FULTON DENTAL, LLC

1000 Chestnut Street
Vestavia Hills, AL 35216
www.fulton-dental.com

Patient Information

Patient Name: ____**Preferred to be called:**____________________

☐ **Male** ☐ **Female** ☐ **Married** ☐ **Single** ☐ **Child** ☐ **Other**_____________________________________

Social Security #: _________________________ **Date of Birth:** ______________**Driver's License** _________________

Phone (Home): _____________________ **(Work):** _____________________ **(Cell):**_____________________________

Preferred appointment times: ☐ **Morning** ☐ **Afternoon** ☐ **Any Time** ☐**M** ☐**T** ☐**W** ☐**T**

Address:____

Street Apartment #

____

City State Zip Code

E-Mail address: ____

Spouse or Responsible Party Information

The following is for: ☐ Self ☐ Patient's spouse ☐ Patient's parent ☐ Person responsible for payment

Name: ____

☐ **Male** ☐ **Female** ☐ **Married** ☐ **Single** ☐ **Child** ☐ **Other** ______________________

Social Security #: _________________________________ **Date of Birth:** ____________________________

Phone (Home): ______________________ **(Work):** _____________________ **(Cell):** ___________________________

Address: ____

Street Apartment #

____

City State Zip Code

Employment Information

The following is for: ☐ Self ☐ Patient's spouse ☐ Patient's parent ☐ Person responsible for payment

Employer Name: ____ **Occupation** ______________________________

Address: ____

Street City State Zip Code

Referral Information

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

☐ **Dental Specialist** ☐ **Patient** ☐ **Friend** ☐ **School** ☐ **Work** ☐ **Yellow Pages** ☐ **Website**

Patient Medical/Dental Information

Previous Dentist: ____

Date of Last Dental Visit: _________________________ Reason for this visit:___________________________________

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

- ☐ AIDS
- ☐ Allergies __________ ___________________
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Artificial Heart Valve
- ☐ Asthma
- ☐ Blood Disease
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Cold Sores/Fever Blisters
- ☐ Contact Lenses
- ☐ Cortisone Medication
- ☐ Diabetes
- ☐ Diet (Restrictions)
- ☐ Dizziness
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ HIV Positive
- ☐ Headaches
- ☐ Head Injuries
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Latex Sensitivity
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Mitral Valve Prolapse
- ☐ Nervous Disorders
- ☐ Oral Contraceptives
- ☐ Pacemaker
- ☐ Psychiatric/Psychological Care
- ☐ Pregnancy Due date:_________
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Seizures
- ☐ Sinus Problems
- ☐ Sexually Transmitted Disease
- ☐ Smoke/Chew Tobacco
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Aspirin Allergy
- ☐ Codeine Allergy
- ☐ Iodine
- ☐ Local Anesthetics
- ☐ Penicillin Allergy
- ☐ Sulfa Allergy

OTHER:
- ☐ _________________
- ☐ _________________

- Do your gums bleed while brushing or flossing? ☐ Yes ☐ No
- Are your teeth sensitive to hot or cold liquids/foods/sweets? ☐ Yes ☐ No
- Do you feel pain to any of your teeth? ☐ Yes ☐ No
- Do you have any sores/lumps in or near your mouth? ☐ Yes ☐ No
- Do you have any head/neck/jaw injuries? ☐ Yes ☐ No
- Have you ever experienced any of the following problems with your jaw:
  ☐ Clicking ☐ Pain ☐ Difficulty in opening/closing ☐ Difficulty in chewing
- Do you have frequent headaches? ☐ Yes ☐ No
- Do you clinch or grind your teeth? ☐ Yes ☐ No
- Do you bite your lips or cheeks frequently? ☐ Yes ☐ No
- Have you ever had prolonged bleeding following extractions? ☐ Yes ☐ No
- Have you had any orthodontic treatment? ☐ Yes ☐ No
- Do you wear dentures or partials? ☐ Yes ☐ No
- Have you ever received oral hygiene instructions regarding the care of your teeth and gums? ☐ Yes ☐ No
- Do you like your smile? ☐ Yes ☐ No
- Have you ever had any problems with dental anesthetic? ☐ Yes ☐ No
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain:____
- Name of Physician: ______________________________________ Phone:______________________
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain:____
- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain:____
- 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

Dental Insurance Information

Primary

Name of Insured: ______________________________ **Is insured a patient?** ☐ Yes ☐ No

Insured's Date of Birth: ____________ **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: ____

Secondary

Name of Insured: ______________________________ **Is insured a patient?** ☐ Yes ☐ No

Insured's Date of Birth: ____________ **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: ____

Cosmetic Information

- **Is there anything about your smile that you would like to change?** ______________________________
- **Are you interested in knowing the options available for a more beautiful smile?** __________________
- **Do you like the appearance of your teeth?** ____
- **Are all of your teeth in alignment (straight)?** ____
- **Do you have any missing teeth?** ____________________ **Are any chipped?** ____________________
- **Is your bite comfortable when chewing and/or biting?** ______________________________________
- **Do you have frequent headaches?** ____
- **Do you have any old fillings or dental treatment that you are unhappy with?** ____________________
- **What would you like to change the most about the appearance of your teeth?** ____________________

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- **Is there anything else you would like for us to know?**______________________________________

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 30 days, unless previously written financial arrangements are satisfied.
I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs of collections, including reasonable attorney fees and waive all claims of exemption under the state of Alabama.

Further, I understand and acknowledge that Photographs and images of me may be shown to other patients and doctors for treatment, educational and promotional purposes and I agree to the same.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

____ Date: ________________ Relationship to Patient: ______________
Signature of patient, parent, guardian

____ Date: ________________ Relationship to Patient: ______________
Signature of guarantor of payment/responsible party

Welcome to our Practice…We're glad you're here!
Dr. Kane Fulton and Team