

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

PATIENT INFORMATION

Patient Name: _____
Gender (M/F): _____ Marital Status: _____ Birth Date: _____ Social Security #: _____
Address: _____
Phone #'s: Home _____ Work _____ Ext. _____
E-mail: _____ I would like to receive correspondences via e-mail
Who Referred You? (Please circle one) Google Drive By/Sign Phone Book Patient(Family/Friend)
Name of Referring Person to Thank: _____ Other (please specify): _____

RESPONSIBLE PARTY (If Patient is a Minor)

Patient Name: _____
Gender (M/F): _____ Marital Status: _____ Birth Date: _____ Social Security #: _____
Address: _____
Phone #'s: Home _____ Work _____ Ext. _____
Email Address: _____

DENTAL INSURANCE INFORMATION

Primary

Name of Insured: _____
Insured's Birth Date: _____ ID/SSN#: _____ Group #: _____
Insured's Address (if different than above): _____
Insured's Employer Name and Address (if different): _____
Patient's relationship to Insured (please circle one): Self Spouse Child Other
Insurance Plan Name and Address: _____

Secondary

Name of Insured: _____
Insured's Birth Date: _____ ID/SSN#: _____ Group #: _____
Insured's Address (If different than above): _____
Insured's Employer Name and Address (If different): _____
Patient's relationship to Insured (please circle one): Self Spouse Child Other
Insurance Plan Name and Address: _____

MEDICAL HISTORY

Physician Name: _____ Physician's Phone #: _____

Have you ever been hospitalized or had any surgeries? Yes No If yes, please explain: _____

Please list any medications you have taken within the past six months: _____

Have you ever taken Fosamax, Boniva, Actonel? Yes No

Do you use tobacco? Yes No Alcohol Products? Yes No Controlled Substances? Yes No

WOMEN ONLY: ARE YOU

PREGNANT/TRYING TO GET PREGNANT? Yes No

TAKING ORAL CONTRACEPTIVES? Yes No

NURSING? Yes No

Are you **allergic** to any of the following?

Aspirin Penicillin Local Anesthetics Acrylic Metal Latex

Sulfa drugs Other, please explain _____

Do you have, or have you had any of the following?

AIDS/HIV <input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No	Leukemia <input type="checkbox"/> Yes <input type="checkbox"/> No
Alzheimer's Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy/Seizures <input type="checkbox"/> Yes <input type="checkbox"/> No	Liver disease <input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis / Gout <input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting /Dizziness <input type="checkbox"/> Yes <input type="checkbox"/> No	Lung Disease <input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valve <input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent Headaches <input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker/Heart surgery <input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joints <input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric care <input type="checkbox"/> Yes <input type="checkbox"/> No
Angina <input type="checkbox"/> Yes <input type="checkbox"/> No	Heart murmur <input type="checkbox"/> Yes <input type="checkbox"/> No	Recent weight loss <input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No	Heart problems <input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic/Scarlet Fever <input type="checkbox"/> Yes <input type="checkbox"/> No
Back Problems <input type="checkbox"/> Yes <input type="checkbox"/> No	Describe _____	Shortness of breath <input type="checkbox"/> Yes <input type="checkbox"/> No
Breathing Problem <input type="checkbox"/> Yes <input type="checkbox"/> No		Sinus Trouble <input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No		Sickle Cell Disease <input type="checkbox"/> Yes <input type="checkbox"/> No
Chemotherapy <input type="checkbox"/> Yes <input type="checkbox"/> No	Hemophilia/bleeding <input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke / TIA <input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital Heart disorder <input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes <input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid malfunction <input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis A, B, or C <input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood pressure <input type="checkbox"/> Yes <input type="checkbox"/> No	Tumors or Growths <input type="checkbox"/> Yes <input type="checkbox"/> No
Chest Pains <input type="checkbox"/> Yes <input type="checkbox"/> No	Hives or Rash <input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers / Colitis <input type="checkbox"/> Yes <input type="checkbox"/> No
Drug Addiction <input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney disease/Dialysis <input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal disease <input type="checkbox"/> Yes <input type="checkbox"/> No
		Other _____

DENTAL HISTORY

Reason for today's visit _____

On scale of 1 – 10 (1=no problem, 10=terrified) how nervous are you about seeing a dentist? _____

Former Dentist _____ Date of last dental visit _____

Broken fillings or teeth Yes No Sensitivity to cold or sweets Yes No

Gums swollen or tender Yes No Jaw pain: clicking or popping Yes No

Grinding teeth Yes No Sores/growths in your mouth Yes No

Do you like your smile? Yes No

If you could improve your smile, what would you change? (Color, shape, etc) _____

I give my consent for the doctors, hygienists and assistants at Middle Creek Dental to take x-rays, perform exams, and provide local anesthetic in order to perform any necessary cleanings, fillings, or crowns.

A fee of \$39.00 may be charged for missed appointments or late cancellations (less than 24 hour notice).

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 the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN _____ DATE ____/____/____

[By executing this agreement, you are agreeing to pay for all services that are received.]

FINANCIAL POLICY

Insurance: Insurance is a contract between you and your insurance company. We are NOT a party to this contract or any possible restrictions. You will be informed *before* treatment begins as to your *estimated* portion of the bill. That portion is due on the date of service. The amount you will be required to pay is an *estimated* portion based on what your insurance company has told us. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your benefits. If your insurance company does not pay or pays less than the estimate, *you* will be required to pay the balance of your bill. We will bill your primary insurance company as a courtesy for you. If your insurance company has not made payment to our office within **30** days, we will ask you to pay the balance due at that time. You will then be responsible for seeking reimbursement from your insurance company.

Required Payments: Any co-payments required by an insurance company *must* be paid at the time of service. Because this is an insurance requirement, we cannot bill you for these.

Payment options if you have insurance:

1. You choose to pay your deductible of \$ _____ and any out-of-pocket portions at the time services are rendered by _____ cash, _____ check, or _____ credit card.
2. On treatment involving laboratory fees (crowns, bridges, or dentures), you may choose to pay 50% of your out-of-pocket portion on the preparation date, and the balance on the completion or delivery date (normally two weeks later).
3. On treatment that exceeds \$300 out-of-pocket expense, you may prefer to take advantage of our monthly payment plan via an authorization on your MasterCard or Visa. Let us know if you are interested in this option and we will provide you with an application.

Payment options if you have no insurance:

1. You choose to pay by _____ cash, _____ check, or _____ credit card on the day that treatment is rendered.
2. On treatment involving laboratory fees (crowns, bridges, dentures, etc.) you may choose to pay 50% on the preparation date and the balance on the completion or delivery date (normally two weeks later).
3. On treatment that exceeds \$300, you may prefer to take advantage of our monthly payment plan via an authorization on your MasterCard or Visa. Let us know if you're interested in this option and we will provide you with an application.

Finance Charges: A finance charge will be imposed on each item of your account which has not been paid within thirty (30) days of the time the item was added to the account. The finance charge will be an ANNUAL PERCENTAGE RATE of eighteen (18%) percent, or one and one-half percent (1.5%) per month. The minimum Finance Charge is \$1.00.

Past Due Accounts: If your account becomes 60 days past due, your account will be turned over to a collection agency.

Returned Checks: You will be charged a fee of \$25 for any checks returned to us by your bank due to insufficient funds.

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SIGNATURE OF PATIENT, PARENT, OR GUARDIAN _____ DATE ____/____/____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

[Please Print Name]

[Signature]

[Date]



We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to signed
- Communications barriers prohibited obtaining the acknowledgement
- Other (Please specify)

