MIDTOWN
DENTAL EXCELLENCE

Patient Information

NAME _____ ☐ MALE ☐ FEMALE

SOCIAL SECURITY # _____ ☐ MARRIED ☐ SINGLE ☐ MINOR

ADDRESS _____
STREET APT.# CITY STATE ZIP

BIRTHDATE _____ E-MAIL _____
MONTH DAY YEAR

TELEPHONE (HOME) _____ (WORK) _____ (CELL) _____

Appointment Confirmation Method: (When we need to confirm that you will be keeping your appointment)

☐ Home ☐ Work ☐ Mobile ☐ E-mail ☐ Text Message

Cleaning Reminder Method: (When we need to reach you to schedule your cleaning appointment)

☐ Home ☐ Work ☐ Mobile ☐ E-mail ☐ Text Message ☐ Do not contact

NAME OF EMPLOYER _____ PROFESSION _____

IF FULL-TIME STUDENT, SCHOOL NAME _____ GRADE _____

PERSON RESPONSIBLE FOR ACCOUNT ☐ PATIENT ☐ GUARDIAN ☐ SPOUSE ☐ FATHER ☐ MOTHER

PRIMARY INSURANCE

NAME of POLICY HOLDER _____

POLICY HOLDER BIRTHDATE _____ SSN# _____

INSURANCE COMPANY _____

ID # _____

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

X _____
PATIENT OR RESPONSIBLE PARTY

_____
DATE

Has any member of your family ever been treated in our office?

☐ YES ☐ NO

Whom may we thank for referring you to our office?

☐ General Dentist: _____

☐ Patient: _____

☐ Internet ☐ Other: _____

Responsible party currently has account with this office? ☐ YES ☐ NO

Card # _____

Exp. Date _____

**We require credit card information be kept on file. In the event you do not show up for your appointment, or cancel less than 24 hrs before your appointment, your card will be automatically charged $145 for a missed cleaning appointment, and $250 for a missed surgical appointment..*

Medical History

Heart Disease/Surgery	*yes/no*	Pulmonary Shunt	*yes/no*	Excessive Bleeding	*yes/no*
Heart Murmur or Defect	*yes/no*	High Blood Pressure	*yes/no*	Sickle Cell Disease	*yes/no*
Irregular Heartbeat	*yes/no*	Low Blood Pressure	*yes/no*	Hemophilia	*yes/no*
Angina/Chest Pain	*yes/no*	Bacterial Endocarditis	*yes/no*	Methemoglobinemia	*yes/no*
Heart Attack/Failure	*yes/no*	Unexplained Fever	*yes/no*	Leukemia	*yes/no*
Congenital Heart Disorder	*yes/no*	Bruise Easily	*yes/no*	Blood Transfusion	*yes/no*
Mitral Valve Prolapse	*yes/no*	Anemia	*yes/no*	Swelling of Limbs	*yes/no*
Scarlet Fever	*yes/no*	Frequent Diarrhea	*yes/no*	Lung Disease	*yes/no*
Rheumatic Fever	*yes/no*	Diabetes	*yes/no*	HIV Positive	*yes/no*
Shortness of Breath	*yes/no*	Excessive Thirst	*yes/no*	Cold Sores/Herpes	*yes/no*
Frequent Cough	*yes/no*	Hypoglycemia	*yes/no*	Stroke	*yes/no*
Sinus Trouble	*yes/no*	Liver Disease	*yes/no*	Epilepsy or Seizures	*yes/no*
Asthma	*yes/no*	Hepatitis A (infectious)	*yes/no*	Fainting or Dizziness	*yes/no*
Tuberculosis	*yes/no*	Hepatitis B or C	*yes/no*	Glaucoma	*yes/no*
Cancer	*yes/no*	Kidney Problems	*yes/no*	Tumors or Growths	*yes/no*
Radiation Treatment	*yes/no*	Renal Dialysis	*yes/no*	Psychiatric Care	*yes/no*
Chemotherapy	*yes/no*	Thyroid Disease	*yes/no*	Alzheimer's	*yes/no*
Osteoporosis	*yes/no*	Parathyroid Disease	*yes/no*	Disease	*yes/no*
Bisphosphonates	*yes/no*	Arthritis/Gout	*yes/no*	*A*lleries (Medicines)	*yes/no*
Osteonecrosis of Jaw	*yes/no*	Rheumatism	*yes/no*	Allergies (Pollen/Dust)	*yes/no*
GI Disease	*yes/no*	Pain in Jaw Joints	*yes/no*	Hives or Rash	*yes/no*
Ulcers	*yes/no*	Artificial Joint	*yes/no*	Need Premedication?	*yes/no*
Recent Weight Loss	*yes/no*	STD	*yes/no*	Ever taken fen-phen?	*yes/no*
Artificial Heart Valve	*yes/no*	Coronary Stent	*yes/no*	Pacemaker	*yes/no*
Heart Pacemaker	*yes/no*				

