The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain optimal oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

DATE

1 ABOUT YOU

NAME

I PREFER TO BE CALLED

EMAIL

BIRTHDATE AGE SSN

HOME ADDRESS

HOME PHONE CELL PHONE

WORK PHONE

EMPLOYER ADDRESS

HOW LONG THERE? OCCUPATION

WHERE & WHEN ARE THE BEST TIMES TO REACH YOU?

WHOM MAY WE THANK FOR REFERRING YOU?

OTHER FAMILY MEMBERS SEEN BY US

PREVIOUS/PRESENT DENTIST NAME

NAME OF PERSON RESPONSIBLE FOR YOUR ACCOUNT

PAYMENT IS DUE IN FULL AT THE TIME OF TREATMENT FOR WORK DONE BY DR. ARMSTRONG. We will submit all claims to your insurance company and they will reimburse you directly. Dental Cleanings will be sent directly to your insurance company and once the insurance company pays us, we will send you a statement for the remaining balance which will be due upon receipt. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to Advanced Dental Concepts of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

SIGNATURE DATE

2 SPOUSE INFORMATION

HIS/HER NAME

EMPLOYER

WORK PHONE

NAME OF RELATIVE OR FRIEND NOT LIVING WITH YOU

RELATION

HOME PHONE WORK PHONE

3 INSURANCE INFORMATION

Primary Carrier

INSURANCE COMPANY

GROUP # INSURED'S ID #

EMPLOYER NAME

INSURED'S NAME

INSURED'S DATE OF BIRTH

INSURED'S RELATIONSHIP TO PATIENT

INSURED'S SSN PATIENT'S SSN

Secondary Carrier

INSURANCE COMPANY

GROUP # INSURED'S ID #

EMPLOYER NAME

INSURED'S NAME

INSURED'S DATE OF BIRTH

INSURED'S RELATIONSHIP TO PATIENT

INSURED'S SSN PATIENT'S SSN

4 MEDICAL HISTORY

PRIMARY CARE PHYSISCAN'S NAME

PHONE

DATE OF YOUR LAST VISIT

ARE YOU CURRENTLY UNDER THE CARE OF A PHYSICIAN? ☐ Yes ☐ No
IF YES, PLEASE EXPLAIN:

DO YOU SMOKE OR USE TOBACCO IN ANY FORM? ☐ Yes ☐ No

HAVE YOU HAD ANY METAL RODS, PINS OR IMPLANTS? ☐ Yes ☐ No

PLEASE LIST ANY PRESCRIPTION OR OVER THE COUNTER DRUGS YOU USE:

HAVE YOU EVER TAKEN FASAMAZ, ACTONEL, BONIVA OR ANY OTHER BISPHOSPHONATE? ☐ Yes ☐ No

Women:

ARE YOU USING BIRTH CONTROL? ☐ Yes ☐ No

ARE YOU PREGNANT? ☐ Yes ☐ No

ARE YOU NURSING? ☐ Yes ☐ No

PLEASE CIRCLE ANY THAT APPLY:

Y N Abnormal Bleeding/Hemophilia
Y N AIDS
Y N Alcohol/Drug Abuse
Y N Anemia
Y N Arthritis
Y N Artificial Bones/Joints/Valves
Y N Asthma
Y N Blood Transfusion
Y N Cancer/Chemotherapy
Y N Colitis
Y N Congenial Heart Defect
Y N Diabetes
Y N Difficulty Breathing
Y N Emphysema
Y N Epilepsy
Y N Fainting Spells
Y N Frequent Headaches
Y N Glaucoma
Y N Hay Fever
Y N Heart Attack/Surgery
Y N Heart Murmur
Y N Hepatitis
Y N Herpes/Fever Blister
Y N High Blood Pressure
Y N HIV
Y N Hospitalized for Any Reason
Y N Kidney Problems
Y N Liver Disease
Y N Low Blood Pressure
Y N Lupus
Y N Mitral Valve Prolapse
Y N Pacemaker
Y N Psychiatric Problems
Y N Radiation Treatment
Y N Rheumatic/Scarlet Fever
Y N Seizures
Y N Shingles
Y N Sickle Cell Disease/Traits
Y N Sinus Problems
Y N Stroke
Y N Thyroid Problems
Y N Tuberculosis (TB)
Y N Ulcers
Y N Venereal Disease

PLEASE LIST ANY SERIOUS MEDICAL CONDITION(S) THAT YOU HAVE EVER HAD:

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

Y N Aspirin
Y N Codeine
Y N Dental Anesthetics
Y N Erythromycin
Y N Jewelry/Metals
Y N Latex
Y N Penicillin
Y N Tetracycline
Y N Other

MEDICAL HISTORY UPDATE: PLEASE NOTE ANY CHANGES IN YOUR HEALTH SINCE YOUR LAST VISIT:

DATE DESCRIPTION INITIALS

DATE DESCRIPTION INITIALS

DATE DESCRIPTION INITIALS

5 DENTAL HISTORY

WHY HAVE YOU COME TO OUR OFFICE TODAY?

ARE YOU CURRENTLY IN PAIN? ☐ Yes ☐ No

DO YOU REQUIRE ANTIBIOTICS BEFORE DENTAL TREATMENT? ☐ Yes ☐ No

HAVE YOU EVER HAD A SERIOUS/DIFFICULT PROBLEM ASSOCIATED WITH ANY PREVIOUS DENTAL WORK? ☐ Yes ☐ No

DO YOU FLOSS DAILY? ☐ Yes ☐ No BRUSH DAILY? ☐ Yes ☐ No

HAVE YOU EVER HAD GUM TREATMENT? ☐ Yes ☐ No

DO YOUR GUMS EVER BLEED? ☐ Yes ☐ No EVER ITCH? ☐ Yes ☐ No

HAVE YOU EVER BEEN DIAGNOSED WITH PERIODONTAL DISEASE? ☐ Yes ☐ No

DO YOU NOW OR HAVE YOU EVER EXPERIENCED PAIN/ DISCOMFORT IN YOUR JAW JOINT (TMJ/TMD)? ☐ Yes ☐ No

ARE YOUR TEETH SENSITIVE TO HEAT, COLD OR ANYTHING ELSE? ☐ Yes ☐ No

DO YOU HAVE ANY LOOSE TEETH? ☐ Yes ☐ No

WOULD YOU LIKE FRESHER BREATH? WHITER TEETH? ☐ Yes ☐ No

ARE YOU HAPPY WITH THE WAY YOUR SMILE LOOKS? ☐ Yes ☐ No
IF NOT, WHAT WOULD YOU CHANGE?

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

SIGNATURE

DATE

Our office is HIPAA Compliant
and is committed to meeting
or exceeding the standards of
infection control mandated by
OSHA, the CDC and the ADA.

ARMSTRONG
ADVANCED DENTAL CONCEPTS
STANLEY ARMSTRONG, DMD

ACKNOWLEDGEMENT *of* RECEIPT *of* NOTICE *of* PRIVACY PRACTICES

I, ______________________________ have received a copy of this office's Notice of Privacy Practices.

____
PRINT NAME

____
SIGNATURE

____
CHILD/CHILDREN'S NAME(S) (IF UNDER 18)

____
DATE

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

armstrongadvanced.com 744 Roosevelt Trail, Suite 104 Windham, Maine 207-892-8325 888-5SMILE1