AESTHETIC
FAMILY DENTAL CENTER

PATIENT INFORMATION

Patient Name _____ , _____ _____
Last Name First Name MI

Address _____

City _____ State _____ Zip Code _____

Social Security # _____-_____-_____ Birth Date _____

Sex ☐ Male ☐ Female ☐ Non-binary

☐ Married ☐ Widowed ☐ Single ☐ Minor ☐ Separated ☐ Divorced

Patient Employer/ School _____

Occupation _____

Employer Phone # _____

Whom may we thank for your referral? _____

CONTACT INFORMATION

Home (_____)_____

Cell (_____)_____

Work (_____) _____ EXT _____

Email Address:

_____

Best time to reach you:

☐ AM ☐ Lunch ☐ PM

In Case of emergency, Contact

Name _____

Relationship _____

Phone (_____) _____

DENTAL INSURANCE

Insurance Company _____ Employer _____

Member ID: _____Group # _____

Subscribers Name (if different than above) _____ Social Security # _____-_____-_____

Birth Date _____

Is the patient covered by additional insurance? ☐ Yes ☐ No (If yes then complete the following)

Subscribers Name _____ Birthdate _____

SS# _____ Relationship to patient _____

Insurance Company _____ Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage and assign directly to Dr. Michael Hansen and Associates all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Aesthetic Family Dental may use my health care information and may disclose such information to my insurance company(ies) and their agents for the purpose of abstaining payment for services and determining insurance benefits or the benefits payable for related services.

Signature of Patient, Parent, or Guardian _____ Date _____

DENTAL HISTORY

Former Dentist _____

Date of last dental visit _____

Date of last dental X-Rays _____

What is your primary concern? _____

_____

Do you like your smile? ☐ Yes ☐ No

Do you have dental anxiety? ☐ Yes ☐ No

Do your gums bleed? ☐ Yes ☐ No

Do you have sensitive teeth? ☐ Yes ☐ No

Do you have jaw pain or locking? ☐ Yes ☐ No

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Patient Name_____ Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions:

Are you under a physician's care now? Yes ☐ No ☐ If yes, please explain_____

Have you ever been hospitalized or had a major operation? Yes ☐ No ☐ If yes, please explain_____

Have you ever had a serious head or neck injury? Yes ☐ No ☐ If yes, please explain_____

Do you take, or have you taken, Phen-Fen or Redux? Yes ☐ No ☐ If yes, please explain_____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes ☐ No ☐ If yes, please explain _____

Are you on a special diet? Yes ☐ No ☐

Do you use tobacco? Yes ☐ No ☐

Do you use controlled substances? Yes ☐ No ☐

Women: Are you

☐ Pregnant ☐ Nursing?
☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa Drugs
☐ Other If other, please explain_____

Do you have, or have you had, any of the following?

AIDS/HIV Positive	☐Yes ☐No	Convulsions	☐Yes ☐No	Hemophilia	☐Yes ☐No	Rheumatic Fever	☐Yes ☐No
Alzheimer's Disease	☐Yes ☐No	Cortisone Medicine	☐Yes ☐No	Hepatitis A	☐Yes ☐No	Rheumatism	☐Yes ☐No
Anaphylaxis	☐Yes ☐No	Diabetes	☐Yes ☐No	Hepatitis B or C	☐Yes ☐No	Scarlet fever	☐Yes ☐No
Anemia	☐Yes ☐No	Drug Addiction	☐Yes ☐No	Herpes	☐Yes ☐No	Shingles	☐Yes ☐No
Angina	☐Yes ☐No	Easily Winded	☐Yes ☐No	High Blood Pressure	☐Yes ☐No	Sickle cell Disease	☐Yes ☐No
Arthritis/Gout	☐Yes ☐No	Emphysema	☐Yes ☐No	High Cholesterol	☐Yes ☐No	Sinus Trouble	☐Yes ☐No
Artificial Heart Valve	☐Yes ☐No	Epilepsy or Seizures	☐Yes ☐No	Hives or Rash	☐Yes ☐No	Spina Bifida	☐Yes ☐No
Artificial Joint	☐Yes ☐No	Excessive Bleeding	☐Yes ☐No	Irregular Heartbeat	☐Yes ☐No	Stomach/Intestinal Disease	☐Yes ☐No
Asthma	☐Yes ☐No	Fainting Spells/Dizziness	☐Yes ☐No	Kidney Problems	☐Yes ☐No	Stroke	☐Yes ☐No
Autism	☐Yes ☐No	Frequent Cough	☐Yes ☐No	Leukemia	☐Yes ☐No	Swelling Limbs	☐Yes ☐No
Blood Disease	☐Yes ☐No	Frequent Diarrhea	☐Yes ☐No	Liver Disease	☐Yes ☐No	Thyroid Disease	☐Yes ☐No
Blood Transfusion	☐Yes ☐No	Frequent Headaches	☐Yes ☐No	Low Blood Pressure	☐Yes ☐No	Tonsillitis	☐Yes ☐No
Breathing Problem	☐Yes ☐No	Genital Herpes	☐Yes ☐No	Lung Disease	☐Yes ☐No	Tuberculosis	☐Yes ☐No
Bruise Easily	☐Yes ☐No	Glaucoma	☐Yes ☐No	Mitral Valve Prolapse	☐Yes ☐No	Tumors or Growths	☐Yes ☐No
Cancer	☐Yes ☐No	Hay Fever	☐Yes ☐No	Osteoporosis	☐Yes ☐No	Ulcers	☐Yes ☐No
Chemotherapy	☐Yes ☐No	Heart Attack/Failure	☐Yes ☐No	Pain in Jaw Joints	☐Yes ☐No	Venereal Disease	☐Yes ☐No
Chest Pains	☐Yes ☐No	Heart Murmur	☐Yes ☐No	Psychiatric Care	☐Yes ☐No	Other: list below	☐Yes ☐No
Cold Sores/Fever Blisters	☐Yes ☐No	Heart Pacemaker	☐Yes ☐No	Radiation Treatment	☐Yes ☐No		
Congenital Heart Disorder	☐Yes ☐No	Heart Trouble/Disease	☐Yes ☐No	Renal Dialysis	☐Yes ☐No		

Have you ever had any serious illness not listed above? ☐Yes ☐No If yes, please explain_____

MEDICATIONS – List any medications you are currently taking and the correlating diagnosis:

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN_____ DATE_____

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CANCELLATION & CONFIRMATION POLICY

When patients cancel appointments on short notice, it denies other patients the opportunity to be seen as quickly as possible. We ask that you please cancel appointments by calling the office within a full 48 hours (2 business days) of your appointment. Texts and emails are not an acceptable means of cancellation.

Broken appointments incur a $50 fee per hour if canceled within 2 business days. For longer appointments such as crowns and root canals, this fee could be **$100-150.** This policy allows us to offer appointments to other patients who may be waiting or in pain and helps our team maintain a smooth, efficient schedule.

Print (Patient/Parent/Guardian) Name: _____
Signature: _____ Date ____/____/_____

OFFICE PAYMENT & INSURANCE POLICY

At our office, we strive to provide high-quality care while maintaining transparent financial policies. Our office utilizes additional material fees that are not covered by insurance and will not be present on an EOB or Pre-estimate. This fee covers the cost of materials used that are above industry standard. Payment is due at the time of service. We accept cash, checks, Cherry, and most major credit cards for your convenience. Balances over 30 days must be paid in full before scheduling any additional appointments.

