



1700 6<sup>th</sup> Ave North  
Bessemer, Alabama 35020  
Phone (205) 434-2031

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## PATIENT REGISTRATION FORM

Patient Name: \_\_\_\_\_  
*(Last, First)*

Date of Birth: \_\_\_\_\_ Email: \_\_\_\_\_  
*(Month, Day, Year)*

Program Status:  No Program (community patient)  Foundry Program  Re-entry  
 Jimmie Hale/ Jessie's Place  Cahaba Valley  Other \_\_\_\_\_

Address: \_\_\_\_\_  
*Number Street Address*

\_\_\_\_\_  
*City/Town State Zip*

\_\_\_\_\_  
*Phone and Cell Phone*

\_\_\_\_\_  
*Emergency Contact (name and phone number)*

### About Our Clinic

We exist to serve the dental needs of Foundry residents, other recovery program residents, and people in the community who need access to low-cost, affordable dental care. Thank you for choosing us as your dental provider. Your presence allows us to help others get the dental care they need.

We are pleased to offer a full range of services at this clinic. Please ask us about dental implants. We try very hard to keep our costs low. One way we do this is by using a large number of volunteers. Most of our front desk helpers, for example, are volunteers from local churches and the community. Since they only work on occasion, and because many people here are Foundry residents getting on-the-job training, we are not as efficient as a typical private practice. We ask your patience in this matter. Also, most of our faculty dentists are volunteers as well. Please thank them when you see them for making this all possible!

(over)

## **Our Fees**

Payment is due at the time of service. You can pay ahead for treatment if you wish. Prices for community members are slightly higher than for Foundry residents. We do not accept dental insurance. If you have complex dental treatment needs, please ask about being a patient in Dr. McCracken's private clinic; fees in this clinic are more in line with normal fees charged by dental specialists.

## **Scheduling & Waiting**

Our clinic may run behind due to the challenges of working within the Foundry schedule and serving as a community clinic. When we get to you, we will give you individual attention and non-rushed service. If waiting is difficult for you, or you have pressing time demands, you may be more comfortable in another clinic.

## **Phones**

Patients often have difficulty reaching us by phone. Our phone is constantly tied up with people calling in and asking about low-cost dental care. At this time, we are not able to afford a complex phone system with multiple lines, or a staff member to run it. The best way to contact us is to drop by the clinic in person; or, you can email us at FoundryDentalCenter@gmail.com.

## **Residency Training**

Many of our dentists are participating in educational programs, such as our implant training course, or in our Advanced Education in General Dentistry (AEGD) residency program. AEGD doctors spend one or two years in this program following dental school. Other dentists serve as faculty advisors for these residents. Most of our dental assistants are in training.

## **Consent**

"I have read the above and give consent for dental procedures to be performed on me. I understand that some of the care providers are in training. I will ask questions if I have them, and I will commit to regular brushing and home care to keep my teeth in the best condition possible."

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Privacy Notice

I have read the Privacy Notice and understand my rights contained in this notice. By way of my signature, I provide the Foundry Dental Center my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the privacy notice.

Foundry Dental Center may release my personal health information to the following persons:

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Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Appointment Cancellation Policy

**\*If you wish to cancel or reschedule an appointment a standard dental appointment, please notify us at least 24 hours in advance.**

Patient will be charged for regular/non-sedation missed appointments when we are not provided at least a 24-hour notice will be as follows:

- **1 Hour Appointment - \$20**
- **2 Hour Appointment - \$40**
- **3 Hour Appointment - \$60**

Patients with 3 or more No-Shows within 6 months must pay the No-Show fees PLUS the cost of the procedure for which they are trying to schedule.

**\*If you wish to cancel or reschedule a SEDATION dental appointment, please notify us at least 48 hours in advance.**

Patients that DO NOT provide a 48-hour cancellation notice for sedation appointments will be charged a \$100 No-show Fee, must repay the \$110 sedation fee and must pay their sedation procedure cost IN FULL before rescheduling their procedure.

I have read and understand FDC Cancellation Policy:

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## The Foundry Dental Center MEDICAL HISTORY

**PATIENT NAME :** \_\_\_\_\_ **DATE OF BIRTH** \_\_\_\_\_ **Today's Date:** \_\_\_\_\_

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions: (Circle correct response)

	Patient Sex	M	F	
Are you under a physician's care now?	Yes	No		If yes, explain: _____
Have you ever been hospitalized or had a major operation?	Yes	No		_____
Have you ever had a serious head or neck injury?	Yes	No		_____
Are you taking any medications, pills or drugs?	Yes	No		_____
Do you take, or have you taken, Phen-Fen or Redux?	Yes	No		List on back or bring list with you
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes	No		_____
Are you on a special diet?	Yes	No		_____
Do you use tobacco?	Yes	No		How much? _____ Cigs or Packs per day
Do you use controlled substances?	Yes	No		_____

Women: Are you...

