## THE UAB DENTAL GROUP

**PATIENT INFORMATION** **DATE:**

| LAST NAME FIRST NAME MIDDLE INITIAL | DATE OF BIRTH | GENDER ☐ MALE ☐ FEMALE |
|---|---|---|
| STREET ADDRESS | CITY | STATE | ZIP CODE |
| SOCIAL SECURITY NUMBER | HOME PHONE NUMBER | WORK PHONE NUMBER | CELL PHONE NUMBER |
| EMAIL ADDRESS | NAME AND ADDRESS OF EMPLOYER |

**RESPONSIBLE PARTY (IF NOT PATIENT)**

| LAST NAME FIRST NAME MIDDLE INITIAL | RELATIONSHIP TO PATIENT | DATE OF BIRTH | GENDER ☐ MALE ☐ FEMALE |
|---|---|---|---|
| STREET ADDRESS | CITY | STATE | ZIP CODE |
| SOCIAL SECURITY NUMBER | HOME PHONE NUMBER | WORK PHONE NUMBER | CELL PHONE NUMBER |
| NAME AND ADDRESS OF EMPLOYER | SIGNATURE OF RESPONSIBLE PARTY |

**EMERGENCY CONTACT**

| PERSON TO CONTACT | RELATIONSHIP TO PATIENT |
|---|---|
| ADDRESS, CITY, STATE, AND ZIP | PHONE NUMBER |
| PATIENT'S PHYSICIAN | PATIENT'S PHYSICIAN'S PHONE NUMBER |

**PRIMARY DENTAL INSURANCE INFORMATION**

| INSURED'S LAST NAME FIRST NAME MIDDLE | RELATIONSHIP TO PATIENT | INSURED'S DATE OF BIRTH | INSURED'S GENDER ☐ MALE ☐ FEMALE |
|---|---|---|---|
| INSURED'S STREET ADDRESS | CITY | STATE | ZIP |
| INSURANCE COMPANY NAME | COMPANY PROVIDING INSURANCE |
| CONTRACT NUMBER | GROUP NUMBER | INSURED'S SOCIAL SECURITY NUMBER |

**Patient/Guardian Signature:** _____ **Date:** _____

# UAB Dental Group
# Business Policies

## Payments
Payment for treatment is due at the time of service, unless prior credit arrangements have been made. Payments may be made by cash, check, Visa, MasterCard, or Discover.

## Insurance
The UAB Dental Group will electronically file any type of dental insurance(s) as a courtesy on behalf of the patient. The patient is responsible for providing complete insurance information.

### In Network/Out of Network Benefits
The patient must ask if his/her treating dentist is an in-network provider for the patient's dental insurance. One dentist may participate in a particular plan, while another may not. If the treating dentist is in network, the patient will be responsible for any deductibles and co-pays on the day of treatment, and for any remaining allowed balance after insurance payments. If the treating dentist is ***not*** in network, the patient will pay for all dental work at the time of treatment, and will be reimbursed after we receive insurance payment.

## Assignment of Benefits for In-Network Services
I, the undersigned, herby authorize payment directly to The UAB Dental Group, the insurance payments otherwise payable to me for all In-Network Services.

## Release of Information

I, the undersigned, hereby authorize the University of Alabama School of Dentistry or the UAB Dental Group to release any and all medical/dental information to his/her insurance company(s) or other physicians or hospitals involved in the treatment. I agree to permit the taking of any or all photographs, recordings, videotaping or drawings which may be made, as deemed necessary or desirable by active members of the faculty, and I understand these are the sole property of the School or the Group and may be used by members of the faculty for purposes of education, including publication in professional journals or books.

I have read and understand the policies outlined above. I am fully aware of my responsibilities as a patient and have asked for clarification for any policy that is not clear to me.

Name (Printed):

Signature: Date:

# The UAB Dental Group

## Missed Appointment Policy

A missed appointment is any appointment for which the patient does not appear or that is cancelled by the patient within 24 hours of the appointment date.

