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		
Have you ever been told that you clench or grind		
Is your drinking water from a well		
Is your drinking water Fluoridated		
Does dental treatment make you nervous		

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., lll, IV

ASSIGNMENT OF BENEFITS

This signature on file is my authorization for the release of information to process my claim. I herby 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: