Responsible Party



STOP-BANG Sleep Apnea Questionnaire

Name: _____

Male / Female

Height: _____

Weight: _____ Age: _____

STOP

S	So, you snore loudly (louder enough to be heard through closed doors or louder than talking)?	Yes	No
T	Do you often feel tired , fatigued or sleepy during the daytime?	Yes	No
O	Has anyone observed you stop breathing or choking or gasping during your sleep?	Yes	No
P	Do you have or are you being treated for high blood pressure ?	Yes	No

BANG

B	BMI more than 35?	Yes	No
A	Age – over 50 years old?	Yes	No
N	Neck circumference – is it greater than 17" if you are male or 16" if you are female?	Yes	No
G	Gender – are you a male?	Yes	No

Epworth Sleepiness Scale

How likely are you to nod off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you haven't done some of these things recently, try to work out how they would have affected you. It is important that you answer each question as best you can. Use the following scale to choose the most appropriate number for each situation.

	Would never nod off 0	Slight chance of nodding off 1	Moderate chance of nodding off 2	High chance of nodding off 3
Sitting and reading				
Watching TV				
Sitting, inactive , in a public place (e.g., in a meeting, theater, or dinner event)				
As a passenger in a car for an hour or more without stopping for a break				
Lying down to rest when circumstances permit				
Sitting and talking to someone				
Sitting quietly after a meal without alcohol				
In a car, while stopped for a few minutes in traffic or at a light				