Mechanicsburg Dental Associates

PATIENT MEDICAL INFORMATION

Today's Date: _____/_____/_____
Social Security Number: _____-_____-_____

General Information (CONFIDENTIAL)

M: ☐ F: ☐ Name: _____ Home Phone: _____
(Title) (Last) (First) (Middle)

Nickname: _____ Birthdate _____/_____/_____ Cell Phone: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Email address: _____

Check Appropriate Box: Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐

Patient's Employer: _____ Work Phone: _____

Patient's Occupation: _____

Business Address: _____

City: _____ State: _____ Zip Code: _____

Spouse's Name: _____

Employer: _____ Work Phone: _____

If patient is a College Student, Name of School/College: _____ Full Time ☐ Part Time ☐

City: _____ State: _____

Whom may we thank for referring you? _____

Person to contact in case of emergency: _____ Phone: _____

Relationship to patient: _____

Responsible Party (THIS INFORMATION IS REQUIRED IF OTHER THAN PATIENT)

Name of person responsible for this account: _____ Relationship to Patient: _____
(If different from above)

Address: _____ Home Phone: _____

City: _____ State: _____ Zip Code: _____

Employer: _____ Work Phone: _____

Is this person currently a patient in our office? Yes ☐ No ☐

Mechanicsburg Dental Associates

PATIENT MEDICAL INFORMATION

Medical Information

Physician: _____

Office Phone: _____

Date of Last Exam: _____

		Yes	No
1.	Do you consider yourself to be in good health?	☐	☐
2.	Are you under medical treatment now? Reason: _____	☐	☐
3.	Have you been hospitalized for any surgical operation or serious illness within the past five years? Type: _____	☐	☐
4.	Are you taking any prescription medication(s) including non-prescription medicine or herbal supplements? Please list: _____ _____ _____ _____	☐	☐
5.	Has there been any change in your general health in the past year?	☐	☐
6.	Do you use tobacco?	☐	☐
7.	Do you use alcohol?	☐	☐
8.	Do you use cocaine or other drugs?	☐	☐
9.	Are you allergic to or have you had any reactions to the following?		
	Latex	☐	☐
	Local Anesthetics (eg. Novocain)	☐	☐
	Penicillin	☐	☐
	Other Antibiotics _____	☐	☐
	Sulfa Drugs	☐	☐
	Barbiturates	☐	☐
	Sedatives	☐	☐
	Iodine	☐	☐
	Aspirin	☐	☐
	Other _____	☐	☐
10.	Are you required to take pre-medication prior to dental treatment (ie. For heart murmur, mitral valve prolapses, joint replacement)?	☐	☐
11.	Women only: Are you pregnant or thinking you might be?	☐	☐
12.	Do you have any psychiatric conditions? Please list: _____ _____ _____	☐	☐

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

	Yes	No		Yes	No		Yes	No
High blood pressure	☐	☐	Thyroid problem	☐	☐	Stomach troubles/ulcers	☐	☐
Heart attack	☐	☐	AIDS or HIV infection	☐	☐	Diabetes	☐	☐
Rheumatic Fever	☐	☐	Kidney Disease	☐	☐	Liver Disease	☐	☐
Low blood pressure	☐	☐	Fainting/Seizures	☐	☐	Hay Fever/Allergies	☐	☐
Heart Disease	☐	☐	Autism	☐	☐	Asthma	☐	☐
Cardiac pacemaker	☐	☐	Cancer (radiation/chemotherapy)	☐	☐	Emphysema	☐	☐
Heart murmur	☐	☐	Leukemia	☐	☐	Tuberculosis	☐	☐
Chest pains	☐	☐	Arthritis	☐	☐	Respiratory problems	☐	☐
Valve replacement	☐	☐	Joint Replacement or Implant	☐	☐	Hepatitis/Jaundice	☐	☐
Stroke	☐	☐				Other _____	☐	☐
Epilepsy/Convulsions	☐	☐						
Osteoporosis/Bisphosphonate	☐	☐						

Medical Information (CONTINUED)

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

	Yes	No
Bleeding gums	☐	☐
Dental sensitivity	☐	☐
Jaw clicking	☐	☐
Orthodontics (ever)	☐	☐
Removeable dental appliances	☐	☐
Mouth ulcers	☐	☐

How many times do you brush your teeth per day?

_____

How often do you floss?

_____

Is there anything we have not asked that you would like for us to know?

_____

_____

_____

Authorization and Release

I certify that the above information has been accurately provided. I authorize the dentist to release any information, including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such dental care, to third party payers and/or health practitioners. Should I have dental benefits that are being assigned to the dentist, I authorize and request that my insurance company pay these benefits directly to the dentist. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or that of my dependents, and also for any charges that may arise from the collection of those fees.