Have you ever had any other serious illness not listed above? *yes/no*

If yes Explain:

_____

_____

Are you taking any medications, aspirin, vitamins, herbals, pills or drugs? If yes please list them

_____

_____

Pharmacy Name & Phone Number:

_____

Dental History

What is the reason for your visit today?

_____

_____

Previous Dentist's Name _____ Telephone _____

How often do you brush your teeth? _____How often do you floss? _____

Have you ever used or are you currently using topical fluoride? *yes/no*

What other dental aids do you use (Interplak, toothpick, etc.)? _____

Have you ever been told to take a pre-medication prior to dental treatment? *yes/no*

Is there anything else about having dental treatment that you would like us to know? *yes/no*

If yes, please describe:_____

Are any of your teeth sensitive to Hot or cold? *yes/no*

Are any of your teeth sensitive to Sweets? *yes/no*

Are any of your teeth sensitive to Biting or chewing? *yes/no*

Have you noticed any mouth odors or bad taste? *yes/no*

Do you frequently get cold sores, blisters or any other oral lesions? *yes/no*

Do your gums bleed or hurt? *yes/no*

Have you noticed any loose teeth or change in your bite? *yes/no*

Does food tend to become caught in between your teeth? *yes/no*

If yes, where?

_____

Do you Clench or grind your teeth while awake or asleep? *yes/no*

Bite your lips or cheeks regularly? *yes/no*

Mouth breathe while awake or asleep? *yes/no*

Have tired jaws, especially in the morning? *yes/no*

Snore or have any other sleeping disorders? *yes/no*

Smoke/chew tobacco or use other tobacco products? *yes/no*

Have you ever had Orthodontic treatment? *yes/no*

Oral surgery? *yes/no*

Periodontal treatment? *yes/no*

A bite plate or mouth guard? *yes/no*

A serious injury to the mouth or head? *yes/no*

If yes, please describe, including cause

_____

Have you experienced Clicking or popping of the jaw? *yes/no*

Difficulty in opening or closing the mouth? *yes/no*

Difficulty in chewing on either side of the mouth? *yes/no*

Headaches, neck aches or shoulder aches? *yes/no*

Sore muscles (neck, shoulders)? *yes/no*

Do you feel nervous about having dental treatment? *yes/no*

If so, what is your biggest concern? *yes/no*

Smile Evaluation

1) Do you like the appearance of your teeth and your smile?

If no, explain: _____

2) Are your teeth all in alignment (straight)? *yes/no*

If not, explain: _____

3) Do you have spaces that you don't like? *yes/no*

If yes, explain: _____

4) Do you like the color of your teeth? *yes/no*

If not, explain: _____

5) Do you like the shape of your teeth? *yes/no*

If not, explain: _____

6) Are your teeth: Chipped, Too Forward, Hidden? *yes/no*

If yes, explain: _____

7) Are your teeth wearing on the biting surfaces? *yes/no*

If yes, explain: _____

8) Are there old silver fillings or dental work you don't like to look at? *yes/no*

If yes, explain: _____

Office Policies

Please take a few minutes to read and review our office policies:

We want to thank you for choosing our practice for your dental health care needs and we appreciate the opportunity to provide you with quality healthcare. Our goal is to make you aware of our office financial policies and procedures. Your clear understanding of our policies is important to our professional relationship. Please read below and initial the items once you fully understand our office policies.

