Patient Information

Personal Information:

_____ First Name

_____ Last Name

_____ Preferred Name

_____/_____/_____ Date of Birth

_____-_____-_____ Social Security Number

Sex ○Male ○Female

_____ Street / House / Apartment No.

_____ City

_____ State

_____ Zip Code

_____ Driver License Number

_____@_____ Email Address

_____ Phone Number

_____ Cell

Can We Text Appointment Reminders / Confirmations To Your cell phone? ○Yes ○No

How did you hear about us? _____

Emergency Contact:

_____ Name

_____ Relationship

_____ Phone Number

Employer:

_____ Employer

_____ Phone Number

Insurance Information:

_____ Primary Insurance and Subscriber

_____/_____/_____ Subscribers Date of Birth

_____ Member Number

_____ Group Number

MORAN PRAIRIE DENTISTRY
Personalized & Comfortable

Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of the 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 If yes:_____
Have you ever been hospitalized or had a major operation? ○ Yes ○ No If yes:_____
Have you ever had a serious head or neck injury? ○Yes ○ No If yes:_____
Are you taking any medications, pills, or drugs? ○Yes ○ No If yes:_____
Do you take, or have you taken, Phen-Fen or Redux? ○Yes ○ No If yes:_____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ○Yes ○ No If yes:_____
Are you on a special diet? ○Yes ○ No If yes:_____
Do you use tobacco? ○Yes ○ No If yes:_____
Do you use controlled substances? ○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 ○Other:_____

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

AIDS/HIV Positive	○Yes ○No	Cortisone Medicine	○Yes ○No
Alzheimer's Disease	○Yes ○No	Diabetes	○Yes ○No
Anaphylaxis	○Yes ○No	Drug Addiction	○Yes ○No
Anemia	○Yes ○No	Easily Winded	○Yes ○No
Angina	○Yes ○No	Emphysema	○Yes ○No
Arthritis/Gout	○Yes ○No	Epilepsy or Seizures	○Yes ○No
Artificial Heart Valve	○Yes ○No	Excessive Bleeding	○Yes ○No
Artificial Joint	○Yes ○No	Excessive Thirst	○Yes ○No
Asthma	○Yes ○No	Fainting Spells/Dizziness	○Yes ○No
Blood Disease	○Yes ○No	Frequent Cough	○Yes ○No
Blood Transfusion	○Yes ○No	Frequent Diarrhea	○Yes ○No
Breathing Problems	○Yes ○No	Frequent Headaches	○Yes ○No
Bruise Easily	○Yes ○No	Genital Herpes	○Yes ○No
Cancer	○Yes ○No	Glaucoma	○Yes ○No
Chemotherapy	○Yes ○No	Hay Fever	○Yes ○No
Chest Pains	○Yes ○No	Heart Attack/Failure	○Yes ○No
Cold Sores/Fever Blisters	○Yes ○No	Heart Murmur	○Yes ○No
Congenital Heart Disorder	○Yes ○No	Heart Pacemaker	○Yes ○No
Convulsions	○Yes ○No	Heart Trouble /Disease	○Yes ○No

Medical History Cont.

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

Hemophilia	○Yes ○No	Radiation Treatment	○Yes ○No
Hepatitis A	○Yes ○No	Recent Weight Loss	○Yes ○No
Hepatitis B or C	○Yes ○No	Renal Dialysis	○Yes ○No
Herpes	○Yes ○No	Rheumatic Fever	○Yes ○No
High Blood Pressure	○Yes ○No	Rheumatism	○Yes ○No
High Cholesterol	○Yes ○No	Scarlet Fever	○Yes ○No
Hives or Rash	○Yes ○No	Shingles	○Yes ○No
Hypoglycemia	○Yes ○No	Sickle Cell Disease	○Yes ○No
Irregular Heartbeat	○Yes ○No	Sinus Trouble	○Yes ○No
Kidney Problems	○Yes ○No	Spina Bifida	○Yes ○No
Leukemia	○Yes ○No	Stomach/Intestinal Disease	○Yes ○No
Liver Disease	○Yes ○No	Stroke	○Yes ○No
Low Blood Sugar	○Yes ○No	Swelling of Limbs	○Yes ○No
Low Blood Pressure	○Yes ○No	Thyroid Disease	○Yes ○No
Lung Disease	○Yes ○No	Tonsillitis	○Yes ○No
Mitral Valve Prolapse	○Yes ○No	Tuberculosis	○Yes ○No
Osteoporosis	○Yes ○No	Tumors or Growth	○Yes ○No
Pain in the Jaw Joints	○Yes ○No	Ulcers	○Yes ○No
Parathyroid Disease	○Yes ○No	Venereal Disease	○Yes ○No
Psychiatric Care	○Yes ○No	Yellow Jaundice	○Yes ○No