Signature of patient or parent (if minor) _____

Mechanicsburg Dental Associates

DENTAL INSURANCE INFORMATION

Patient Name _____ Date _____

DENTAL INSURANCE
Policy #1

INSURANCE INFORMATION

INSURANCE CO._____

ADDRESS _____

CITY _____ STATE _____

PHONE _____ ZIP_____

ID #_____

GROUP #_____

EMPLOYER INFORMATION

COMPANY _____

CITY_____

STATE _____ ZIP_____

POLICY HOLDER INFORMATION

EMPLOYEE / SUBSCRIBER NAME

_____

SS # _____

DATE OF BIRTH _____

RELATIONSHIP TO PATIENT _____

DENTAL INSURANCE
Policy #2

INSURANCE INFORMATION

INSURANCE CO._____

ADDRESS _____

CITY _____ STATE _____

PHONE _____ ZIP_____

ID #_____

GROUP #_____

EMPLOYER INFORMATION

COMPANY _____

CITY_____

STATE _____ ZIP_____

POLICY HOLDER INFORMATION

EMPLOYEE / SUBSCRIBER NAME

_____

SS # _____

DATE OF BIRTH _____

RELATIONSHIP TO PATIENT _____

Mechanicsburg Dental Associates

FINANCIAL POLICY ACKNOWLEDGEMENT

The following information is designed to make you aware of our financial policy.
Please do not hesitate to contact us at any time if you have questions regarding this policy.

We are committed to providing you with the highest quality of care, and our fees are a reflection of the quality of care we provide. By offering a variety of financial alternatives, we continue our commitment to enabling you to receive the dental care you need. We accept cash, personal checks, and major credit cards as forms of payment. We have also partnered with a third-party company to offer the flexibility of deferred interest and extended payment options for major services.

All recommended treatment options and associated fees will be communicated to you prior to the start of treatment. Payment is expected at the time of service. It is our policy that the parent or guardian accompanying a child to our office for treatment is responsible for payment for all services rendered.

Check policy: If your check is returned for any reason, we will debit your account for the amount of the check as well as for a processing fee of $50.00.

A delinquent account impedes our ability to provide you with the quality dental care that you deserve; as such, accounts outstanding over 60 days will be charged a $5 per month billing charge. If your account is turned over to a collection agency you will be responsible for the associated fees.

Appointments: We are committed to respecting your time and ask that you make every effort to keep the appointment time reserved exclusively for you. We understand that there may be times when you are unable to keep your scheduled appointment, however any appointment missed without a 24-hour notice may be subject to a missed appointment fee of $50.00 per hour. Should you find it necessary to reschedule an appointment, please provide us with a notice of 24 hours to enable us to offer that time to another patient.

Insurance: As a courtesy to our patients with dental insurance benefits, we will submit your claim and provide any necessary information to assist you in receiving any relevant benefits. We are participating providers with several PPO networks—due to the great variety of networks and insurance companies, however, it is always best to verify that our office participates with YOUR specific plan. (We do not participate with any DMO, HMO, or DHMO plans.) We require that any applicable deductibles and estimated patient copayments be paid at the time treatment is provided to patients covered by participating plans. If you have an out-of-network policy, payment in full is expected on the day of service, and your insurance carrier will reimburse you directly. Please contact your insurance carrier prior to your visit to obtain essential and up-to-date information about your coverage. Providing us with this information will expedite the processing of your claims. Please note that we do not participate with ANY medical insurance plans.

IMPORTANT FACTS ABOUT DENTAL INSURANCE BENEFITS

- ☐ Dental insurance is a contract between the patient and the insurance company. It is a benefit designed to assist you with the cost of dental care. At no time should insurance benefits compromise your doctor's diagnosis or affect your choice of treatment.
- ☐ It is your responsibility to understand your dental insurance and the benefits selected by you and/or your employer.
- ☐ You are responsible for the fees of all services rendered. Any claims not paid by your insurance company after 90 days is your responsibility.

PATIENT NAME (please print): _____

(dependents): _____

PATIENT SIGNATURE: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____ Date of Birth: _____

I have been given a copy of Mechanicsburg Dental Associates' *Notice of Privacy Practices* ("*Notice*"), which describes how my health information is used and shared. I understand that the Practice has the right to change this *Notice* at any time. I may obtain a current copy by contacting the Practice Privacy Officer.

My signature below acknowledges that I have been provided with a copy of the *Notice of Privacy Practices*:

_____ _____

Signature of Patient or Personal Representative *Date*

_____

Print Name

_____

Personal Representative's Name Title (e.g. Guardian, Health Care Power of Attorney)

For Facility Use Only: Complete this section if you are unable to obtain a signature.

If the patient or personal representative is unable or unwilling to sign this *Acknowledgement*, or the *Acknowledgement* is not signed for any other reason, state the reason:

_____

_____

Completed by:

_____ _____

Signature of Practice Representative *Date*

_____

Print Name and Title