

MAIN STREET DENTAL
Dr. Erin Cox

Patient Name _____

Other family members in practice (please list names and ages)

Whom may thank for referring you _____

When was your last visit _____

Previous Dentist (name, location and phone number) _____

How often did you have your teeth cleaned / visits per year _____

	yes	no
Have you ever visited a Periodontist (Gum Specialist) for your cleanings	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been told that you clench or grind	<input type="checkbox"/>	<input type="checkbox"/>
Is your drinking water from a well	<input type="checkbox"/>	<input type="checkbox"/>
Is your drinking water Fluoridated	<input type="checkbox"/>	<input type="checkbox"/>
Does dental treatment make you nervous	<input type="checkbox"/>	<input type="checkbox"/>

Any other information that you feel would be helpful to know _____

Patient Signature _____

Date _____

Dr. Erin Cox

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

***** You may refuse to sign this Acknowledgement *****

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

Print Name

Signature

Date

For Office Use Only

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

- Individual refused to sign
- Communications barrier prohibited obtaining the acknowledgement
- An emergency prevented us from obtaining acknowledgement
- Other (please specify)

Dental/Medical History

Patient Name:

Birth Date:

Date Created:

Are you under a physician's care now? If yes, please include name and phone number: Yes No If yes

Have you ever been hospitalized, had a major operation or had a serious head or neck injury? Yes No If yes

Are you taking any medications, pills, or drugs? If yes, please list below. Yes No

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No If yes

Do you require premedication for your dental visits? If yes, please list medication and dose. Yes No If yes

Women: Are you...

Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic
 Metal Latex Sulfa Drugs Local Anesthetics
 Tetracyclin

Other allergies? If yes

Do you use any recreational drugs? Yes No If yes

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

AIDS/HIV Positive Yes No Cortisone Medicine Yes No Hemophilia Yes No Radiation Treatments Yes No
 Alzheimer's Disease Yes No Diabetes Yes No Hepatitis Yes No Recent Weight Loss Yes No
 Anaphylaxis Yes No Drug Addiction Yes No Renal Dialysis Yes No Anemia Yes No
 Herpes Yes No Rheumatic Fever Yes No Angina Yes No Emphysema Yes No
 High Blood Pressure Yes No Rheumatism Yes No Arthritis/Rheumatism Yes No Epilepsy or Seizures Yes No
 High Cholesterol Yes No Scarlet Fever Yes No Artificial Heart Valve Yes No Excessive Bleeding Yes No
 Hives or Rash Yes No Shingles Yes No Artificial Joint Yes No Excessive Thirst Yes No
 Hypoglycemia Yes No Sickle Cell Disease Yes No Asthma Yes No Fainting Spells/Dizziness Yes No
 Irregular Heartbeat Yes No Sinus Trouble Yes No Blood Disease Yes No Frequent Cough Yes No
 Kidney Problems Yes No Spina Bifida Yes No Blood Transfusion Yes No Frequent Diarrhea Yes No
 Leukemia Yes No Stomach/Intestinal Disease Yes No Breathing Problems Yes No Frequent Headaches Yes No
 Liver Disease Yes No Stroke Yes No Bruise Easily Yes No Low Blood Pressure Yes No
 Swelling of Limbs/Gout Yes No Cancer Yes No Glaucoma Yes No Lung Disease Yes No
 Thyroid Disease Yes No Chemotherapy Yes No Tobacco Use Yes No Mitral Valve Prolapse Yes No
 Tonsillitis Yes No Chest Pains Yes No Heart Attack/Failure Yes No Osteoporosis Yes No
 Tuberculosis Yes No Cold Sores/Fever Blisters Yes No Heart Murmur Yes No TMJ or jaw pain Yes No
 Tumors or Growths Yes No Congenital Heart Disorder Yes No Heart Pacemaker Yes No Parathyroid Disease Yes No
 Ulcers Yes No Convulsions Yes No Heart Trouble/Disease Yes No Psychiatric Care Yes No

Have you ever had any serious illness not listed Yes No If yes

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:

X

Date: _____

FINANCIAL POLICY- OFFICE OF MAIN STREET DENTAL

We are committed to providing you with the best possible care. Your clear understanding of our financial policy is important to our professional relationship. Prior to treatment, you must complete our patient information and medical history forms, read and approve our privacy policy and submit your insurance card for photocopying. Please ask if you have any questions about our fees, financial policy or your responsibilities.

Your appointment time is reserved exclusively for you. If you cannot keep your appointment, you must provide our office with a 48- hour notice to avoid a broken appointment fee of \$50.00.

We will do everything we can to inform you in advance of the anticipation costs of your treatment, including an estimate of the benefit your insurance company is likely to pay. Such information does not preclude the possibility that additional costs may be included if unanticipated treatment becomes necessary, nor will it absolve you of your obligation to pay for such treatment. Keep in mind that your treatment needs are not connected to or determined by you insurance benefits.

Insurance is a contract between you and your insurance company. Not all services are a covered benefit in all contracts. We file insurance claims as a courtesy to our patients. We will not become involved in any disputes between you and your insurance company regarding deductibles, co-payments, covered services, "usual and customary", allowances or other issues other than to provide factual information as necessary. You, the patient, are ultimately and completely responsible for payment of your account.

Payment for dental treatment is always due at time of service. If you do not have insurance, or if your insurance will not reimburse us directly (for example: Out-of State Blue Cross Blue Shield), payment in full is expected at the time of service, unless otherwise arranged in advance.

There are payment options available for those unable to pay in full at time of service. These options must be agreed upon prior to treatment being rendered. Please ask a member of our staff to further elaborate.

After 90- days of invoice date, all accounts are subject to interest. Interest at the rate of one percent per month will be added to your account until the balance has been paid in full.

If an account is referred to, or purchased by, a collection agency, a fee will be assessed(33.3%) of the outstanding balance and added to your ledger. In addition, you will be responsible for any fees added by or incurred by the collection agency collecting the debt.

I have read the above policy and understand my responsibility for my account. I, the patient, am ultimately and completely responsible for payment of my account and agree to the above terms.

Signature of Patient or Responsible Party

Date

Complete Printed Name- First/Middle/Last/ Jr., Sr., III, IV

ASSIGNMENT OF BENEFITS

This signature on file is my authorization for the release of information to process my claim. I hereby authorize payment to Main Street Dental of the benefits otherwise payable to me.

Signature of Patient or Responsible Party

Date

PATIENT REGISTRATION

ID: _____ Chart ID: _____
First Name: _____ Last Name: _____ Middle Initial: _____

Preferred Name: _____

Patient is : Responsible Party Policy Holder

Responsible Party: (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ Address 2: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Birth date: _____ Social Security #: _____ Drivers Lic#: _____

Responsible Party is Policy Holder for Patient Primary Policy Holder Secondary Policy Holder

Patient Information:

Address: _____ Address 2: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Sex: Female Male Marital Status: Married Single Divorced Separated Widowed

Birth date: _____ Social Security #: _____ Drivers Lic#: _____

E-mail: _____ I would like to receive email correspondences

Patient Information (section 2):

Employment Status: Full Time Part Time Self Employed Retired Unemployed

Student Status: Full Time Part Time

Preferred Dentist: _____ Preferred Hygienist: _____ Preferred Pharmacy: _____

Referred By: _____

Medicaid ID: _____

Primary Insurance Information:

Name of Insured: _____ Relationship to Insured: Self Spouse Child Other

Employer ID: _____ Carrier ID: _____

Insured Social Security #: _____ Insured Birth date: _____

Employer: _____ Insurance Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City, State, Zip: _____ City, State, Zip: _____