



**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](mailto: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](mailto:schedule@accessibledental.org)

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## 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.

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: \_\_\_\_/\_\_\_\_/\_\_\_\_

***This information is proprietary and confidential. Any reproduction or unauthorized use is strictly prohibited.***



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



## 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.





**PRIVATE PAY AGREEMENT FOR COMPREHENSIVE DENTAL TREATMENT AND/OR REHABILITATION**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**ACKNOWLEDGEMENT**

I hereby authorize Accessible Dental Services, Inc., (“ADS”) to provide comprehensive dental treatment and/or rehabilitation for myself, or for the above-named patient. I understand that the treatment and/or rehabilitation (including but not limited to the following: comprehensive exam, periodic exam, limited exam, x-rays and full mouth x-ray series, prophylaxis (cleaning), fluoride treatment, periodontal scaling and root planning, amalgam and composite restorations, and extractions) may include services that are not covered 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 comprehensive oral treatment and/or rehabilitation. As such, I agree that ADS may bill my, or the patient’s, Medicaid/Department of Human Services, Medicare, or other third-party insurance for the comprehensive oral treatment and/or rehabilitation 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 agree and understand that for any non-covered services, ADS may bill me and/or the legal guardian. I further agree and understand that this Acknowledgement constitutes me and/or the legal guardian being informed before the services are rendered with regards to the nature of services to be rendered, the services that may not be covered, the estimated charge for services (see Appendix A: ADS Non-Covered Service Fee Schedule), and that I will be personally responsible for payment of any non-covered services.

With regards to any non-covered services, 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 charges for non-covered 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 Appendix A: ADS Non-Covered Service Fee Schedule. Appendix A: ADS Non-Covered Service Fee Schedule represents a good faith estimate of the fees for the services provided to you by ADS.



**PRIVATE PAY AGREEMENT FOR COMPREHENSIVE DENTAL TREATMENT AND/OR REHABILITATION  
(CONTINUED)**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

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, 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 and/or Rehabilitation.***

\_\_\_\_\_  
Signature of Parent/Guarantor

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Relationship to Patient (Self/Guarantor)



**APPENDIX A: ADS NON-COVERED SERVICE FEE SCHEDULE**

<p><b>Non-Sedation Services</b></p>	<p>Non-covered non-sedation services will be billed per the applicable third-party insurance’s reimbursement rates. If the patient does not have insurance, services will be billed per the Pennsylvania Medical Assistance Program Dental Fee Schedule.</p> <p>For reference, the Pennsylvania Medical Assistance Program Dental Fee Schedule is published at:  <a href="https://www.pa.gov/content/dam/copapwp-pagov/en/dhs/documents/providers/documents/dental-care/Dental%20Fee%20Schedule.pdf">https://www.pa.gov/content/dam/copapwp-pagov/en/dhs/documents/providers/documents/dental-care/Dental%20Fee%20Schedule.pdf</a></p> <p>Common non-sedation services include:</p> <ul style="list-style-type: none"> <li>• D0120 - Periodic Evaluation</li> <li>• D0150 - Comprehensive Evaluation</li> <li>• D0220 - Intraoral Periapical Images</li> <li>• D0274 - Bitewing Four Images</li> <li>• D1110 - Prophylaxis</li> <li>• D2161 - Amalgam four or more surfaces</li> <li>• D4341 - Periodontal scaling and root planning</li> <li>• D9920 - Behavior Management</li> </ul>
<p><b>Sedation Services</b></p>	<p>Non-covered sedation services will be billed at a flat fee of \$2,000 to include all necessary dental services.</p> <p>Common sedation services include:</p> <ul style="list-style-type: none"> <li>• D0120 - Periodic Evaluation</li> <li>• D0150 - Comprehensive Evaluation</li> <li>• D0220 - Intraoral Periapical Images</li> <li>• D0274 - Bitewing Four Images</li> <li>• D1110 - Prophylaxis</li> <li>• D2161 - Amalgam four or more surfaces</li> <li>• D4341 - Periodontal scaling and root planning</li> <li>• D7140 - Extraction</li> <li>• D9920 - Behavior Management</li> <li>• D9222 - Deep sedation/general anesthesia</li> </ul>



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