Patient Information

We are pleased to welcome you to our office. Please take a moment to complete this form as best you can. If you have any questions we'll be glad to help you.

Name ____ Gender [ ]Male [ ]Female
Last First Mi

Birthdate ________/________/________ SSN_________-______-________ Married [ ]Yes [ ] No

Contact information:

Home phone: (_______) - ________ - __________ Cell phone: (_______) - ________ -_______

Work phone: (_______) - _________ - _________ Email: __________________________

Address: ____
City State Zip code

Preferred contact method: [ ] Home [ ] Cell [ ] Work [ ] Email

Student Status if dependent over 19: [ ] Nonstudent [ ] Part time [ ] Full time

How did you hear about us? ____

Occupation: ____

Insurance Information:

Employer:____

Insurance company: ___________________________ Subscriber's Employer: _____________________

Subscriber ID: ________________________________ Group number: __________________________

Group name: ________________________________ Subscriber's SSN: ________________________

Subscriber's birthdate: _____/_____/________

Your relationship to subscriber: [ ] Self [ ] Spouse [ ] Child

Secondary Insurance:

Insurance company: ___________________________ Subscriber's Employer: _____________________

Subscriber ID: ________________________________ Group number: __________________________

Group name: _________________________________ Subscriber's SSN: ______________________

Subscriber's birthdate: ____/____/____ Your relationship to subscriber: [ ] Self [ ] Spouse [ ] Child

Financial Policy

Name: ____
(Last) **(First)** **(MI)**

PAYMENT

PLEASE CHECK ONE PAYMENT OPTION

____ OPTION 1: Payment in full at each appointment (self-pay or out of network insurance).

____ OPTION 2: Copayment at each appointment of estimated amount not covered by insurance.

PAYMENT ARRANGEMENTS ARE REQUESTED AT THE TIME OF YOUR VISIT

In an effort to provide you with flexible payment arrangements, we have expanded our payment methods.
Our office is fully approved and is an accredited user of the Visa and MasterCard Health Care Program which will enable you to use your Visa and MasterCard to automatically cover amounts not paid by your insurance. You may also choose a comfortable amount to be automatically billed to you Visa or MasterCard on a monthly basis.

PLEASE CHECK ONE PAYMENT METHOD

____ METHOD 1: Payment at time of service by cash, check, credit card, or CareCredit
____ METHOD 2: Payment plan with automatic monthly billing to your Visa or MasterCard
____ METHOD 3: Guarantee any amount not covered by insurance with Visa or MasterCard on file

Initial: ________

AUTHORIZATION OF INSURANCE

Initial: _________ I hereby authorize payment directly to the dental office of Mindful Dental of the Insurance benefits otherwise payable to me.

BROKEN APPOINTMENTS

Initial: _______ I am aware that a $50 fee is charged when I, or a member of the family, does not attend a dental appointment and does not give the office a 24 hour notice of a cancellation.

I have read and understand the financial policy at Mindful Dental.

Signature ____ **Date** ____________________

Current Dental Health

Do any of the following problems apply to you?

[ ] Sensitivity
[ ] Tooth pain or discomfort when chewing
[ ] Headaches, ear aches, neck pain
[ ] Mouth ulcers or cold sores
[ ] Jaw joint pain
[ ] Broken tooth or fillings
[ ] Grinding or clenching teeth
[ ] Bleeding, swollen or irritated gums
[ ] Loose, tipped or shifted teeth

Have you had any of the following?

[ ] Dentures
[ ] Partial dentures
[ ] Braces
[ ] Gum treatments
[ ] Implants
[ ] **Required to take antibiotics prior to dental treatment**

Do you smoke or use chewing tobacco? [ ] yes [ ] no
How much? ________________________ For how long? ______________________________

I would like to learn more about:

[ ] Replacing missing teeth
[ ] Making my teeth whiter
[ ] Making my teeth straighter
[ ] Closing spaces between my teeth
[ ] Repairing chipped teeth
[ ] Replacing old crowns that don't match

Please tell us when:

Your last cleaning was: ____
Your last set of complete x-rays: ____

What is the most important thing to you about your future smile and dental health?

____

What is the most important thing to you about your dental visit today?

____

Medical History

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.

- Are you under a physician's care now? [ ] yes [ ] no
  Name and Number: ____
- Have you ever been hospitalized or had a major operation? [ ] yes [ ] no
  Please explain: ____
- Have you ever had a serious head or neck injury? [ ] yes [ ] no
  Please explain: ____
- Are you taking any medications, pills, or drugs? [ ] yes [ ] no
  Please explain: ____
- Have you ever taken Fosamax, Boniva, Actonel, or any medications containing bisphosphonates? [ ] yes [ ] no
- Are you on a special diet? [ ] yes [ ] no
- Do you use controlled substances? [ ] yes [ ] no

Women: Are you
[ ] Pregnant/Trying to get pregnant? [ ] Taking oral contraceptives? [ ] Nursing?

Are you allergic to any of the following?
[ ] Aspirin [ ] Penicillin [ ] Codeine [ ] Local Anesthetics [ ]Acrylic [ ] Metal [ ] Latex [ ] Sulfa Drugs [ ] Other
If other, please explain: ____

Please check if you have, or have had, any of the following:

[ ] AIDS/HIV Positive
[ ] Alzheimer's Disease
[ ] Anaphylaxis
[ ] Anemia
[ ] Angina
[ ] Arthritis/Gout
[ ] Artificial Health Valve
[ ] Artificial Joint
[ ] Asthma
[ ] Blood Disease
[ ] Breathing Problem
[ ] Bruise Easily
[ ] Cancer
[ ] Chemotherapy
[ ] Chest Pains
[ ] Cold Sores/ Fever Blisters
[ ] Congenital Heart Disorder
[ ] Convulsions
[ ] Cortisone Medicine

[ ] Diabetes
[ ] Drug Addiction
[ ] Dry mouth
[ ] Emphysema
[ ] Epilepsy or Seizures
[ ] Excessive Bleeding
[ ] Fainting spells/ Dizziness
[ ] Heart Attack/ Failure
[ ] Heart Murmur
[ ] Heart Pacemaker
[ ] Heart Trouble/ Disease
[ ] Hemophilia
[ ] Hepatitis A
[ ] Hepatitis B or C
[ ] Herpes
[ ] High Blood Pressure
[ ] High Cholesterol
[ ] Hives or Rash
[ ] Hypoglycemia

[ ] Irregular Heartbeat
[ ] Kidney Problems
[ ] Leukemia
[ ] Liver Disease
[ ] Low Blood Pressure
[ ] Lung Disease
[ ] Mitral Valve Prolapse
[ ] Osteoporosis
[ ] Pain in Jaw joints
[ ] Parathyroid Disease
[ ] Psychiatric Care
[ ] Radiation Treatments
[ ] Renal Dialysis
[ ] Rheumatism
[ ] Shingles
[ ] Sickle Celle Disease
[ ] Sinus Trouble
[ ] Stomach/ Intestinal Disease
[ ] Stroke

[ ] Swelling of Limbs
[ ] Thyroid Disease
[ ] Tonsillitis
[ ] Tuberculosis
[ ] Tumors or Growths
[ ] Ulcers
[ ] Venereal Disease
[ ] Yellow Jaundice
[ ] Other serious illnesses not listed above, explain:
____
____
____
____
____
____
____
____
____

Comments:
____

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** ______________

HIPAA CONSENT OF SERVICES

Your Health Information May Be Used . . .

TO PROVIDE TREATMENT
We will use your HEALTH INFORMATION within our office to provide you with the best dental care possible. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care between hygienist, dental assistant, dentist, and business office staff. In addition, we may share your health information with physicians, referring dentists, clinical and dental labs, pharmacies or other health care personnel providing you treatment.

TO OBTAIN PAYMENT
We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically. We will be sure to only work with the companies with similar commitment to the security of our health information.

TO CONDUCT HEALTH CAREOPERATIONS
Your health information may be used during performance evaluations of our staff. Some of our best teaching opportunities use clinical situations experienced by patients receiving care at our office. As a result, health information may be including in training programs. It is also possible that health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine process of certification, licensing or credentialing activities.

IN PATIENT REMINDERS
Because we believe regular care is very important to your oral and general health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you or your family. These communications are an important part of our philosophy of patterning with our patients to be sure they receive the best preventive and restorative care modern dentistry provide. They may include postcards, folding postcards, letters, telephone reminders, email or texting.

PUBLIC HEALTH AND NATIONAL SECURITY
We may require to disclose to Federal Officials or military authorities health information necessary to complete an investigation related to public health information necessary to complete an investigation related to public health or national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic or the understanding of new side effects of a drug treatment or a medical device.

FAMILY, FRIENDS, AND CARE GIVERS
We may share your health information with those you tell us will be helping you with home hygiene, treatment, medication, or payment. We will be sure to ask your permission first. If there is an emergency, where you are unable to tell us what you want, we will use our very best judgement when sharing your health information only when it will be important to those participating in providing your care.

CONSENT FOR SERVICES
- Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any such collections to the patients account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.
- A late charge may apply to an unpaid balance exceeding 30 days.
- I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient's examination.
- I grant permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.
- A service charge of 1 ½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

ANESTHETICS: Most procedures are performed with a local anesthetic (commonly referred to as *Novocain and Zyloccaine)*. In addition, sedative and pain medications can be used to help minimize anxiety and discomfort. In rare instances, allergic reactions may occur, so you are requested to inform our office staff of any known allergies you may have. Some sedative or pain medication may cause drowsiness. Therefore, when these medications are used, you would need to make arrangements for transportation with another person to and from the office. Nitrous Oxide Sedation (laughing gas) is used as well.

INFORMED CONSENT AND AURTHORIZATION: I certify that I have read and understand this Informed Consent, which outlines the general treatment considerations as well as the potential problems and complication of dental treatment. I understand that potential complications and problems may include, but are not limited to, those described in the treatment and discussed with me. I understand that during and following the treatment, and in the future, conditions may become apparent that warrant additional or alternative treatment pertinent to the success of comprehensive treatment. Recognizing the potential problems and risks of dental treatment, authorization is given for dental treatment to be rendered by the dentist and office staff. I also approve any modification in design, materials, or care, if it is felt this is for my best interests.

Patient Signature ____ *Date* ___________