W. Kane Fulton, D.M.D
1000 Chestnut Street
Vestavia Hills, Al 35216
www.fulton-dental.com

Welcome to our office! We appreciate the confidence you place in us to provide your dental care. To assist us in better serving you, please complete the following confidential forms.

Patient Information

Patient Name: ______________________________ **Preferred Name:** ____________
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other

Social Security #: ____________________ **Birth Date:** ____________________

Phone (Home): ____________ **(Cell):** ____________ **(Work):** ____________

Email Address: ______________________________

Preferred appointment times: ☐ Morning ☐ Afternoon ☐ Evening ☐ Any Time ☐ Mon ☐ Tue ☐ W ☐ TH

Address: ______________________________
Street Apt#

____
City State Zip Code

Spouse or Responsible Party Information

The following is for: ☐ Self ☐ the patient's spouse ☐ the patient's parent ☐ the person responsible for payment

Name: ______________________________

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other

Social Security #: ____________________ **Birth Date:** ____________________

Phone (Home): ____________ **(Cell):** ____________ **(Work):** ____________

Address: ______________________________
Street Apt #

____
City State Zip Code

Employment Information

The following is for: ☐ Self ☐ the patient's spouse ☐ the patient's parent ☐ the person responsible for payment

Employer's Name: ____________________ **Occupation:** ____________________

Address: ______________________________
Street City State Zip Code

Referral Information

Whom may we thank for referring you to our practice? ______________________________

☐ Dental Office ☐ Patient ☐ Friend ☐ Work ☐ Yellow Pages ☐ Website ☐ Movie Theatre ☐ Other

Dental Insurance Information

Insurance Plan Name and Address: ____

Name of Insured: ______________________________________ **is insured a patient?** ☐ Yes ☐ No
Last First MI

Insured's Birth Date: ______________ **ID #:** ____________________ **Group #:**________________

Insured's Address: ____
Street City State Zip Code

Insured's Employer Name: ____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other ______________________________

Secondary:
Insurance Plan Name and Address: ____

Name of Insured: ______________________________________ **is insured a patient?** ☐ Yes ☐ No
Last First MI

Insured's Birth Date: ______________ **ID #:** ____________________ **Group #:** ________________

Insured's Address: ____
Street City State Zip Code

Insured's Employer Name: ____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other ______________________________

Cosmetic Information

Are you happy with your smile? ☐ Yes ☐ No

Is there anything you would like to change about your smile? ☐ Yes ☐ No **If yes, please explain:** ________________

Would you like whiter teeth? ☐ Yes ☐ No

Would you like to have straighter teeth? ☐ Yes ☐ No

Do you have missing teeth? ☐ Yes ☐ No

Do you have chipped or uneven teeth? ☐ Yes ☐ No

Do you have old fillings or dental treatment that you are unhappy with? ☐ Yes ☐ No **If yes, please explain:** __________

Permission to Use Photographs

As an educational tool for our patients and/or potential patients, we often take photographs to better explain aspects of your existing dental health or planned treatment to you. We request your permission to show these photographs to better explain treatment options to other patients.

I hereby give Fulton Dental the right and permission to use my photographs for educational or promotional purposes in print and/or electronically, including for example such purposes as publicity, illustration, advertising and web content.

Signature of patient, parent or guardian: ________________________________ **Date:** ______________

Fulton Dental

Health Information

Previous Dentist Name: ______________________________________ Date of Last Dental Visit: __________________

Do you have, or have you ever had any of the following? Please check those that apply:

☐ AIDS/HIV
☐ Allergies
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Cancer__________
☐ Chew Tobacco
☐ Depression
☐ Diabetes
☐ Dizziness
☐ Drug/Alcohol Abuse
☐ Eating Disorders
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Growths
☐ Hay Fever
☐ Headaches
☐ Head Injuries
☐ Heart Conditions
☐ Heart Murmur
☐ Heart Stent
☐ Hepatitis A
☐ Hepatitis B
☐ Hepatitis C
☐ High Blood Pressure
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Mitral Valve Prolapse
☐ Nervous Disorders
☐ Osteoporosis
☐ Pacemaker
☐ Pregnancy
Due date:__________
☐ Psychiatric Problems
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Seizures
☐ Sinus Problems
☐ Smoke? How much per day__________
☐ Stent
☐ Stomach Problems
☐ Stroke
☐ Thyroid Disease
☐ Tuberculosis
☐ Tumors
☐ Ulcers

