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: _____
First Last MI Preferred Name

Gender (M/F):_____ Marital Status: _____ Birth Date: _____ Social Security #: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Phone #'s: Home _____ Work _____ Ext. _____

Cell _____ Other _____ Emergency Contact _____
Name Phone #

E-mail: _____ ____ I would like to receive correspondences via e-mail

Employer: _____
Name Address City State/Zip

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 (<u>If Patient is a Minor</u>)

Patient Name: _____
First Last MI Preferred Name

Gender (M/F): _____ Marital Status: _____ Birth Date: _____ Social Security #: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Phone #'s: Home _____ Work _____ Ext. _____

Email Address: _____

DENTAL INSURANCE INFORMATION

<u>Primary</u>

Name of Insured: _____
First Last MI

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: _____

<u>Secondary</u>

Name of Insured: _____
First Last MI

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	__Yes __No	Emphysema	__Yes __No	Leukemia	__Yes __No
Alzheimer's Disease	__Yes __No	Epilepsy/Seizures	__Yes __No	Liver disease	__Yes __No
Arthritis / Gout	__Yes __No	Fainting /Dizziness	__Yes __No	Lung Disease	__Yes __No
Artificial Heart Valve	__Yes __No	Frequent Headaches	__Yes __No	Pacemaker/Heart surgery	__Yes __No
Artificial Joints	__Yes __No	Glaucoma	__Yes __No	Psychiatric care	__Yes __No
Angina	__Yes __No	Heart murmur	__Yes __No	Recent weight loss	__Yes __No
Asthma	__Yes __No	Heart problems	__Yes __No	Rheumatic/Scarlet Fever	__Yes __No
Back Problems	__Yes __No	Describe_____		Shortness of breath	__Yes __No
Breathing Problem	__Yes __No			Sinus Trouble	__Yes __No
Cancer	__Yes __No	_____		Sickle Cell Disease	__Yes __No
Chemotherapy	__Yes __No	Hemophilia/bleeding	__Yes __No	Stroke / TIA	__Yes __No
Congenital Heart disorder	__Yes __No	Herpes	__Yes __No	Thyroid malfunction	__Yes __No
Diabetes	__Yes __No	Hepatitis A, B, or C	__Yes __No	Tuberculosis	__Yes __No
Blood Disease	__Yes __No	High Blood pressure	__Yes __No	Tumors or Growths	__Yes __No
Chest Pains	__Yes __No	Hives or Rash	__Yes __No	Ulcers / Colitis	__Yes __No
Drug Addiction	__Yes __No	Kidney disease/Dialysis	__Yes __No	Venereal disease	__Yes __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 _____/_____/ 202__

[*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** _____/_____/ 202__

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]

For Office Use Only

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)

_____
_____
_____