Once you have completed the enclosed forms, please return them to Accessible Dental Services via the fax, e-mail, or the mailing address listed below:

Fax: (724) 772-9642
E-mail: schedule@accessibledental.org
Mailing Address:
Accessible Dental Services, Inc.
P.O. Box 189
641 Reno Street
Rochester, PA 15074

For any questions, please call or email us at:

Phone: (724) 775-0448 x3009 (Please leave a voicemail – we will return your call)
Email: schedule@accessibledental.org

PATIENT INFORMATION

PLEASE PRINT VERY CLEARLY

Patient Name: _____ Date: _____/_____/_____

Address: _____
Street City State Zip Code

Date of Birth: _____ Social Security Number: _____

Patient's Agency: _____ House Name: _____

Day Phone #: _____ Night Phone #: _____

Agency Contact Name: _____ Phone #: _____

Emergency Contact: _____ Phone #: _____

Medical Insurance: _____
Name Subscriber # Group #

Dental Insurance: _____
Name Subscriber # Group #

Please provide a copy of insurance cards if able.

Does your insurance (Med/Dent) require a Preauthorization? Yes ☐ No ☐

Primary Care Physician: _____
Name Phone #

Address: _____
Street City State Zip Code

Authorization: I hereby authorize payment directly to Accessible Dental Services, Inc. of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment.
I hereby authorize Accessible Dental Services, Inc. to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the anesthesia/dental medical histories are correct to the best of my knowledge. I grant the right to the dentists to release my anesthesia/dental histories and other information about my dental treatment to third party payors and/or other health professionals.

Signature: _____ Date: _____/_____/_____

ACCESSIBLE DENTAL SERVICES INC.

PRE-ANESTHETIC QUESTIONNAIRE AND MEDICAL HISTORY

Patient Name: _____ Date of Birth: _____/_____/_____

Who is providing this information? Name: _____ Date: _____/_____/_____

Relationship to Patient: ☐ Physician ☐ Nurse ☐ House Manager ☐ Parent ☐ Patient

Patients Information: Age: _____ Height: _____ Weight: _____ lbs. Sex: Male ☐ Female ☐

Patient's Physician Name: _____ Phone Number: _____

Date of last PCP visit: _____/_____/_____ Reason: _____

Has the patient had any emergency medical treatment in the last two years: Yes ☐ No ☐
If Yes, Reason: _____
Has the patient had a serious illness or operation? Yes ☐ No ☐
List if any: _____
Has the patient experienced "trouble" with a previous anesthetic: Yes ☐ No ☐
If yes, please explain_____
Does the patient smoke? Yes ☐ No ☐ If Yes, how many packs per day and how long? _____

Has the patient had any allergies or adverse reactions to any drug or medication? Yes ☐ No ☐
If Yes, List drugs and describe reaction: _____
Does the patient require an antibiotic before dental treatment due to heart defects or artificial joint replacement?
Yes ☐ No ☐ If Yes, what is the reason for antibiotic? _____
Is the patient on any blood thinners (ex: Coumadin, Warfarin, Plavix, or Aspirin)? Yes ☐ No ☐
If Yes, List: _____
List all medications on next page (page 2) ➔
Describe Physical limitations: None ☐ Needs Assistance (i.e. walker) ☐ Non-ambulatory (wheelchair) ☐
Describe the ability to communicate: Good ☐ Somewhat verbal ☐ Non-verbal ☐
Describe the patient's ability to interact: Easily follows instructions ☐ Needs guidance ☐ Combative ☐
Does the patient tolerate injections and/or blood draw: Easily ☐ Needs guidance ☐ Combative ☐

High Blood Pressure	Yes ☐	No ☐	Asthma	Yes ☐	No ☐	Intellectual Disability	Yes ☐	No ☐
Angina/Chest Pain	Yes ☐	No ☐	COPD/Emphysema	Yes ☐	No ☐	Seizures	Yes ☐	No ☐
Irregular Heart Beat	Yes ☐	No ☐	Shortness of Breath	Yes ☐	No ☐	Paralysis	Yes ☐	No ☐
Dizziness/Fainting	Yes ☐	No ☐	Coughing/Wheezing	Yes ☐	No ☐	Autism	Yes ☐	No ☐
Heart Attack	Yes ☐	No ☐	Sleep Apnea	Yes ☐	No ☐	Downs Syndrome	Yes ☐	No ☐
Stroke/CVA	Yes ☐	No ☐	Loud Snoring	Yes ☐	No ☐	Psychiatric Disorder	Yes ☐	No ☐
Mini-Stroke/TIA	Yes ☐	No ☐	Pneumonia	Yes ☐	No ☐	Exhibits Pica (eats objects)	Yes ☐	No ☐
Mitral Valve Prolapse	Yes ☐	No ☐	Aspirates Food	Yes ☐	No ☐	Crohn's Disease	Yes ☐	No ☐
Heart Surgery	Yes ☐	No ☐	Gastric Reflux	Yes ☐	No ☐	Ulcerative Colitis	Yes ☐	No ☐
Congenital Heart Defects	Yes ☐	No ☐	Requires Oxygen	Yes ☐	No ☐	Cancer/Malignancies	Yes ☐	No ☐
Abnormal Bleeding	Yes ☐	No ☐	Breathing Treatments	Yes ☐	No ☐	Bladder/Kidney Problems	Yes ☐	No ☐
Aspirin or Blood Thinners	Yes ☐	No ☐	Diabetes	Yes ☐	No ☐	Artificial Joints	Yes ☐	No ☐
Anemia	Yes ☐	No ☐	Requires Insulin	Yes ☐	No ☐	Limited neck Movement	Yes ☐	No ☐
Sickle Cell	Yes ☐	No ☐	Hyper/Hypothyroidism	Yes ☐	No ☐	Visual Impairment	Yes ☐	No ☐
Blood Transfusion	Yes ☐	No ☐	Hepatitis	Yes ☐	No ☐	Glaucoma	Yes ☐	No ☐
			HIV/AIDS	Yes ☐	No ☐	Hearing Impairment (Deaf)	Yes ☐	No ☐
			TB	Yes ☐	No ☐	Eczema	Yes ☐	No ☐

