Mann Family Dental, LLC
New Patient Information Form

Date:_____

Name : _____ Title:_____

Address: _____City:_____ State: _____ Zip _____

SS No:_____ DOB: / / Sex:_____ Marital:_____

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

Email:_____

Who may we thank for your referral?_____

Emergency Contact

Name:_____ Relationship:_____

Cell Number:_____Work/Home:_____

Primary Dental Insurance Coverage

Insurance Company:_____ Subscriber ID:_____

Subscriber Name:_____ Relationship To Patient:_____

Insurance Claims Address:_____

SS No:_____ DOB: / / Employer:_____ Group #:_____

Secondary Dental Insurance Coverage

Subscriber Name:_____ Relationship To Patient:_____

Insurance Claims Address:_____

SS No:_____ DOB: / / Employer:_____ Group #:_____

Insurance Company:_____ Subscriber ID:_____

Responsible Party

Print Name:_____ Relationship To Patient (If Minor):_____

Signature:_____

Mann Family Dental, LLC
Informed Consent
General Consent for Treatment

All dental and anesthetic procedures have associated risks. These may be, but are not limited to:

- Drug reactions and side effects
- Damage to adjacent teeth or fillings
- Post-operative infection
- Post-operative bleeding that might require additional treatment
- Delayed healing of an extraction site, (dry socket) necessitating additional care
- Sinus involvement during removal of upper molars which may require additional treatment or surgical repair at a later date.
- Involvement of the nerves during removal of teeth resulting in temporary or possibly permanent numbness or tingling of the lip, chin, tongue, or other areas
- Bruising, swelling, sensitivity, or pain
- Failure of the dental procedure necessitating additional treatment
- Breakage of dental instruments inside tooth canals making additional treatment necessary
- Complications during treatment necessitating referral to a specialist

I understand the recommended treatment for my conditions, the risks of such treatment, any alternatives and risks, as well as the consequences of doing nothing. Any fee(s) involved have also been explained. All my questions have been answered, and I have not been offered any guarantees.

Patient Signature: _____

Print Name: _____Date:_____

I am the parent or guardian of _____ who is a minor child, and I do hereby authorize and consent to any x-ray, examination, anesthetic, or dental treatment rendered under the general, direct, or indirect supervision of **Dr. Mann** and his associates, staff members, or agents, as they may deem necessary.

Parent or Guardian Signature (if Patient under 18): _____

Print Name:_____Date:_____

Office Use: Witnessed By: _____

Mann Family Dental, LLC

Self Payment and Insurance Authorization Release

I the undersigned, certify that I have insurance coverage with (leave blank if self pay) _____ and assign directly to **Dr. Tyler Mann, DDS** all insurance benefits, if any, otherwise payable to me for services rendered.

I understand that I am financially responsible for all charges incurred whether or not paid by insurance and that all amounts deemed my responsibility for co-pays, co-insurance, deductibles and or non-covered services will be paid in full on the date of service unless otherwise agreed upon in advance by **Dr. Tyler Mann, DDS** or his authorized representative.

I hereby authorize **Dr. Tyler Mann, DDS** access to any and all information necessary to secure payments on my behalf for services rendered under his care. I authorize the use of my signature on all insurance submissions whether paper and/or electronic.

I understand that it is my responsibility to contact my insurance company or my Employee Benefits Coordinator where I work regarding coverage, benefits, deductibles, and/or pre-certification requirements.

I understand that if there are any fees incurred at the absence of appointment or negligence on my behalf I am responsible for covering any balance of lab fee, missed appointment fee, or equipment fee before being scheduled for future appointments.

Patient Signature: _____

Parent Signature(if patient under 18):_____

Print Name:_____

Date: _____

Office Use: Witnessed By: _____

Mann Family Dental, LLC
Acknowledgement of Receipt of
Notice of Privacy Practice
(Available Upon Request)

The Health Insurance Probability and Accountability Act of 1996 requires that health care providers give patients a copy of the office Notice of Privacy Practices and make a good faith effort to obtain an acknowledgement of receipt of same. *You may refuse to sign this acknowledgement form.*

By signing this form I confirm that I have received a copy of the office Notice of Privacy Practices.

Print name _____

Sign name _____

Date _____

OFFICE USE ONLY

- o Patient refused to sign
- o Emergency situation
- o Unable to communicate with patient

Other_____

Health History provided to Mann Family Dental, LLC

Patient Name:_____ DOB:____/____/____ DATE:_____

Dental History Do you have a specific dental problem: Yes No_____

Have you had routine dental care in the past: Yes No _____

Do you like your smile? Yes No _____

Do you have any of the following? (Please check all that apply to you)

☐ Broken Fillings ☐ Swelling in mouth ☐ Injury to teeth or jaw ☐ Bleeding gums ☐ Decayed Teeth

Medical History

Are you under the care of a physician, past or present? Yes No _____

Have you ever had a serious injury to the head or neck? Yes No _____

Have you had any artificial joint replacements? Yes No if yes when?_____

Do you have any allergies to the following medications or materials? Yes No _____

☐ Penicillin ☐ Codeine ☐Metal ☐Latex
☐Other_____

Tobacco Use? Yes No If yes what type: _____

Current Medication:_____

Women (Please Check) ☐ Pregnant (# Weeks)_____ ☐ Not Pregnant ☐ Nursing ☐ Taking Contraceptives

Do you now or have you ever had the following?

Cancer	Yes No	Kidney Problems	Yes No	Osteoporosis	Yes No
Breathing Difficulty	Yes No	Renal Dialysis	Yes No	IV Bisphosphonates	Yes No
Tuberculosis	Yes No	Mental Disabilities	Yes No	Endocarditis	Yes No
Thyroid Disease	Yes No	Drug Addiction	Yes No	Bleeding Issues	Yes No
Asthma	Yes No	Stroke	Yes No	High Blood Pressure	Yes No
Diabetes	Yes No	Cold Sores	Yes No	Low Blood Pressure	Yes No
Artificial Joint	Yes No	Psychiatric Care	Yes No	Seizures/Epilepsy	Yes No
Hepatitis	Yes No	Hives or Rash	Yes No	Heart Condition	Yes No
AIDS/HIV Positive	Yes No	Pacemaker	Yes No	Liver Condition	Yes No

Have you ever had any other serious illness not checked above? Yes No _____

Do you wish to discuss anything privately with the dentist? Yes No _____

X_____ Date:_____

Patient Signature (Parent or Guardian) To the best of my knowledge the above information is correct

Reviewed by Doctor or RDH _____ Date: _____