Patient ID #
For Office Use:

A One Day Dentures

Patient History Information

Name: _____
(First Name) (Middle Name) (Last Name)

Sex: ____M ____F Date of Birth: ___/___/___ Single: ___ Married: ___ Divorced: ___

Social Security Number: _____-_____-_____ Email: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Race: __African American __Asian American __Caucasian __Hispanic __Other

Name of Family Physician: _____ City: _____ State: _____

Physician Phone: _____ Emergency Contact: _____ Phone: _____

Name of Pharmacy: _____ City: _____ State: _____

Pharmacy Phone: _____

PLEASE ANSWER THE FOLLOWING QUESTIONS:

*What is your reason for today's visit: _____

_____

*Have you received treatment in our office previously? ____Yes ____No

If so, when?_____

*How did you first learn about A One Day Dentures, P.C. (circle one)

1. Magazine 2. Newspaper
3. Radio 4. Billboards/Sign
5. Brochure/Mail 6. Television
7. Yellow Pages 8. Friend/Relative
9. Internet/Website

*Did you call our toll-free information service? __Yes __No

IF YOU HAVE INSURANCE, PLEASE LET THE FRONT DESK KNOW RIGHT AWAY

*****PAYMENT IS DUE AT TIME OF SERVICE*****

DENTAL INSURANCE

Primary Insurance Company:
Group Number:
Employer:
Business Phone:
Employee:
Date of Birth:
Employee Social Security Number:

Secondary Insurance Company:
Group Number:
Employer:
Business Phone:
Employee:
Date of Birth:
Employee social Security Number:

Do you currently have partials or dentures? ___Yes ___No

If yes, how long? _____

DENTAL HISTORY

Please circle

YES	NO	Are you wearing dentures or partials? (please circle which one)
YES	NO	If yes, do you use denture adhesives (cream, powder or paste)?
YES	NO	Have you had teeth extracted in the past?
		If yes, any problems?
YES	NO	Have you ever had bad reactions to dental anesthesia? (Novacaine?)
		If yes, please explain
YES	NO	Do you grind your teeth?

MEDICAL HISTORY

Have you ever had or do you have any of the following:
(Please circle all that apply)

Allergies	Heart Murmur
Asthma	Headaches
Anemia	Hepatitis
Angina	Hypertension (High Blood Pressure)
Anxiety	Immune System Disorder (including HIV / AIDS)
Arthritis	Irregular Heartbeat
Bleeding Problems	Jaundice
Breathing Problems	Liver Disease
Cancer	Psychiatric Disorders
Circulation Problems	Prosthetic (false) joints, hips, valves
Depression	Rheumatic Fever
Diabetes	Sinusitis
Epilepsy (seizures)	Stroke
Fainting Spells	Tuberculosis
Gout	Venereal Disease
Heart Attack / Heart Trouble	Other Illness

Please circle

YES	NO	Do you smoke or use tabacco?
YES	NO	Do you use illegal drugs (marijuana, cocaine, etc.)?
YES	NO	Do you drink alcoholic beverages?
YES	NO	Do you take birth control pills or use other forms of hormonal contraceptives?
YES	NO	Do you grind your teeth?

List all your medications, prescription & over-the-counter (including herbal) supplements:

1. _____	11. _____
2. _____	12. _____
3. _____	13. _____
4. _____	14. _____
5. _____	15. _____
6. _____	16. _____
7. _____	17. _____
8. _____	18. _____
9. _____	19. _____

To the best of my knowledge, the above questions have been answered accurately. I understand that the fee for dentures, extractions, and other services must be paid on the first visit after you are seen by the dentist. The practice gladly accepts cash, major credit cards, and Care Credit as payment; however, we are unable to accept personal checks.

Patient Signature: Date:

Patient Consent for
Use and Disclosure of Health Information
𝒜 One Day Dentures, P.C. 1325 W 14 Mile Rd, Madison Heights, MI 48071

By signing, I authorize ***A One Day Dentures, P.C.*** to use and/or disclose my protected health information (PHI) to carry out treatment, payment activities and healthcare operations.

I understand I have the right to read the Notice of Privacy Practices before I decide whether to sign this Consent. The notice provides a description of treatment, payment activities, and healthcare operations, the uses and disclosures ***A One Day Dentures, P.C.*** may make of my protected health information, and of other important matters about my protected health information. A copy of the notice accompanies this consent and I am encouraged to read it carefully and completely before signing this consent.

I understand that at any time I may obtain the most recent version of the Notice of Privacy Practices by contacting the following office:

𝒜 One Day Dentures, P.C.
Address: 1325 W 14 Mile Rd, Madison Heights, MI 48071
PH: (248)577-1300 FAX: (248)577-0100

I understand that I have the right to refuse to sign this consent. ***A One Day Dentures, P.C.*** will not condition my treatment (and, if applicable, payment for my health care or eligibility for benefits) on whether I provide authorization for the requested use of disclosure-except in limited circumstances. (e.g. If the treatment is research-related or is necessary for the purpose of creating protected health information for disclosure to a third party.)

I understand that I have the right to revoke this Consent in writing by sending my revocation to the Contact Officer listed above. I understand that revocation of the Consent will not affect any action(s) taken by A ***One Day Dentures, P.C.*** before they received my written revocation.

I understand this authorization will expire on: ***One year from today's date.***

I._____, have had full opportunity to read and consider the content of the Consent and the Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information (PHI) in order to carry out treatment, payment activities and health care operations.

Signed by:_____ Date:_____
Signature of Patient or Legal Guardian

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTILTLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT

A One Day Dentures

"Home of the One Day Dentures"
1325 W. 14 Mile Rd. Madison Heights, MI 48071
Phone (248)577-1300 • Fax (248) 577-0100

FINANCIAL POLICY

Payment Policy:

- Full payment is due at the time the services are provided. This includes the insured patient's estimated copayments.
- For treatments requiring more than one visit, A One Day Dentures requires a down payment of at least 70% of the treatment plan total with the remaining balance due prior to delivery of your prosthesis.
- Patients are responsible for balances of any portion unpaid by your dental insurance, even after the initial estimated copayment has been paid.

Refund Policy:

- Should you discontinue treatment and request a refund, A One Day Dentures will issue a refund for any services not received. A One Day Dentures will not issue refunds once dentures or partials have been **completed /processed**; additionally, all remaining balances are the patient's sole responsibility.
- Dentures and partials not **completed /processed**, "In Progress", can be refunded: less lab fees which is a minimum of **$500 per prosthesis or 10% of total treatment plan whichever is greater.**
- Refunds for approved amounts are issued within 15 business days from the request date. Cash payments are refunded by check.
- All Immediate Denture/Partial treatment plans are nonrefundable and must be completed within 1 year from the date treatment is started. Requests after 1 year will incur additional fees.

Forms of Payment:

- A One Day Dentures accepts cash, Visa, MasterCard, Care Credit, certified checks, and money orders.

I have read the following A One Day Dentures Financial Policy and I have agreed to the terms.

Signature_____ Date_____

I have been informed of the treatment plan and the estimated fee. I accept responsibility for all charges including those not paid by my insurance company under the guidelines stated above.

Signature_____ Date_____

If agreement is signed by a personal representative on behalf of the patient, complete the following as the responsible party:

Personal representative name: _____