

FULTON DENTAL, LLC

1000 Chestnut Street
Vestavia Hills, AL 35216
205.822.3838

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 today's visit: _____

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

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

- 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
- Have you had jaw surgery/TMJ surgery? 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.

Signature of patient, parent or guardian _____ Date: _____

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? _____
- 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.

In an effort to provide all our patients with the best dental care possible, we ask that a 48 hour cancellation notice be given to allow us the opportunity to adjust our schedule and accommodate another patient. Failed appointments and appointments cancelled without 48 hours notice will be charged a \$45.00 fee.

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

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

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