Advanced AD Dentistry at Century Square

Dr Andreea Larhs, DDS, PS

Personal Information

Full Name:_______________________________ I prefer to be called:________________

Person responsible for account:_______________________________

Home Address:_______________________________CITY____________STATE_____ZIP________

Mailing Address:_______________________________CITY____________STATE_____ZIP________

SSN:________________ DOB:______________ Drivers License/State Issued: ____________________

Home Phone: ______________ Cell Phone: ______________ Work Phone: ______________ Email: ____________________

Where would you like to be contacted for appointment reminders? Please circle: Home / Work / Cell / Email

Employer:_______________________________ Occupation: ____________________

Employer Address:_______________________________CITY____________STATE_____ ZIP ________

Married_______ Single ________ Domestic Partner _______Widowed________ Other: ____________________

Spouse/Partner's Name:_______________________________DOB:____________________

Spouse's Employer:_______________________________

Emergency Contact NOT living with you:_______________________________ Ph. #________________

Who may we thank for your referral? ☐ Coworker/Friend (Name)________________ ☐ Google/ Review Site ____________

☐ Referring Doctor/ Clinic (Name) ________________ ☐ Work in Building ☐ Insurance PPO ☐ Other ____________

Primary Insurance Information

Name of Insured:_______________________________ SSN:____________________ DOB:____________

Employer:_______________________________ Policy #:____________________ Group #____________

Insurance Co._______________________________ Insurance Co. Address: ____________________

Insurance Co. Phone #:_______________________ City:________________ STATE_____ ZIP:________

Secondary Insurance Information (if applicable)

Name of Insured:_______________________________ SSN: ____________________ DOB:____________

Employer:_______________________________ Policy #: ____________________ Group #____________

Insurance Co._______________________________ Insurance Co. Address:_______________________________

Insurance Co. Phone #:_______________________ City:________________STATE_____ZIP:________

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Your Oral Health History

Reason for today's visit? ______________________________

Are your teeth sensitive to hot, cold, sweets or pressure? ______________________________

Is there anything you would like to change with your smile? ______________________________

Would you like to know more about: ☐ Veneers ☐Implants ☐Whitening ☐Botox/Dermal Fillers ☐Other: ________________

Have you ever suffered from prolonged dry mouth? ______________________________

Do you wear dentures/partials? ______________________________

Have you ever had jaw pain/clicking/popping? ______________________________

Have you ever had injuries to teeth/jaw/jaw joints? ______________________________

Do you have any fears/concerns about dental treatment? ______________________________

Have you ever had any unusual experiences with dental care? ______________________________

Anything else you would like us to know about your dental history and / or experiences? ______________________________

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PLEASE READ

Responsibilities and Release:

I understand that I am financially responsible for all charges whether paid by insurance or not. I authorize the doctor to release all information necessary to secure payment of benefits. I authorize and request my insurance company to pay directly to the dentist the insurance benefits otherwise payable to me. I authorize the use of my signature below on all insurance submissions. I understand that my dental insurance may pay less than the actual bill of services.

Responsible Party Signature:______________________________ Date: ________________

Relationship to Patient:______________________________

Office Guidelines:

- As a courtesy to you we will bill your insurance; however this is NOT a guarantee of insurance payment. Payment of dental services not covered or paid by your insurance is required at the time services are provided.
- For your convenience financing may be obtained for full and/or partial treatment through CareCredit, a third party financing company. We can help you with the application process.
- **YOUR APPOINTMENT IS SPECIFICALLY RESERVED FOR YOU.** A fee of $**60.00 PER HOUR** will be charged to and paid by the patient for any appointment that is cancelled without at least two business days notice.
- A 1.5% per month (18% annually) finance charge may be added to any account with a past due balance of 90 days starting from the date services are rendered.
- We do not accept DSHS, Medicare or Medicaid.
- Nitrous oxide is available at $52.00 per hour. Payment is due at the time of service. This is not a covered benefit on any insurance plan.
- Parking validation for your dental appointment is available at the 3rd and Stewart garage only.

I have read and understand the above stated guidelines and services.

Responsible Party Signature:______________________________ Date: ________________

Relationship to Patient:______________________________