- We accept insurance on assignment, meaning we will file claims on your behalf. However, you must pay your deductible and any patient portion at the time of service.
- Your **estimated** portion is due at the time of your visit. If your insurance does not cover the estimated amount, you will be responsible for the remaining balance.
- Our office **does not guarantee** that your insurance will pay. If a claim is unpaid after **60 days**, you may be billed directly. Any balance **not paid within 90 days** may be turned over to collections.
- Our office **will not** enter disputes with insurance companies regarding claim denials. Filing claims is a **courtesy** we provide, but it is ultimately **the patient's responsibility** to know and understand their insurance benefits. If a claim is denied, we will notify you and provide any necessary documentation for you to dispute the claim directly with your insurer.

I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Aesthetic Family Dental may use my health care information and may disclose such information to my insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.
Print (Patient/Parent/Guardian) Name: _____
Signature: _____ Date ____/____/_____

PHOTO CONSENT

I, _____ grant permission to Aesthetic Family Dental and its employees the irrevocable and unrestricted right to reproduce the photographs and/or video images taken of me or members of my family, for the publication, promotion, or advertising, in any manner or in any medium. I hereby release Aesthetic Family Dental and its legal representatives for all claims and liability relating to said videos or images. OR **___ I DO NOT give permission.**

Print (Patient/Parent/Guardian) Name: _____
Signature: _____ Date ____/____/_____

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PATIENT CONSENT FOR USE OF ARTIFICIAL INTELLIGENCE (AI)

Our dental practice uses certain Artificial Intelligence ("AI") technologies to support and enhance patient care, administrative operations, and clinical documentation. AI technology is used only as a tool to assist qualified dental professionals. Final clinical decisions are made solely by licensed dentists and appropriate clinical staff.

By signing this form, I acknowledge and understand that AI technologies may be used to assist dental professionals in evaluating records, images, and other clinical information. AI-generated information does not replace professional judgment, diagnosis, or treatment recommendations. A licensed dentist will review relevant clinical information and make all final decisions regarding my diagnosis, treatment, and care. My protected health information ("PHI"), including dental records, radiographs, photographs, treatment plans, and clinical notes, may be processed by AI systems used by the practice. Such use will be conducted in accordance with applicable federal and Pennsylvania privacy laws, including HIPAA where applicable. The practice takes reasonable measures to safeguard patient information and uses vendors that are expected to maintain appropriate security protections and confidentiality obligations. AI systems may occasionally produce inaccurate, incomplete, or incorrect results. Any AI-generated recommendations will be reviewed by dental professionals before being relied upon for patient care. I voluntarily consent to the use of AI technologies by the dental practice as described above.

Print (Patient/Parent/Guardian) Name: _____

Signature: _____ Date ____/____/_____

HIPAA- AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient's Name _____D.O.B. _____/_____/_____

Authorization for release of Protected Health Information to family members, significant others, and/or friends.

I authorize the release of all health information including diagnosis, dental records, digital x-rays rendered, and the release of financial and/or insurance claims information. This authorization for the release of information will remain in effect until terminated in writing.

This information may be released to:

Name: _____Relationship: _____

Name: _____Relationship: _____

(__) Information may only be released to me.

Authorization for release of PHI to Dental/Medical Professionals for treatment, payment and healthcare operations.

I authorize the release of my Protected Health Information as necessary for treatment, payment and healthcare operations by electronic transmission, including e-mail, facsimile and by U.S. Mail. It is the policy of Aesthetic Family Dental to protect the electronic transmission of PHI as well as to fulfill our duty to protect the confidentiality and integrity of our patient's PHI as required by law, professional ethics, and accreditation requirements. The information released will be limited to the minimum necessary to meet the requestor's needs.

Acknowledgement of receipt of Notice of Privacy Practices

I have read and/or been given a copy of Aesthetic Family Dental Notice of Privacy Practices, which describes how my health information is used and shared. I understand that Aesthetic Family Dental has the right to change this notice at any time. I understand that I may obtain a current copy by asking Aesthetic Family Dental. My signature below acknowledges that I have read and/or been provided with a copy of the Notice of Privacy Practices.

Print (Patient/Parent/Guardian) Name: _____

Signature: _____ Date ____/____/_____