Patient Registration

MYDENTAL
Keeping Your Smile Beautiful

PATIENT INFORMATION							
Last Name		First		M.I.		Birth Date	
Street Address						Social Security No.	
City		State				ZIP	
Phone No.		E-mail Address					
Gender ☐ Male ☐ Female		Marital Status	☐ Under age 18 ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed				
Employer Name		Occupation				Employer Phone No.	
Other family member seen here							

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)							
Policy Holder's Last Name		First		M.I.		Birth Date	
Street Address						Social Security No.	
City		State				ZIP	
Phone No.		Relation to Patient:	☐ Self ☐ Spouse ☐ Child ☐ Other:				
Insurance Plan Name		ID/SSN				Group No.	

EMERGENCY CONTACT INFORMATION			
Name		Phone No.	

REFERRAL INFORMATION			
Whom may we thank for referring you to our practice?			
Friend or Relative		Another Patient	
☐ Insurance ☐ Website ☐ Drive By ☐ Newspaper ☐ Mail ☐ School ☐ Work ☐ Other:			

DENTAL HISTORY			
Former Dentist:			
Reason for today's visit:			
Date of last exam:		Date of last dental x-rays:	
DO YOU HAVE ANY OF THE FOLLOWING?			
☐ Bad breath ☐ Bleeding gums ☐ Clicking or popping jaw	☐ Food collection between teeth ☐ Grinding teeth ☐ Loose teeth	☐ Periodontal treatment ☐ Dry mouth ☐ Sensitivity to hot/cold/sweet	☐ Broken fillings ☐ Sensitivity when biting ☐ Previous Orthodontic work

DISCLAIMER AND SIGNATURE			
By my signature below, I certify the information I provided above is true, accurate, and complete. If there is any change, I will inform myDental at the next appointment. Furthermore, I allow myDental to carry automated electronic communication via email, text, and phone listed under my record involving, but not limited to, reminders, follow ups, offers, etc. I have an option to change my communication preference at any time.			
Signature of Patient/Guardian		Date	

Medical History

MYDENTAL
Keeping Your Smile Beautiful

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your 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.

Patient Name			
Name of Primary Care Physician		Phone No.	
What is your estimate of your general health?	☐ Excellent ☐ Good ☐ Fair ☐ Poor		

Are you under a physician's care now?	☐ Yes	☐ No	If yes, please explain:
Have you ever been hospitalized or had a major operation?	☐ Yes	☐ No	If yes, please explain:
Have you ever had a serious head or neck injury?	☐ Yes	☐ No	If yes, please explain:
Are you taking any medications, pills, or drugs?	☐ Yes	☐ No	If yes, please explain:
Do you take, or have you taken, Phen-Fen or Redux?	☐ Yes	☐ No	
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	☐ Yes	☐ No	
Are you on a special diet?	☐ Yes	☐ No	
Do you use tobacco?	☐ Yes	☐ No	
Do you use controlled substances?	☐ Yes	☐ No	
Do you snore?	☐ Yes	☐ No	
Do you currently use a CPAP machine?	☐ Yes	☐ No	
Have you ever been diagnosed with sleep apnea?	☐ Yes	☐ No	

WOMEN: ARE YOU

Pregnant / Trying to get pregnant? ☐ Yes ☐ No Taking oral contraceptives? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

☐ Asprin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs

☐ Other:

DO YOU HAVE, OR HAVE YOU HAD, ANY OF THE FOLLOWING?

☐ AIDS/HIV Positive	☐ Cortisone Medicine	☐ Hemophilia	☐ Radiation Treatments
☐ Alzheimer's Disease	☐ Diabetes	☐ Hepatitis A	☐ Recent Weight Loss
☐ Anaphylaxis	☐ Drug Addiction	☐ Hepatitis B or C	☐ Renal Dialysis
☐ Anemia	☐ Easily Winded	☐ Herpes	☐ Rheumatic Fever
☐ Angina	☐ Emphysema	☐ High Blood Pressure	☐ Rheumatism
☐ Arthritis/Gout	☐ Epilepsy or Seizures	☐ High Cholesterol	☐ Scarlet Fever
☐ Artificial Heart Valve	☐ Excessive Bleeding	☐ Hives or Rash	☐ Shingles
☐ Artificial Joint	☐ Excessive Thirst	☐ Hypoglycemia	☐ Sickle Cell Disease
☐ Asthma	☐ Fainting Spells/Dizziness	☐ Irregular Heartbeat	☐ Sinus Trouble
☐ Blood Disease	☐ Frequent Cough	☐ Kidney Problems	☐ Spina Bifida
☐ Blood Transfusion	☐ Frequent Diarrhea	☐ Leukemia	☐ Stomach/Intestinal Disease
☐ Breathing Problem	☐ Frequent Headaches	☐ Liver Disease	☐ Stroke
☐ Bruise Easily	☐ Genital Herpes	☐ Low Blood Pressure	☐ Swelling of Limbs
☐ Cancer	☐ Glaucoma	☐ Lung Disease	☐ Thyroid Disease
☐ Chemotherapy	☐ Hay Fever	☐ Mitral Valve Prolapse	☐ Tonsillitis
☐ Chest Pains	☐ Heart Attack/Failure	☐ Osteoporosis	☐ Tuberculosis
☐ Cold Sores/Fever Blisters	☐ Heart Murmur	☐ Pain in Jaw Joints	☐ Tumors or Growths
☐ Congenital Heart Disorder	☐ Heart Pacemaker	☐ Parathyroid Disease	☐ Ulcers
☐ Convulsions	☐ Heart Trouble/Disease	☐ Psychiatric Care	☐ Venereal Disease

