Ascent Dental Group

Welcome to Ascent Dental Group

Thank you for selecting our dental healthcare team! To help us meet all your dental healthcare needs, please fill out this form completely.

Patient Information **Today's Date:**_____

Name: _____ Birthdate: _____ Age:____ SSN#_____ Gender: ☐M ☐F
Address:_____ City:_____ Zip:_____
Email:_____ Home Phone:_____
Cell Phone:_____ Work Phone:_____
Person to contact in case of Emergency:_____Phone:_____
How did you hear about our office?_____
I will be paying for today's service by:
☐Cash ☐Check ☐Credit Card ☐Care Credit

Responsible Party
Name of Person Responsible for account:_____ Relationship to Patient:_____
Address (if different from above):_____ City: _____ Zip: _____
Email: _____ Home Phone: _____ Cell Phone:_____
Driver's License #_____ Birthdate:_____ SSN#_____
Employer:_____ Address of Employer:_____
Work Phone:_____ Is this person currently a patient in our office? ☐Yes ☐No

Dental Insurance Information
Name of the Insured:_____ Relationship to Patient:_____
Birthdate:_____ SSN#:_____
Insurance Company:_____ Insurance Company Phone:_____
Member ID#_____ Group#:_____
Employer:_____ Address of Employer:_____

Handle Me with Care

☐ I gag easily.
☐ I am uncomfortable about needles.
☐ I don't like the feel of the ultrasonic cleaner.
☐ I hate the noise of the drill.
☐ My teeth are very sensitive.
☐ I feel out of control when in the dental chair.
☐ I can't tolerate the sound of scraping noises.
☐ I have health problems we need to discuss.
☐ I don't like cotton in my mouth.
☐ Pain relief is a top priority for me.
☐ I have difficulty listening and remember what I am told in the dental chair.
☐ I feel uncomfortable about what is said about my dental hygiene.

Dental History

Please mark any of the following to indicate yes in response to the question:

☐ Do your gums bleed when you brush or floss?
☐ Are your teeth currently causing pain?
☐ Have you had any difficult extractions before?
☐ Have you ever had any head, neck, or jaw injuries?
☐ Do you have any sores or lumps in or near your mouth?
☐ Do your teeth experience sensitivity to cold or hot temperatures?
☐ Do you snore?
☐ Do you grind your teeth?
☐ Do you have frequent headaches?
☐ Have you ever had TMJ/TMD?
☐ Have you had any orthodontic treatment?

Patient Medical History

		Yes	No
1.)	Are you under medical treatment now?	☐	☐
2.)	Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?	☐	☐
3.)	Are you taking any medication including non-prescription meds? If yes list medications:_____	☐	☐
4.)	Do you use tobacco?	☐	☐
5.)	Do you use controlled substances?	☐	☐
6.)	Do you have allergies or allergic reactions? If yes, please describe?_____	☐	☐
7.)	Do you need to be pre-medicated before dental procedures due to medical conditions? If yes, please describe?_____	☐	☐
8.)	Woman only:		
	a. Are you pregnant or think you may be pregnant?	☐	☐
	b. Are you nursing?	☐	☐
	c. Are you taking oral contraceptives?	☐	☐

9.) Please indicate if you have experienced any of the following:

☐ Allergies	☐ Anemia	☐ Arthritis	☐ AIDS
☐ Asthma	☐ Back Problems	☐ Blood Disease	☐ Cancer
☐ Chest Pains	☐ Diabetes	☐ Dizziness	☐ Easily Winded
☐ Emphysema	☐ Epilepsy	☐ Excessive Bleeding	☐ Fainting
☐ Glaucoma	☐ Head Injuries	☐ Heart Attack	☐ Heart Disease
☐ Heart Murmur	☐ Heart Troubles	☐ Hepatitis	☐ High Blood Pressure
☐ HIV	☐ Jaundice	☐ Joint Replacement	☐ Kidney Disease
☐ Leukemia	☐ Liver Disease	☐ Mental Disorders	☐ Mitral Valve Prolapse
☐ Nervous Disorders	☐ Radiation	☐ Rheumatism	☐ Physiological Treatment
☐ Rheumatic Fever	☐ Pace Makers	☐ Recent Weight Lost	☐ Respiratory Problems
☐ Stomach Problems	☐ Stroke	☐ Sinus Problems	☐ Thyroid Problems
☐ Tuberculosis	☐ Tumors	☐ Swollen Ankles	☐ Venereal Disease
☐ Ulcers	☐ Other:_____		

Authorization and Release

Patients with Insurance Coverage

As a courtesy to our patients, we are glad to help you obtain the appropriate benefit from your insurance company. However, it is the responsibility of the patient to understand and be aware of the benefits covered and those that are not covered. Procedures not listed in the benefit booklet are the responsibility of the patients. Any portion not covered/paid by the insurance must be paid by patient. We will do our best to obtain the maximum benefit payment from your insurance, but will not let your insurance tell us what treatment is best for you. Due to insurance limitations, new dentistry technologies may not be covered and will be an out of pocket expense.

Broken Appointments-REQUIRED 48 HOUR NOTICE

If you need to reschedule or cancel an appointment, we do require a 48 hour notice. Our office will make every effort to place a courtesy call, text, and/or email to remind you of your appointment. For this reason, it is important to keep us updated with changes in phone number, address, and email address. Ultimately you are responsible for your appointment. A $50 fee per hour will be charged for appointments cancelled without a 48 hour notice. Larger appointments will result in a $100 per hour.

Account Balances

PAYMENT IS **REQUIRED** AT TIME OF SERVICE. There will be a 5% monthly charge on account balances left over 30 days. If left over 90 days, the account will be turned over to a collection agency. Patient agrees to pay all court cost and fees associated with collection (45%). Returned checks will be charged a $50 fee. Dental Records are property of Ascent Dental Group. A $15 fee will be accessed for a copy or transfer of records.

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information or failing to update my information has the potential of being hazardous to my health.
I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.
I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third party insurance carriers, payors, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

If there is ever a discrepancy with myself and Ascent Dental Group I agree to discuss with office to resolve issue prior to writing a negative review online.
I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any). I understand my rights to the HIPPA procedures and practices of the office.

Signature of patient: _____ Date: _____
(Parent or Guardian if minor)

Doctor's Signature:_____ Date:_____