AVANT DENTISTRY

Patient Name: _____ Today's Date:_____
Last, First MI (Preferred Name)

Email: _____ (*for appointment reminders and helpful dental facts*)

Sex: M F Preferred pronoun:_____ Marital Status: _____ Birth Date: _____ S.S *#:*_____

Phone (Home): _____ (Cell): _____ (Work): _____ Preferred #: (please circle) Home Cell Work

Address: _____
Street Apartment #

_____
City State Zip Code

Preferred Pharmacy:_____ Phone:_____

Health Information

Date of Last Dental Visit: _____ Reason for today's visit: _____

Have you ever had any of the following? Please check those that apply:

- ☐ Acid Reflux/GERD
- ☐ Allergies _____
- ☐ Anemia
- ☐ Anticoagulants
- ☐ Arthritis
- ☐ Artificial Joints:_____
- ☐ Asthma
- ☐ Blood Disorder
- ☐ Cancer/Chemo/Radiation tx
- ☐ Diabetes:_____
- ☐ Dizziness/Vertigo
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV
- ☐ IV Bisphosphonates
- ☐ Joint Replacement
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Migraines
- ☐ Nervous Disorders
- ☐ Oral Bisphosphonates
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Premedication:_____
- ☐ Pregnancy
  Due date:_____
- ☐ Pulmonary Embolism
- ☐ Radiation Treatment
- ☐ Recreational drugs (THC, CBD products, etc.)
  Type: _____
- ☐ Respiratory Problems
- ☐ Rheumatism
- ☐ Seizure disorder:_____
- ☐ Sinus Problems
- ☐ Sleep Apnea
- ☐ Smoking / Tobacco
  __#packs/day? __Years?
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy

OTHER:

☐ _____

Please list any current medications (both prescription & over the counter):_____

_____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician & address: _____ Phone: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature of patient, parent or guardian : _____ Date:_____

Spouse or Responsible Party Information

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

Name: _____

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

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address_____
Street City, State Zip Code Phone

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Stree**t** City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

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

Insurance Plan Name and Address: _____

_____

Release of Information

In accordance to the HIPAA Privacy Act, please note that for all patients over the age of 18, we are unable to release any information (including but not limited to treatment plan, treatment history, appointment dates, financial information, insurance information, etc.) to anyone (including family members, policy holders, etc.) unless given written authorization. Please list the name(s) of the person(s) you allow us to share your information. If none, please write "NONE."

Name	Relationship to patient	Phone number

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐Another patient, relative

☐ Google ☐ Yelp ☐Facebook ☐ Website ☐ Insurance company ☐Washingtonian Magazine ☐ Other _____

Name of person or office referring you to our practice: _____

Consent for Services

Consent for Services:

1. I hereby authorize the doctor or designated staff to take x-rays, study models, photographs and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis.
2. Upon such diagnoses, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to be responsible for payment of all services on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1/2% late charge (18% APR) may be added to my account.
4. I hereby give Dr. Yu the absolute right and permission to use my photographs/ slides for educational or promotional purposes. The undersigned completely and forever releases any right to present or future compensation in connection with the use of said photographs/slides.

Cancellation Policy (see our Financial Policy for more details):

We, at Avant Dentistry, kindly request 48 business hour notice for appointment cancellations and last minute re-scheduling. We never double-book our appointment slots—this allows us to give you the attention and the highest quality of care on which we pride ourselves. We reserve the right to assess a fee, up to 25% of the estimated treatment cost or reservation deposit, on your account. While we understand that unforeseen circumstances may occur, we ask that you please respect the time that we have reserved exclusively for you.

I have read the above conditions (1 through 4) of treatment and policies, and agree to their content.

_____ Date: _____ Relationship to Patient: _____

Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible party

Acknowledgement of Receipt of HIPAA Notice of Privacy Practices

I acknowledge that I have reviewed/received a copy of Avant Dentistry's HIPAA Notice of Privacy Practices. If I lose my copy, I am aware that I can request a new copy at any time.

_____ Date: _____ Relationship to Patient: _____

Signature of patient, parent or guardian

AVANT DENTISTRY'S FINANCIAL POLICY

At Avant Dentistry, we are committed to delivering the highest quality dental care. This commitment is reflected in:

- Using the **best available dental materials** and **top-tier laboratories** to ensure excellent, lasting results
- Pursuing ongoing **continuing education** to stay at the forefront of dental advancements
- Offering **dedicated, unrushed appointment time** to give each patient the personal care and attention they deserve.