Have you ever had any other serious illness not listed above? ☐ Yes ☐ No If yes, please explain:

COMMENTS

DISCLAIMER AND SIGNATURE

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/Guardian		Date	

Financial Policy

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

General
Thank you for choosing our practice as your Dental Care Provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to treatment. All patients must complete our Information and Insurance form before seeing the doctor.

Payment
Payment is always expected at the time of treatment unless we know your insurance will be paying 100%. All options for payment will need to be discussed with one of our Scheduling Coordinators or our Business Administrator.

WE ACCEPT CASH, VISA, MASTERCARD, AMERICAN EXPRESS, DISCOVER, CARE CREDIT

Treatment Plan
If it is discovered that you need any dental treatment, a treatment plan with an *estimated* co-pay, will be prepared prior to the beginning of any procedures. Treatment could be altered if your dental needs change. The patient will be notified of any changes in treatment.

Dental Insurance
Our office will gladly work with you to help get the maximum benefit available to you. Most dental insurance plans do not cover 100% of your cost of treatment. Therefore, you will be expected to pay your deductible and your *estimated* co-payment on the day services are rendered. We will gladly file your insurance claim. Many variables exist from carrier to carrier (i.e. deductibles, annual maximums, allowable fee limitations, non-covered procedures and other restrictions), therefore, we cannot guarantee any estimated charges. Because your insurance is an agreement between you and the insurance company, ultimately you are responsible for all charges. Please know that we will do everything possible to see that you receive the full benefits from your insurance company. If for some reason the payment for any dental claim is not received within 45 days, you will receive a statement for the entire balance due. If payment is not made within 45 days of receipt of the statement, your account may be turned over to collections. Charges that are denied or not covered by the insurance company are your responsibility.

Collection Costs
Account balances more than 45 days past due may be sent to collections. Patients will be responsible for costs of collections including, but not limited to, collection agency fees, attorney fees and court costs.

Usual and Customary Rates
Our practice is committed in providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Adult Patients
Adult patients are responsible for full payment at time of service.

Minor Patients
The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to be approved by Visa/MasterCard, American Express, Discover, CareCredit, or payment by cash at time of service has been verified.

Missed Appointments
The time you reserve with us is yours and yours alone. In the event that you will not be able to keep your appointment, we respectfully request you to notify a Scheduling Coordinator at least 48 hours prior to your scheduled appointment date. Of course, emergencies do happen--and we understand. Please help us serve you better by keeping scheduled appointments.

I have read the above financial policy and agree to the content. I also understand that I am ultimately financially responsible for any balance on my account.

Patient Name		Relationship to Patient	
Signature of Patient/Guardian		Date	

HIPAA Acknowledge and Consent

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize myDental to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g. my insurance company)
- The day-to-day healthcare operations of your practice

I have also been informed of, and given the right to review and secure a copy of *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPPA. I understand that myDental reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Patient Name		Relationship to Patient	
Signature of Patient/Guardian		Date	

Appointment Policy

Reserved appointment time in a dental office is limited and valuable. It is extremely important that all patients honor their reserved dental appointments. Failure to do so deprives our other patients from receiving needed dental care in a timely fashion.

A cancellation fee of $100.00 will be issued for any broken appointments without a 48-hour notice.

For Monday through Friday appointments, 50% of your copayment for the proposed treatment is collected at the time you schedule your appointment.

For Saturday appointments, 100% of your copayment for the proposed treatment is collected at the time you schedule your appointment.

Medicaid / CHIP Patients

MCNA Dental, DentaQeust, Amerigroup, and UnitedHealthcare are notified through our automated system if you cancel or no show for your appointment. In order to keep your insurance active, you must follow your insurance company's policy.

Please feel free to discuss this and other policies with our staff. Do not hesitate to call our office if you have any questions.

Patient Name		Relationship to Patient	
Signature of Patient/Guardian		Date	

Use of Photographic/Video Image Consent Form

I consent that myDental may use my photographs. video, and/or testimonial on their website and/or social media tools which includes but is not limited to their Facebook page, Google Plus page. I understand that these images, videos, and/or testimonial will not be used for any other commercial purposes.

I understand that I may revoke this authorization at any time, but such revocation must be in writing and received by myDental. Revocation affects disclosure moving forward and is not retroactive.

Patient Name		Relationship to Patient	
Signature of Patient/Guardian		Date	