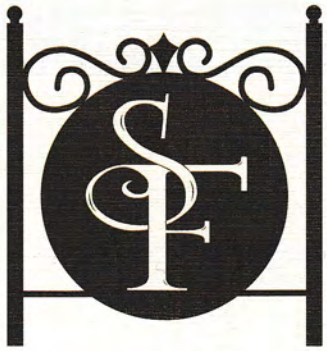

Please take a few minutes to answer the following questions so we can better assist you with your dental needs.

Patient Information

Date _____ Soc. Sec. # _____ Birthdate _____

Name _____ Home Ph# _____

Address _____ Cell Ph# _____

City _____ State _____ Zip _____

Email _____ Business Ph# _____

How do you prefer to be contacted regarding appointments? _____

Sex ☐ M ☐ F ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Single ☐ Widowed

Employer _____ Occupation _____

Business Address _____

Who should we thank for referring you? _____

In case of emergency, who should we contact? _____ Phone _____

Primary Insurance

Person Responsible for Account _____

Relationship to Patient _____ Birthdate _____ SS# _____

Address _____ Home Ph# _____

City _____ State _____ Zip _____

Responsible Party Employed By _____ Business Ph# _____

Please bring your insurance card to your appointment so that we may make a photocopy.

Dental History

Former Dentist _____

City, State _____

Estimated Date of Last Dental Visit _____

Please check all that apply:

- Bad Breath ☐
- Bleeding Gums ☐
- Blisters on Lips or Mouth ☐
- Grinding Teeth ☐
- Lip or Cheek Biting ☐
- Loose Teeth or Broken Fillings ☐
- Orthodontic Treatment ☐
- Pain Around Ear ☐
- Periodontal Treatment ☐
- Sensitivity to Cold ☐
- Sensitivity to Heat ☐
- Sensitivity to Sweets ☐
- Sensitivity When Biting ☐
- Frequent Headaches ☐
- Jaw, Head or Neck Injuries ☐
- Jaw Difficulty: Clicking and/or Pain ☐
- Tooth Pain ☐

Medical History

Physician's Name _____ Date of Last Visit _____

	Yes	No
1. Are you currently under medical treatment?	☐	☐
2. Have you ever had any serious illness or operations?	☐	☐
3. Are you currently taking any medications? We need a list of all OTC, herbs, ED medications, and any other medications. _____	☐	☐
4. Do you smoke/drink alcohol?	☐	☐
5. Do you use cocaine or other drugs?	☐	☐

6. Have you had any allergic reactions to the following:	Yes	No
Local Anesthetics (eg. novocaine)	☐	☐
Penicillin	☐	☐
Sulfa Drugs	☐	☐
Erythromycin	☐	☐
Sedatives	☐	☐
Codeine	☐	☐
Aspirin	☐	☐
Other	☐	☐
7. (Women Only) Are You:		
Pregnant?	☐	☐
Nursing?		
Taking Birth Control Pills?	☐	☐

Please check all that apply:

- AIDS ☐
- Anemia ☐
- Arthritis, Rheumatism ☐
- Artificial Heart Valves ☐
- Artificial Joints ☐
- Asthma ☐
- Back Problems ☐
- Bleeding Abnormally, with Extractions or Surgery ☐
- Blood Disease ☐
- Cancer ☐
- Chemical Dependency ☐
- Chemotherapy ☐
- Chronic Fatigue Syndrome ☐
- Circulatory Problems ☐
- Congenital Heart Lesions ☐
- Cortisone Treatments ☐
- Cough - persistent or bloody ☐
- Diabetes ☐
- Emphysema ☐
- Epilepsy ☐
- Fainting or Dizziness ☐
- Glaucoma ☐
- Headaches ☐
- Heart Murmur ☐
- Heart Problems ☐
- Hepatitis - Type _____ ☐
- Herpes ☐
- High Blood Pressure ☐
- HIV Positive ☐
- Jaundice ☐
- Jaw Pain ☐
- Kidney Disease ☐
- Latex Sensitivity ☐
- Liver ☐
- Low Blood Pressure ☐
- Mitral Valve Prolapse ☐
- Nervous Problems ☐
- Pacemaker ☐
- Psychiatric Care ☐
- Radiation Treatment ☐
- Respiratory Disease ☐
- Rheumatic Fever ☐
- Scarlet Fever ☐
- Shortness of Breath ☐
- Sinus Trouble ☐
- Skin Rash ☐
- Stroke ☐
- Swelling of Feet/Ankles ☐
- Swollen Neck Glands ☐
- Thyroid Problems ☐
- Tonsillitis ☐
- Tuberculosis ☐
- Tumor or Growth on Head/Neck ☐
- Ulcer ☐