**Multiple Missed Appointments**

In order to better serve our patients, it is important to fill all open visit spaces each day. Missed appointments do not allow us enough time to call other patients in need of an appointment to fill the space. Therefore, we may not be able to reschedule an appointment for you without doctor approval if you have (3) or more consecutive missed appointments OR if you have (5) or more missed appointments in 6 months. Furthermore, (3 ) or more consecutive missed appointments may result in a $20 missed appointment charge.

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**Surgical Procedures; Implants; Dentures; All Custom Labs**

Missed surgical procedures or cancellation of treatment that includes custom lab costs and other fees to prepare for appointed procedures may also be the responsibility of the patient. Fees for custom work are costly and these items are unusable by the practice as they are specific to a patient.

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## Tardiness Policy

In order to ensure that all of our patients are seen in a timely manner, it is important that patients present to the office on time for their appointments. Patients who are more than 15 minutes late to a scheduled appointment may be subject to rescheduling.

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The UAB Dental Group recognizes the occasional need to reschedule or cancel an appointment. In order to better serve all of our patients, the above policies will be subject to doctor discretion by circumstance.

I have read and understand the Cancellation and Tardiness Policy presented to me by The UAB Dental Group.

Name (Print):

Signature: Date:

**UAB Dental Group** **Today's Date:** _____

# Medical History Form

**Patient's Name**_____ **Date of Birth**_____ **Dentist**_____

**Chart No**_____ **Incoming BP**_____ **Pulse**_____

**Please Check ONLY the Box for any condition you have had in the past or have now**

| Cardiovascular | Box | Addl Comments |
|---|---|---|
| Congestive Heart Failure | | |
| Heart Attack/Disease | | When_____ |
| Angina or Chest Pain | | Type_____ |
| Heart Surgery | | When_____ |
| Hypertension | | How Long_____ |
| Infective Endocarditis | | When_____ |
| Congenital Heart Defect | | Surgery_____ |
| Prosthetic Heart Valve | | |
| Arrhythmias | | |
| Pacemaker/Defibrilator | | |
| Heart Transplant | | When_____ |
| Other Heart Problems | | |
| Blood Thinners | | Type_____ |
| Aneurysm | | |
| Shortness of Breath | | |
| Swollen Ankles | | |
| Sleep Disorder | | |
| **Hematologic** | | |
| Blood Transfusion | | When_____ |
| Anemia | | |
| Hemophilia | | |
| Leukemia | | When_____ |
| Sickle Cell Disease | | Type_____ |
| Bleeding Tendencies | | |
| **Neurologic** | | |
| Glaucoma | | |
| Hearing Loss | | |
| Severe Headaches | | |
| Fainting Spells | | |
| Stroke/CVA | | When_____ |
| Seizures/Epilepsy | | Hospitalized_____ |
| Psychiatric Treatment | | |
| Paralysis | | |
| **Gastrointestinal** | | |
| Stomach Ulcers | | |
| Gastritis/Colitis | | |
| Hepatitis | | |
| Liver Disease | | |
| Yellow Jaundice | | |
| Cirrhosis | | |
| Eating Disorders | | |
| Diet Suppressants | | |
| **Women Only** | | |
| Currently Pregnant | | Trimester_____ |
| Currently Breast Feeding | | |
| Use of Oral Contraceptives | | |