☐ Codeine Allergy
☐ Latex Allergy
☐ Penicillin Allergy
☐ Sulfa Allergy

- Reason for this visit: ____
- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
- Do you need to pre-medicate before dental treatment? ☐ Yes ☐ No If yes, please explain: ______________________________
- Do your gums bleed while brushing or flossing? ☐ Yes ☐ No
- Do you have swollen or irritated gums? ☐ Yes ☐ No
- Are your teeth sensitive to sweets, hot or cold? ☐ Yes ☐ No If yes, please explain: ___________________________________
- Are any of your teeth loose? ☐ Yes ☐ No
- Do you experience bad breath regularly? ☐ Yes ☐ No
- Do you have pain on any of your teeth? ☐ Yes ☐ No
- Do you need nitrous (gas) for dental visits? ☐ Yes ☐ No
- Do you have frequent headaches? ☐ Yes ☐ No
- Do you wake up with headaches? ☐ Yes ☐ No
- Do you notice your jaw clicking or popping ☐ Yes ☐ No
- Do you clinch and/or grind your teeth? Yes or No If yes, please explain: ____
- Do you snore or have you been told you snore? Yes or No: ____
- Do you have Sleep Apnea? Yes or No If yes, please explain: ____
- Do you wear a CPAP? Yes or No If yes, please explain: ____
- Do you have any health problems that need further clarification? If yes, please explain: _______________________________

Signature of Patient, parent or guardian: ____ Date: __________________

Financial Policy

We are committed to providing you with the best possible care. If you have dental insurance, we anticipate helping you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy. We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize however, that:

1. Your insurance is a contract between you and your employer and the insurance company. We are not a party to that contract.
2. Not all services are covered in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
3. Co-payments, deductibles and your estimated out of pocket must be paid at the time of service.
4. Some dental insurances will send payment reimbursement to the patient only, if this applies to your dental contract, then payment will be due at the time of service.
5. If you have no insurance, payment for service is due at the time of service *unless* payment arrangements have been approved in advance by our staff. We accept cash, checks, Visa, MasterCard, Discover, and American Express.

We must emphasize that our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patient, all charges are your responsibility from the date the services are rendered and are to be paid in full within 90 days. We realize that temporary financial problems may arise and we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information, or any uncertainty regarding insurance coverage, please do not hesitate to ask us. We are here to help you.

Responsibility for Non-Covered Sevices

There are certain routine services that are necessary for the maintenance of good health and standard dental care, but are not covered by insurance contracts. I hereby acknowledge, understand and agree to be fully responsible for any and all amounts charged by Fulton Dental for any non-covered services. Any questions regarding whether a certain service is covered by my insurance contracts should be discussed with someone in the office of my insurance carriers. We do not render services on the basis that the insurance companies will pay our fees.
I understand and agree to pay for any and all services not covered by my insurance contract.
I grant my permission to Fulton Dental to contact me at home or work to discuss matters related to this form.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by Dr. Fulton, I agree to pay therefore the reasonable value of said services, at the time services are rendered, or within five (5) days of billing if credit shall be extended. I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

Consent Form

I hereby authorize Fulton Dental and its licensed providers to treat me or the person under my care with the following dental procedures (if or when needed): prophylaxis (dental cleaning), restorations (fillings), crowns (caps), fixed bridgework, cosmetic dentistry, non-surgical treatment of the gums, nitrous oxide (laughing gas), all emergency services and any other treatment Dr. Fulton considers necessary to create better health for my mouth. I understand that no guarantees or warranties have been made to me concerning the results of treatments or procedures.

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures.

I have read and fully understand all of the information provided.

Signature of Patient, parent or guardian: ____ Date: ______________________