To maintain this high standard of care, we have established the following financial policies:

Payment Policy

- **Payment is due at the time services are provided.**
- We accept **cash, check**, and all major credit cards. **3% merchant fee** will be charged for **all credit cards**. Debit cards (this includes FSA/HSA cards), however, are exempt of a merchant fee.
- We also offer **financing through Cherry**—please speak with a team member for details.
- **Returned checks** and **balances over 60 days** are subject to **collection fees** and a **finance charge of 1.5% per month (18% annually).**

Treatment Reservation Deposit

- We require a **Reservation Deposit of 25% of the estimated treatment cost** for all reserved treatment appointments.
- This amount will be applied to your future treatment and helps us reserve dedicated time for your care.

Cancellation & Rescheduling Policy

To ensure fairness and efficiency in our scheduling, we request the following:

- Please provide **at least 48 business hours** notice for all cancellations or appointment changes.
- **Business hours are Monday–Thursday, 9:00 AM to 5:00 PM.**
    - For Monday appointments, cancellations must be made by the **previous Wednesday during business hours** to avoid penalties.
- This policy applies to **all appointments**, including those canceled due to **illness**.
    - We understand that emergencies can happen, so we offer a **one-time courtesy waiver** in the event of illness or other unforeseen circumstances.
    - After this waiver is used, **standard cancellation/rescheduling fees** will apply:
        - For **routine hygiene appointments**: a **$125 fee** will be charged.
        - For **treatment appointments** (e.g. deep cleanings, crowns, root canals, fillings): a fee equal to **25% of the originally estimated cost** will be charged (i.e., the Treatment Reservation Deposit).

Dental Insurance

- For those with dental insurance, we will gladly assist in filing claims. We are considered out-of-network for all dental plans. We will file all necessary paperwork for you with our fees due at the time services; your insurance company will then reimburse you directly based upon your plan.

By choosing our practice, you are choosing quality without compromise. We thank you for valuing the level of care we are proud to provide.

I, _____(*print name)* have read, understand, and agree to adhere to Avant Dentistry's Financial Policy, and by signing, I grant permission for Avant Dentistry to submit claims to my insurance company on my behalf.

Signature: _____ Date: _____

Patient: _____

Today's Date: _____

Adult Airway Screening Form

Adult Airway Questionnaire	Yes (Y)/ No (N)
Do you breathe through your nose?	
Do you have any nasal allergies?	
Do you snore or have you been told you snore while sleeping?	
Do you stop or pause your breathing while sleeping?	
Do you wake up fatigued?	
Do you have morning tension or migraine headaches?	
Do you easily get tired or fall asleep during the day?	
Do you clench or grind the teeth during the night?	
Do you clench or grind the teeth during the day?	
Do you have facial pain?	

NOSE (Nasal Obstruction Symptoms Evaluation) Questionnaire

Over the past 1 month, how much of a problem were the following conditions for you?

	Not a problem (0)	Very MILD (1)	MODERATE (2)	FAIRLY BAD(3)	SEVERE (4)
Nasal Congestion or stuffiness					
Nasal Blockage or obstruction					
Trouble breathing through my nose					
Trouble Sleeping					
Unable to get enough air through my nose during exercise or exertion					

NOSE score (multiply your score *5): _____

Patient: _____

Today's Date: _____

Child Age: _____years _____months

Pediatric Airway Questionnaire (Y)/ (N)

While sleeping, does your child snore more than half the time?	
While sleeping, does your child always snore?	
While sleeping, does your child snore loudly?	
While sleeping, does your child have "heavy" or loud breathing?	
While sleeping, does your child have trouble breathing, or struggle to breathe?	
Have you seen your child stop breathing during the night?	
Does your child occasionally wet the bed, sleepwalk, or have night terrors (circle any)?	
Does your child tend to breathe through the mouth during the day?	
Does your child have a dry mouth on waking in the morning?	
Does your child wake up unrefreshed in the morning?	
Does your child wake up with headaches in the morning?	
Is it hard to wake up your child in the morning?	
Does your child have a problem with sleepiness during the day?	
Has a teacher or supervisor commented-your child appears sleepy during the day?	
Did your child stop growing at a normal rate at any time since birth?	
Is your child overweight?	
This child does not seem to listen when spoken to directly	
This child often has difficulty organizing tasks and activities	
This child often is easily distracted by extraneous stimuli	
This child often fidgets with hands or feet, or squirms in seat	
This child often is "on the go" or often acts as if "driven by a motor"	
This child often interrupts or intrudes on others (butts in conversations or games)	