| Respiratory | Box | Addl Comments |
|---|---|---|
| Hayfever | | |
| Sinus Trouble | | |
| Allergy/Hives | | |
| Asthma | | Inhaler use_____ |
| Emphysema | | O2 Therapy_____ |
| Bronchitis | | |
| Tuberculosis | | Diagnosed_____ |
| Breathing Difficulties | | When_____ |
| **Dermatologic** | | |
| Allergy to Latex | | |
| Allergy to Food or Drugs | | Types(s)_____ |
| Skin Rash | | Location_____ |
| Fever Blisters | | Frequency_____ |
| Canker Sores | | |
| **Endocrine** | | |
| Diabetes | | Type_____ |
| Thyroid Disease | | Hyper____ Hypo____ |
| Steroid Use | | |
| **Genitourinary** | | |
| Kidney Problems | | |
| Dialysis | | Schedule_____ |
| Sexually Transmitted Disease | | Type_____ |
| **Musculoskeletal** | | |
| Arthritis | | Type_____ |
| Joint Replacement | | Location_____ |
| Bone Disorders | | |
| Muscle Disorders | | |
| **Other** | | |
| Prostate Problems (Male) | | |
| HIV Positive | | |
| IV Drug Addiction | | |
| Drug Addiction | | Type_____ |
| Do you Drink Alchohol | | How Often_____ |
| Tumor or Cancer | | |
| Cobalt Treatment | | Location_____ |
| Chemotherapy | | |
| Organ Transplant | | Type_____ |
| Tobacco Use | | How Much_____ |
| Unexplained Weight loss or Gain | | |
| Other Conditions Not Listed | | |
| Reaction to General Anesthesia | | Type_____ |
| **Specific Drug Allergies** | | |
| Local Anesthestics | | Type_____ |
| Antibiotics | | Type_____ |
| Codiene/Narcotics | | Type_____ |
| Aspirin/NSAIDS | | Type_____ |

PLEASE COMPLETE OTHER SIDE

PLEASE COMPLETE OTHER SIDE

**UAB Dental Group** **Today's Date:** _____

Patient's Name_____ Medical HX Form Cont'd

1. Are you Currently Under the Care of a Physician? Yes_____ No_____

Please Provide the following information about your Primary Care Physician

Physician Name _____

Address _____

Phone Number Fax _____

Date of Last Visit _____

2. Have you ever been hospitalized or had any operations? Yes____ No____

If yes, please list

**Year** **Reason**

_____

_____

_____

_____

_____

_____

_____

_____

3. Are you Currently taking any Prescribed Medications, Herbals or Over-the-Counter drugs? Yes____ No____

If yes, please list

**Current Medication** **Dose**

_____

_____

_____

_____

_____

_____

_____

_____

_____

**Dentist Medication Notes Only**

**To the best of my knowledge, all of the preceding answers are true and correct.**
**If I ever have changes in my health or if my medications change,**
**I will inform my dentist at the next appointment without fail. To aid safely in treating me, I give permission to consult other health care providers concerning my health history should the need arise.**

**Patient Signature :**_____ **Date:**_____

**Medical History Updates- Clinical Staff Use Only**

| Date: | Med Hx Change |
|---|---|
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# University of Alabama
# School of Dentistry

## Acknowledgement of Receipt of Notice of Health Information Practices

I understand that The University of Alabama School of Dentistry, may use my health information for treatment, billing and healthcare operations. I have been given a copy of the organization's Notice of Health Information Practices that describes how my dental health information is used and shared. I understand that the organization has the right to change this notice at any time. I may obtain a current copy by contacting the University of Alabama School of Dentistry.

**My signature below constitutes my acknowledgement that I have been provided with a copy of the Notice of Health Information Practices.**

Print (Patient's Name) _____ Dental Chart Number _____

Signature of Patient or Legal Representative _____ Date _____

If signed by a legal representative, relationship to patient: _____

**For Office Use Only**

School of Dentistry Representative's Name _____ Department _____

Revised 3/3/04

PS 15501

PLEASE BRING YOUR DRIVING LICENSE AND INSURANCE CARD(S) ALONG WITH THE COMPLETED PAPERWORK.

WE ALSO NEED THE NAME, DATE OF BIRTH, AND THE PLACE OF EMPLOYMENT OF THE PRIMARY SUBSCRIBER FOR INSURANCE TO BE FILED.

THANK YOU,

FACULTY PRACTICE