THE FOUNDRY DENTAL CENTER

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

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!

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: _____

Rev 12/2020

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 purposed 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:

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

MEDIA CONSENT

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: _____

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DENTAL IMPLANTS & YOU

We enjoy doing dental implants for our patients, and they are often the best treatment choice for people, providing function and health in a variety of situations. However, we have found that sometimes our patients are confused regarding treatment with implants. And for good reason! Implants are a multi-step process and can be confusing. This FAQ document addresses some common questions. We hope it better explains implants and implant procedures. Please let us know if you have further questions, or if you would like to speak to your dentist for any questions you might have.

1. **How long does it take?**
   Implants can take quite a long time. Generally, there are 2-3 steps in the process. First is growing the bone. Many patients have good bone already and skip this step. Second is placing the implant, which must heal for 3-6 months. Finally, you must restore the implant, making the actual teeth that go on the implant. Depending on your situation, implant therapy can take 4-12 months or longer, in some cases years. Ask your dentist for an estimate of the time you will be in treatment.

2. **Do they always work?**
   The success rate of the implants is very good, typically 95% or higher. Some host factors decrease the success rate: smoking, diabetes, poor overall health, poor healing, etc. If an implant fails to integrate in the first year, we will try it again for you, at no charge. Other factors may be involved.

3. **What about maintenance?**
   You must clean your implant! Every day, twice a day, just like teeth. And you must come in for regular check-ups every 6 months. If you see a regular dentist, you should come back to see us every year to check your implants. *If you have not been back to see us for 2-3 years, and you develop an issue with your implants, you will have to pay for the repairs/replacements.*

4. **Is the cost of the implant all there is?**
   Each patient should have a complete implant plan with all the charges on it. Sometimes, though, patients pay the implant fee, and forget about the restoration fee. Make sure to budget for both expenses. While it is ok to leave implants unrestored for a short while, over time they sometimes deteriorate. So it is best to restore the implants in timely manner.

Thank you, and we look forward to your successful implant treatment!

Patient Signature: _____ Date: _____

THE FOUNDRY DENTAL CENTER

IMPLANTS AND RELATED CONSENT

Patient Name: _____ Date: _____

1. The purpose and the nature of the implant surgery procedures have been explained to you, including what is necessary to place the implant under the gum into the bone.

2. A doctor has carefully examined your mouth. Alternatives to this treatment have been explained. You have tried or considered these methods but desire an implant to help secure the replaced missing teeth. Your questions have been answered.

3. You have further been informed of the possible risks and complications involved with surgery, drugs, and anesthesia. Such complications include pain, swelling, infection and discoloration. Numbness of the lip, tongue, chin, cheek, or teeth may occur. The exact duration may not be determinable and may be irreversible. Also possible are thrombophlebitis (inflammation of the vein), injury to teeth present, bone fractures, sinus penetration, delayed healing, and allergic reactions to drugs or medications used. In rare cases, such complications may be life-threatening.

4. You have been informed that if nothing is done any of the following could occur: bone disease, loss of bone, gum tissue inflammation, infection, sensitivity, and/or looseness of teeth followed by need of extraction. Also possible are temporomandibular joint (jaw) problems, headaches, referred pains to back of the neck and facial muscles, and tired muscles when chewing. In addition, you have been informed that if nothing is done an inability to place implants at a later date due to changes in oral or medical conditions could exist.

5. Your doctor has explained to you that there is no method to predict accurately the gum and the bone healing capabilities in each patient following the placement of an implant.

6. It has been explained to you that in some instances implants fail and must be removed, and also that the practice of dentistry is not an exact science; no guarantees or assurances as to the outcome of the results of treatment or surgery can be made. You have been informed that there is a risk that the implant surgery may fail, which might require further corrective surgery or the removal of the implant with possible corrective surgery associated with removal.

7. You have been informed that excessive smoking, alcohol, or blood sugar may affect gum healing and may limit the success of the implant. You agree to follow your doctor's home care instructions. You agree to report to your doctor for regular examinations as instructed.

8. You agree to the type of anesthesia, depending on the choice of the doctor, and not to operate a motor vehicle or hazardous device for at least 24 hours or more until fully recovered from the effects of the anesthesia or drugs given for your care.