Have you ever had any serious illness not listed above? ○Yes ○No

If yes:_____

Comments:_____

_____

_____

_____

_____

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Acknowledgement of Private Practices

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly

Obtain payment from third-party payers for my health care services

Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of my health care provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my healthcare provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices.* Importantly the updated 09/23/2013 version of the NOPP reflecting the OMNIBUS rule.

I understand that I may request in writing that you restrict how my private information is used to disclose to carry out treatment, payment or healthcare operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Dependent Family members are also covered by this acknowledgement.

_____ _____

Print Name Date

_____

Signature

Financial Policy

Welcome! Thank you for selecting us as your dental health care providers. Our goal is to provide you and your family with optimal dental care. We want you to feel welcome and as comfortable as possible throughout our relationship. We encourage you to ask questions and to be involved in treatment decisions. This includes understanding your treatment plan as well as our financial policy.

FINANCIAL AGREEMENT: Our dental office is a third party to your insurance company and as a courtesy to our insured patients, we submit claims to your insurance company free of charge. We will help you to receive your maximum allowable benefits. In order to do this we need your insurance card and/or insurance policy with you on your first visit of every calendar year (your insurance year may not run January-December) all of our doctors will diagnose treatment based on your dental health NOT your insurance coverage. Patients are expected to pay for services at the time they are rendered. Our patients who have dental insurance are expected to pay the amount of their estimated copay and deductible at the time of service. We must emphasize that this is only an estimate and all charges you incur are your responsibility regardless of your insurance coverage. After receiving payment from your insurance company a refund will be given if you overpaid, or a statement will be sent out to collect the remaining out of pocket expenses for the services that were rendered,the guarantor will receive the bill for anyone on the insurance plan. Delinquent balances over 60 days will be charged interest at a rate of 1.5% per month in addition to a $5.00 monthly billing fee per statement. Accounts over 90 days will be turned over to collections, you will be responsible for all costs of collections including, but not limited to, agency fees, attorney fees, rebilling charges and court costs**.** Payments may be made using cash, check, Visa, Mastercard and/or Discover. All card payments will have a charge added to total transaction amount.We also offer CARECREDIT which is a financing option that is available only for healthcare expenses!
CANCELLATION & NO SHOW POLICY: In order to serve you and our other patients the best we can, we try to maintain an efficient appointment system. Your appointment time is reserved for you! For cancellations we request 24 hours advance notice. An answering machine is available for messages left after business hours. After 3 missed appointments or cancelled appointments we will place you on a short call list, which means we will phone you when an appointment time becomes available on short notice. This gives you the opportunity to know if your busy schedule has an opening for a dental appointment within the next few hours.

CONSENT: I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO MY DENTAL OFFICE, AND I AUTHORIZE MORAN PRAIRIE DENTISTRY TO CHARGE A FEE BASED ON THE TOTAL TRANSACTION AMOUNT IF USING A DEBT/CREDIT CARD.The undersigned hereby authorize the presiding Doctor and/or staff to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the presiding Doctor and/or staff to make a thorough diagnosis for the patient's dental needs. I also authorize the presiding Doctor and/or staff to perform any and all forms of treatment, medications and therapy that may be indicated, and agreed upon. I also understand the use of anesthetic agents embodies a certain risk.

_____ _____

Patient Name *Date*

_____

Signature