PRE-ANESTHETIC QUESTIONNAIRE AND MEDICAL HISTORY (Page 2)

Patient Name: _____

Please list all medications:

Medication	Strength	Frequency (i.e. qid, q6h, etc.)

Please list all Diagnoses:

1.
2.
3.
4.
5.
6.
7.
8.

CONSENT FOR COMPREHENSIVE DENTAL TREATMENT

Patient Name: _____ Date:_____/_____/_____

ACKNOWLEDGEMENT

I hereby authorize the dental office to administer such medication and provide comprehensive oral rehabilitation. I understand that the treatment may include, but is not limited to the following: comprehensive examination, full mouth x-ray series, cleaning and fluoride treatment, periodontal scaling and root planning, minor periodontal surgery, soft tissue excisions and biopsy of lesions, amalgam and composite restorations, crowns, bridges, root canal treatment and extractions.

I hereby certify that I am the legal guardian of the above referenced client or have otherwise been empowered to give consent on behalf of this client for dental treatment and extractions. This consent shall remain in force until unless otherwise terminated by me.

I have read the above, my questions have been answered, and I consent to Comprehensive Dental Treatment.

_____ _____/_____/_____
Name of Parent/Guardian (Please Print Full Name) Date

_____
Signature of Parent/Guardian

_____
Relationship to Patient (please include phone number of Parent/Guardian in case of emergency)

ACESSIBLE DENTAL SERVICES – PRIVATE PAY AGREEMENT

Patient Name: _____ Date:_____/_____/_____

ACKNOWLEDGEMENT

I have authorized Accessible Dental Services (ADS) to provide comprehensive oral treatment and/or rehabilitation for myself or for the above-named patient. I understand that the treatment and/or rehabilitation (i.e. comprehensive examination, full mouth x-ray series, cleaning and fluoride treatment, periodontal scaling and root planning, minor periodontal surgery, soft tissue excisions and biopsy of lesions, amalgam and composite restorations, crowns, bridges, root canal treatment and extractions) may not be covered entirely by my, or the patient's, insurance.

I hereby certify that I am the patient, the legal guardian of the above referenced patient, or have otherwise been empowered to give consent on behalf of this patient for dental treatment and extractions. As such, I agree that ADS may bill my, or the patient's, Medicare, Medicaid/Department of Public Welfare or other third party insurance for the dental treatment provided. Billing shall be the responsibility of ADS; I will cooperate to the degree necessary to provide documentation regarding insurance coverage, as from time to time it may be necessary to secure payment from the appropriate entity.

I am the patient and/or I agree to act as guarantor for any unpaid services and/or invoices that qualify for private pay. ADS will send a consolidated statement, of 30 days, to me as the patient or designee. Payment will be due 30 days from the consolidated statement date. In the event payment is not received, ADS reserves the right to recoup private pay charges for unpaid services via utilization of a collection agency. In the event that I, or the patient, does not qualify for dental coverage through an insurance plan, I will act as guarantor, and in accordance with the No Surprises Act, ADS will charge for services per the ADS Private Pay Fee Schedule outlined below. The ADS Private Pay Fee Schedule represents a good faith estimate of the fees for the services provided to you by ADS.

ADS Private Pay Fee Schedule

Non-Sedation Services	Services will be billed per the Pennsylvania Medical Assistance Program Dental Fee Schedule published at: https://www.dhs.pa.gov/providers/Documents/Dental%20Care/Dental%20Fee%20Schedule.pdf
Sedation Services	$1,500 for necessary dental services including, but not limited to: • Diagnostic and Preventative Care • Restorations • Periodontal Scaling and Root Planning • Extractions • Professional Anesthesia

I understand that ADS offers payment plans for dental services and that failure to pay in full and/or engage in a qualifying payment plan will disqualify myself and/or the patient from scheduling for future dental appointments with ADS.

I have read, understand, and agree to, the above. My questions have been answered and intending to be legally bound hereby I consent to the Private Pay Agreement for Comprehensive Dental Treatment.

_____ _____/_____/_____

Signature of Parent/Guarantor Date

_____ _____

Printed Name Relationship to Patient (Self/Guarantor)

Patient Name: _____ Date:_____/_____/_____

COMMUNICABLE DISEASES RELEASE STATEMENT

Thank you for your continued trust in our office. Despite our careful attention to health and safety protocols, there is still a chance that you could be exposed to a communicable disease (cold, flu, COVID-19, etc.) in our office. Be assured that we are following State and Federal guidelines and recommended universal personal protection and disinfection protocols to the best of our ability to limit transmission of any disease in our office.

By signing below, you acknowledge that you accept the risk of, and consent to, treatment.

_____ _____

Name of Parent/Guardian (Please print full name) Date

_____

Signature of Parent/Guardian

_____

Relationship to Client (please include phone number of Parent/Guardian in case of emergency)

_____

Witness Signature & Print Full Name