9. To the best of your knowledge, you have provided an accurate report of your physical and mental health history. You have also reported any prior allergic or unusual reactions to drugs, food, insect bites, anesthetics, pollen,

dust, blood or body diseases, gum or skin reactions, abnormal bleeding or any other conditions related to your health.

10. You consent to photography, filming, recording, x-rays, and additional professional staff observing the procedures to be performed for the advancement of implant dentistry, as well as using your information for teaching and lecture purposes.

11. You agree to notify the doctor's office of all changes to your address and/or telephone number within a reasonable time frame (two to four weeks).

12. You request and authorize medical/dental services for yourself, including implants and other surgery. If any unforeseen condition arises in the course of treatment which calls for the performance in addition to or different from that now contemplated, you further authorize and direct your doctor, associate or assistant, to do whatever they deem necessary and advisable under the circumstances, including the decision not to proceed with implant procedures.

13. You have been informed that you may have to go without a dental prosthesis (such as a denture) for some length of time after implant surgery, if, in the opinion of your doctor, wearing such a prosthesis may jeopardize the success of the implants. This length of time may be between 2-14 days, or longer in some circumstances.

Legal Rights

You will receive a copy of this informed consent if you request one. You are not waiving any of your legal rights by signing this consent form.

Signatures

Your signature below indicates your willingness to participate in this program of treatment.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

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LIMITED TREATMENT CONSENT

As part of the AIE and CIRP implant training programs, we are offering you a "limited treatment plan" that is focused on dental implants. For some patients, this may actually be a fairly complete plan, such as someone already wearing dentures and just getting implants and new dentures. Other patients may have additional needs not covered by this limited plan, such as fillings or cleanings.

If you wish to have a comprehensive treatment plan, we are happy to appoint you with one of our dentists to get a more thorough dental evaluation and x-rays and to generate a treatment plan to more fully manage your dental needs. This could include fillings, crowns, periodontal therapy, and other such general dentistry, along with your dental implants.

If you have additional treatment needs, and only get dental implants as part of this limited plan, your other needs may not be met. If left untreated, these needs can become worse and may eventually lead to complications such as loss of teeth, or other negative outcomes.

On the other hand, some patients already have a general dentist, and are only interested in implants, which makes the limited treatment plan an excellent choice. Let us know how we can best serve you.

We want all of our patients to have the best oral health possible. Whether your dental home is with us, or you have a dentist already and just need implants, everyone should have regular dental care, checkups, cleanings, and treatment.

Patient Signature:_____Date: _____

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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	
Are you taking any medications, pills or drugs?	Yes	No	
Do you use controlled substances?	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	
Do you use tobacco?	Yes	No	How much?_____Cigs or Packs per day

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	Convulsions	Y N	Hemophilia	Y N	Radiation Treatment	Y N
Anaphylaxis	Y N	Cortisone Medicine	Y N	Hepatitis A	Y N	Renal Dialysis	Y N
Anemia	Y N	Diabetes	Y N	Hepatitis B or C	Y N	Rheumatic Fever	Y N
Angina	Y N	Drug Addiction	Y N	High Blood Pressure	Y N	Rheumatism	Y N
Arthritis/Gout	Y N	Emphysema	Y N	High Cholesterol	Y N	Sickle Cell Disease	Y N
Artificial Heart Valve	Y N	Epilepsy or Seizures	Y N	Kidney Problems	Y N	Sinus Trouble	Y N
Asthma	Y N	Excessive Bleeding	Y N	Liver Disease	Y N	Stomach/Intestinal Disease	Y N
Blood Disease	Y N	Fainting Spells/Dizziness	Y N	Low Blood Pressure	Y N	Stroke	Y N
Breathing Problems	Y N	Glaucoma	Y N	Lung Disease	Y N	Thyroid Disease	Y N
Cancer	Y N	Heart Attack/Failure	Y N	Osteoporosis	Y N	Ulcers	Y N
Chemotherapy	Y N	Heart Trouble/Disease	Y N	Psychiatric Care	Y N		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:

Rev 12/2020

Medication List

Name:_____ Date:_____

Emergency Contact Name/Number:_____

Name of Prescription	Strength and Frequency	Condition taken for	Prescribing Physician	How long have you been taking?

Allergies	Pharmacy