Assignment and Release

I hereby authorize payment directly to _____ for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party _____ Date _____

CONSENT TO PERFORM DENTISTRY

- I hereby authorize and direct the dentist Angela S. Fennell, D.M.D. and/or dental auxiliaries of his/her choice, to perform the following dental treatment or oral surgery procedure(s), including the use of any necessary or advisable local anesthesia, radiographs (x-rays), or diagnostic aids.
- Preventive hygiene treatment (prophylaxis) and the application of topical fluoride.
- Application of plastic “sealants” to the grooves of the teeth.
- Treatment of diseased or injured teeth with dental restorations (fillings and crowns).
- Replacement of missing teeth with dental prostheses (fixed bridges, removable partial or full dentures, implants).
- Removal (extraction) of one or more teeth.
- Treatment of diseased or injured oral tissues (hard and/or soft).
- Use of sedative drugs to control apprehension and/or disruptive behavior.
- Treatment of malposed (crooked) teeth and/or oral development or growth abnormalities.
- Use of general anesthesia to accomplish the necessary treatment.
- I understand that there are risk involved in this treatment and hereby acknowledge that this risk/s will be explained to me, that I will have an opportunity to ask questions regarding the treatment and the risks, and that I fully understand the same.
- I agree to the use of local anesthesia and the use of nitrous oxide/oxygen analgesia depending on the judgment of the doctor. Nitrous oxide/oxygen may occasionally produce nausea and vomiting. I am also aware that the nose piece leaves an indention or ring around the nose which disappears shortly after the procedure. I understand and have been informed of the above risks and complications.
- I recognize that during the course of treatment unforeseen circumstances may necessitate additional or different procedures from those discussed. I therefore authorize and request the performance of any additional procedures that are deemed necessary or desirable to oral health and well being in the professional judgment of the dentist.
- There are possible risks and complications associated with the administration of local anesthesia, sedation, and drugs. The most common of these are swelling, bleeding, pain, nausea, vomiting, bruising, tingling, and numbness of the lips, gums, face and tongue, allergic reactions, hematoma (swelling or bleeding at or near the injection site), fainting, lip and cheek biting resulting in ulceration and infection of the mucosa. I also understand that either are rare potential risks such as unfavorable reactions to medications in respiratory and cardiovascular collapse (stopping or breathing and heart function) and lack of oxygen to the brain that could result in coma or death. I understand and have been informed of the above risks and complications.
- I also authorize the doctor to use photographs, radiographs, other diagnostic materials and treatment records for the purposes of teaching, research and scientific publications.
- I will be advised that the success of the dental treatment to be provided will require that the patient and the parents follow post-operative and post-care instruction of the dentist. I agree that the success of the treatment requires that all post-operative and post-care instructions are to be followed and that regular office visits as scheduled by my dentist and his/her auxiliaries must be maintained.
- I hereby state that I have read and understand this consent, and that all questions about the procedures will be answered in a satisfactory manner; and I understand that I have the right to be provided answers to questions which may arise during and after the course of my treatment.
- I further understand that this consent will remain in effect until such time that I choose to terminate it.