Consent to Care

_____ I wish to be treated by Midtown Dental Excellence. While I am a patient, I permit my doctor(s), the office employees, and all the persons caring for me in the ways they judge are beneficial to me. I understand that this care may include tests, examinations, and dental treatment.

Missed/Cancelled Appointments

_____ Office hours are by appointment and we do value your time. Because of the level of service we provide our patients, your appointment is especially held just for you, so that we have the right amount of time for your procedure at our office. When you make an appointment, please be sure that you will be able to keep it. If you cannot make an appointment as scheduled, please notify the office 24 hours BEFORE your appointment time or as soon as possible . **Cancellations must be made during normal office hours or over the phone by speaking directly to one of our dental professionals, email, voicemail and/or text cancellation will incur a fee. A charge of $145 will be automatically processed for any appointments cancelled with less than 24 hours' notice for your appointment.**

Please know that we understand that emergencies and unforeseen patient treatment problems may arise, causing schedule changes on both your end and ours. That being said the office will be flexible in accommodating any unforeseen events that might arise in your schedule, however we expect you to respect our time as we respect yours and constant last minute cancellations and or no shows will be penalized with a fee.

Financial Agreement

_____ We are doing everything possible to minimize the cost of dental care. You can help a great deal by eliminating the need for us to bill you. Full payment is expected at the time of service unless other arrangements have been made in advance. Patients with an outstanding balance must make payment arrangements prior to scheduling further appointments. If you are experiencing financial difficulty, please let us know. Often we can defray payments, set-up 3rd party financing or arrange a gradual repayment schedule.

Returned Checks

_____ There is a $25.00 charge for any check returned to us from the bank that is unpaid.

Collections

_____ As previously stated, all fees are due at the time of service. Any charges remaining unpaid 60 days after the date of service are considered overdue. We will make every effort to arrange an equitable payment schedule. However, if no effort is made to pay the balance due, the bill will be sent to a collection agency. You will be responsible for any additional collection agency fees. In this situation, the responsible person will be asked to seek periodontal care elsewhere.

_____ I have read and understand the above financial policy of Midtown Dental Excellence. I understand that charges not covered by my insurance company, as well as applicable copayment and deductibles, are my responsibility.

_____ I have provided Midtown Dental Excellence accurate information of my insurance status, and allow my Insurance Company to assign benefits to Midtown Dental Excellence as necessary. I authorize Midtown Dental Excellence to release pertinent information to my insurance company when it is requested.

_____ If it becomes necessary to forward an amount to a collection agency, I will also be responsible for the fee charged by the agency for the cost of the collection, in addition to the original amount due. This may amount to be as much as 40% of the original fee.

Patient Signature: _____

Patient Name: _____

Date: _____

HIPAA Consent

Release of Information

Midtown Dental Excellence may seek, release and verify all or part of the patient's dental and/or financial records to any person, corporation, or governmental agency which is or may be liable under a statute, regulation, or contract to the office, the patient, a family member, for all or part of Midtown Dental Excellence charges.

Publications of Records

I authorize photos, slides and x-rays of my care and treatment during or after its completion to be used for the advancement of dentistry and for reimbursement purposes.

Medical Authorization to Release Information & Payment Request

I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of dental or medical information about me to be released to the carriers for information needed for claims. I request that direct payment of authorized benefits be made on my behalf. I assign benefits payable for dentists or organization to submit a claim to insurance for payment.

HIPPA

By signing this form you will consent to our use and disclosure of your health information to carry out treatment, paying activities, and healthcare operations. I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices.

I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, paying activities and health care options.

We welcome you to our office and thank you for your reading, understanding and consenting to our policies.

Patient Signature: _____

Patient Name: _____

Date: _____