Pregnant/Trying to become pregnant? Yes No    Taking Oral Contraceptives? Yes No    Nursing? Yes No

All Patients: Are you allergic to any of the following? (Circle if Yes)

Aspirin    Penicillin    Codeine    Local Anesthesia    Acrylics    Metal    Latex    Sulfa drugs

Other If yes, explain \_\_\_\_\_

Do you have, or have you ever had, any of the following? Circle Y for Yes and N for No

AIDS/HIV Positive	Y N	Cortisone Medicine	Y N	Hemophilia	Y N	Radiation Treatment	Y N
Alzheimer's Disease	Y N	Diabetes	Y N	Hepatitis A	Y N	Recent Weight Loss	Y N
Anaphylaxis	Y N	Drug Addiction	Y N	Hepatitis B or C	Y N	Renal Dialysis	Y N
Anemia	Y N	Easily Winded	Y N	Herpes	Y N	Rheumatic Fever	Y N
Angina	Y N	Emphysema	Y N	High Blood Pressure	Y N	Rheumatism	Y N
Arthritis/Gout	Y N	Epilepsy or Seizures	Y N	High Cholesterol	Y N	Scarlet Fever	Y N
Artificial Heart Valve	Y N	Excessive Bleeding	Y N	Hives or Rash	Y N	shingles	Y N
Artificial Joint	Y N	Excessive Thirst	Y N	Hypoglycemia	Y N	Sickle Cell Disease	Y N
Asthma	Y N	Fainting Spells/Dizziness	Y N	Irregular Heartbeat	Y N	Sinus Trouble	Y N
Blood Disease	Y N	Frequent Cough	Y N	Kidney Problems	Y N	Spina Bifida	Y N
Blood Transfusion	Y N	Frequent Diarrhea	Y N	Leukemia	Y N	Stomach/Intestinal Disease	Y N
Breathing Problems	Y N	Frequent Headaches	Y N	Liver Disease	Y N	Stroke	Y N
Bruise Easily	Y N	Genital Herpes	Y N	Low Blood Pressure	Y N	Swelling of Limbs	Y N
Cancer	Y N	Glaucoma	Y N	Lung Disease	Y N	Thyroid Disease	Y N
Chemotherapy	Y N	Hay Fever	Y N	Mitral Valve Prolapse	Y N	Tonsillitis	Y N
Chest pains	Y N	Heart Attack/Failure	Y N	Osteoporosis	Y N	Tuberculosis	Y N
Cold Sores/Fever Blisters	Y N	Heart Murmur	Y N	Pain in Jaw Joints	Y N	Tumors or Growths	Y N
Congenital Heart Disorder	Y N	Heart Pacemaker	Y N	Parathyroid Disease	Y N	Ulcers	Y N
Convulsions	Y N	Heart Trouble/Disease	Y N	Psychiatric Care	Y N	Venereal Disease	Y N
Yellow Jaundice	Y N						

Have you ever had any serious illness not listed above?

Explain: \_\_\_\_\_

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform this office of any changes in medical status.

Signature of Patient, Parent or Guardian

DATE:



## MEDIA CONSENT

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Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

I hereby consent to the participation in interviews, the use of quotes, and the taking of photograph, movies, or video tapes for the Foundry Dental Center. I also grant the right to edit, use, and reuse said products for nonprofit purposes including use in print, on the internet, and all other forms of media. I also hereby release the Foundry Dental Center and its agents and employees from all claims, demands, and liabilities whatsoever in connection with the above.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Por la presente doy mi consentimiento para la participación en entrevistas, el uso de citas y la toma de fotografías, películas o cintas de video para el Centro Dental de Foundry. También concedo el derecho de editar, usar y reutilizar dichos productos con fines sin fines de lucro, incluido el uso en impresión, en Internet y todas las demás formas de medios. También libero al Centro Dental de Foundry y a sus agentes y empleados de todas las reclamaciones, demandas y responsabilidades en relación con lo anterior.

Firma del Paciente: \_\_\_\_\_ Fecha: \_\_\_\_\_

Firma del Testigo: \_\_\_\_\_ Fecha: \_\_\_\_\_