Date: _____ Patient Name: _____

Signature: Patient or Guardian: _____

Help us get to know you by checking the appropriate responses:

When I think about coming to the dentist I feel:

- o Comfortable – I have no anxiety about seeing the dentist or dental procedures
- o Anxious – I don't want to come but I make myself. However, I am seldom comfortable
- o Fearful – I have stayed away from the dentist because of my fear. I avoid coming unless absolutely necessary
- o Extremely fearful – I cannot cope with dental visits and have avoided the dentist for years

I have avoided the dentist because of:

- o My anxiety and fear
- o Past experiences
- o Cost
- o No time
- o Lack of trust
- o Other _____

My childhood dental experiences were:

- o Completely pain free and comfortable
- o Somewhat uncomfortable
- o Painful
- o Traumatic
- o I did not go to the dentist as a child

My dental experiences as an adult have been:

- o Completely pain fee and comfortable
- o Somewhat uncomfortable
- o Painful
- o Traumatic
- o I have not seen a dentist as an adult or my visits have been very few

I have a fear or concerns about:

- o Experiencing pain
- o Not being numb
- o Needles
- o Unnecessary or wrong treatment
- o Gagging
- o Losing Control
- o Having something put over my mouth
- o Losing my teeth. Ultimately wearing a partial or denture
- o Catching a disease
- o Being scolded or made to feel ashamed

The following makes me feel uncomfortable:

- o The sounds of a dental drill
- o Laying down in the dental chair
- o The smells in a dental office
- o Having to wait in the reception area
- o Being numb

To understand what's going on in my mouth, my preference is:

- o To know all the details
- o To be shown pictures and movies
- o To read pamphlets and brochures
- o To be given the bottom line
- o To read pamphlets and brochures

My immediate concern about my teeth and smile:

_____

Acknowledgment of Receipt of HIPAA Policies and Procedures

I have received and reviewed a copy of our dental practice's privacy, security and breach notification policies and procedures.

I understand that I should ask our dental practice's Privacy Official if I have any questions about these policies and procedures.

Date: _____

Print Name: _____

Signature: _____

Please list any other parties who can have access to your health information:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I authorize contact from this office to confirm my appointments, treatment, health, & billing information via:

- o Cell phone
- o Home phone
- o Work phone
- o Text message
- o Email
- o All of the above

Angela Fennell, D.M.D.,PC 4000 Balmoral Dr., Ste. 102 Huntsville, AL 35801

Insurance Policy

Importance of patient awareness regarding insurance benefits:

Dr. Fennell realizes how important insurance benefits are to our patients. **We ask that you carefully review your policy and/or contact tour insurance carrier so you are aware of benefits, frequencies, limitations, and/or restrictions**. Please be informed that dental insurance is a contract between you and your insurance company. Our role is to assist you with filing your claims. Dr. Fennell is providing the highest quality of care for you and your family regardless of insurance frequencies, limitations and/or restrictions. Please be aware that your insurance may have a yearly allowance (maximum) and anything over the amount will be your responsibility. Your insurance mails a copy of the explanation of benefits (EOBs) to you. Please pay attention to these statements. Check your policy to see if you have a deductible, and if your insurance pays at a percentage or by their allowed fee schedule. Please provide us with a copy of your insurance card and benefit booklet (if available) at your first visit or at the time of your dental coverage changes. It is your responsibility to provide us with any future changes in your insurance. If any services have been provided with any other provider within the existing benefit year, please advise us.

_____ Initials (I understand the above information)

Financial Policy

In order to provide you with the highest quality dental care on a sound business basis, we provide our patients with **estimates** of fees. Patients, parents, and/or guardian are responsible for the patient portion on the date of service. This is not your insurance company's responsibility. We will file all necessary claims to your insurance as a courtesy to you. It is your responsibility to call your insurance company if you have not paid your claim within 45 days from the date of service. Any balance beyond 45 days is your responsibility.

Financial options that we provide at this time:

- Cash or check on the date of service
- American express
- MasterCard
- Visa
- Discover
- Care Credit

It is your responsibility to complete treatment and follow recommended maintenance schedule. If the treatment and maintenance plan are not followed and/or appointments are missed, adverse results could affect your dental health. If you do not proceed with your treatment plan in a timely manner, further treatment for the involved teeth, supporting tissues, adjacent and opposing teeth, muscles or joints can be affected.

_____ Initials (I understand the above information)

Appointment Commitment

We appreciate you choosing us to meet your dental needs. We take this responsibility seriously and have qualified team members to accommodate you during your appointment time. If circumstances occur, we request that you give us at least 24 hours' notice. We understand there are some circumstances out of your control and we will take those into consideration. There may be a fee of $95.00 per broken appointment, one in which you do not show or call.

_____ Initials (I understand the above information)