Welcome to Mill Pond Dental Group

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely. If you have any questions or need assistance, please ask us, we will be happy to help.

**Patient Information**

Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_

SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: M F

Home Phone: (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work: (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell Phone: (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer/School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about us? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long since your last visit? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Former Dentist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How do you prefer to be contacted? Email\_\_\_ Text\_\_\_ Telephone\_\_\_\_

**Insurance Information**

Primary Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy #/Member ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| Do you have any additional insurance? Y/N If yes, complete the following |

Secondary Insurance (If Applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy #/Member ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Medical History

Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Office Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Last Exam: \_\_\_\_\_\_\_\_

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Yes No Yes No | | | | | | |
| 1. Are you under medical treatment now? |  |  |  | 1. Do you use controlled substances? |  |  |
| 1. Have you ever been hospitalized for any surgical operations or serious illness within the last 5 years?   *(If so, please list on Page 4)* |  |  |  | 1. Are you allergic to or have you any reactions to the following?  * *Latex Rubber* * *Local Anesthetics (e.g. Novacain)* * *Aspirin* * *Any Metals (e.g. nickel, mercury)* |  |  |
| 1. Are you taking any medications(s) including non-prescription medicine?   *(If so, please list on Page 4)* |  |  |  | * *Penicillin or any other Antibiotics* * *Sulfa Drugs* * *Sedatives* |  |  |
| 1. Have you ever taken Fosamax, Boniva, Actonel or any medications containing bisphosphonates? |  |  |  | 1. Women only:  * Are you pregnant or think you may be pregnant? * Are you nursing? * Are you taking oral contraceptives? |  |  |
| 1. Do you use tobacco? |  |  |  |  |  |  |
| 1. Do you have or have you had any of the following?   Yes No Yes No Yes No | | | | | | |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| * High Blood Pressure |  |  | * Heart Disease |  |  | * Anemia |  |  | |
| * Low Blood Pressure |  |  | * Cardiac Pacemaker |  |  | * Diabetes |  |  | |
| * Kidney Disease |  |  | * Heart Attack |  |  | * Emphysema |  |  | |
| * Epilepsy/Seizures |  |  | * Angina/Chest Pains |  |  | * Hay Fever/Allergies |  |  | |
| * Fainting/Dizzy Spells |  |  | * Thyroid Problem |  |  | * Tuberculosis |  |  | |
| * Asthma |  |  | * Stroke |  |  | * Radiation Therapy |  |  | |
| * Respiratory Issues |  |  | * Endocarditis |  |  | * Glaucoma |  |  | |
| * Rheumatic Fever |  |  | * Cancer |  |  | * Mitral Valve Prolapse |  |  | |
| * AIDS or HIV Infection |  |  | * Arthritis |  |  | * Liver Disease |  |  | |
| * Hepatitis/Jaundice |  |  | * Joint Replacement |  |  | * Acid Reflux |  |  | |
| * Sexually Transmitted Infection |  |  | * Osteoporosis |  |  |  |  | |
| Please list any other conditions your doctor should know about on Page 4. | | | | | | | | | |

**I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE**

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of patient (or parent/guardian if minor) Date

Patient Dental History

Previous Dentist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Last Exam: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Yes No Yes No | | | | | |
| 1. Do your gums bleed while brushing or flossing? |  |  | 1. Have you received oral hygiene instructions regarding the care of your teeth or gums? |  |  |
| 1. Are your teeth sensitive to hot/cold or sweet liquids/foods? |  |  | 1. Do you clench or grind your teeth? |  |  |
| 1. Do you have any sores or lumps in or near your mouth? |  |  | 1. Have you ever had prolonged bleeding following extractions? |  |  |
| 1. Do you feel pain in any of your teeth? |  |  | 1. Have you had any orthodontic treatment? |  |  |
| 1. Have you had any head, neck or jaw injuries? |  |  | 1. Do you wear dentures or partials?   If yes, date of placement\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| 1. Do you have frequent headaches? 2. Have you ever experienced any of the following problems in your jaw?  * Clicking * Pain (joint, ear, side of face) * Difficulty in opening or closing * Difficulty in chewing |  |  | 1. Have you lost any teeth or have any teeth been removed?    1. Reason for loss \_\_\_\_\_\_\_\_\_\_\_\_\_    2. Have they been replaced?    3. Are you happy with the replacement?    4. Would like to know about permanent replacement? | * A   A  A   * A   A   * A   A |  |
| 1. How often do you brush? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  | 1. Do you experience dry mouth? |  |  |
| 1. Do you use dental floss? |  |  | 1. Are you happy with your smile? |  |  |

**I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE**

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of patient (or parent/guardian if minor) Date

Patient Medical History Explanation

|  |
| --- |
| Please list any medications and supplements currently taking: |
| Please list any past or current medical procedures/surgeries: |
| Please list any allergies not captured above: |

Financial Policy and Information

**Payment Options:**

Cash, Check, Visa, MasterCard, American Express or discover Card

* We offer a 5% bookkeeping courtesy adjustment to patients who pay for their entire treatment with cash or check **prior** to beginning care for treatment plans of $500 or more.
* Checks are accepted with valid ID. There will be a $25 service charge for a returned check.

Payment plans are offered through CareCredit or Lending Club upon approval

* Allows you to pay over time with NO INTEREST
* Convenient, low monthly payment plans
* No annual fees or pre-payment penalties

**Please note:**

* Payment is expected at the time of service rendered.
* If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.
* We accept PPO insurance. We will file your claims as a courtesy at no charge. It is the patient’s responsibility to provide us with current insurance information.

*Note: If any payment from an insurance company becomes 30 days past due, you will immediately be billed for the entire balance.*

* We will file pre-treatment estimates, at your request. Please be aware that most insurance companies may have expirations. In ALL cases, it may delay important dental care.
* Not ALL services are covered by insurance. In the event your insurance plan determines a service to be “Not Covered”, you will be responsible for the fee for service. Our staff cannot guarantee your eligibility and coverage.
* Insurance limitations and regulations vary with all insurance plans. Therefore, if your insurance plan denies a service, you will be responsible for the complete charge. We do not base your treatment plan on what your insurance plan covers or doesn’t cover. We are working for you, not the insurance company.
* Past due accounts may be turned over to a collection agency. Any fees incurred due to this, will be added to the outstanding balance. This may include late fees, collection agency fees, court fees etc.

**Scheduling Policies**

* We respect our patient’s time and attempt to schedule appointments that are convenient for you. Your time is important to us. Our office requires a minimum of 48 hours notification so we can make your reserved time available for other patients.
  + Broken appointments (w/o notice) incur a fee of $50 per 60 minutes scheduled appointment.
  + Broken appointment fees must be paid before any further appointments may be reserved.

**I have read and understand the above information.**

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of patient (or parent/guardian if minor) Date

NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT

We keep a record of the health care services we provide you. You make ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to so. You may see your record or get more information about it by contacting this office.

Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This form will be retained in your dental records.