PATIENT INFORMATION

Has any member of your family been a patient in our office? ☐ **Yes** ☐ **No**

Name: _____ Salutation: _____

Address 1: _____ City: _____ State: _____ Zip: _____

Address 2: _____ City: _____ State: _____ Zip: _____

Home: _____ Cell: _____ Work: _____

D.O.B. _____ Age: ____ Sex: ____ SS#: _____ Email _____

FAMILY INFORMATION

Minor Single Married Name of Spouse: _____

Employer: _____ Address: _____

Emergency Contact: _____ Phone: _____

SUBSCRIBER/ RESPONSIBLE PERSON

Name: _____ D.O.B. _____

Address: (if different than above) _____ City: _____ State: _____

Home: _____ Work: _____ SS#: _____

Employer: _____ Address: _____ City: _____ St: _____

Dental Insurance Carrier: _____ Group/policy#: _____

Phone: _____ Mailing address: _____

How did you hear about us? _____

CONSENT FOR SERVICES: As a condition of your treatment by this office, financial arrangements must be made in advance. All emergency dental services, or any dental services performed without previous financial arrangements must be paid in advance.In consideration for the professional services rendered to me, or at my request, by the doctor, I agree to pay the reasonable value of said services. I grant my permission to you or your assignee, to telephone my insurance company to verify coverage, and telephone me at my home to discuss matters related to this form.

Signature of patient, parent or guardian: _____ Date: _____

Print Name: _____ Relationship to patient: _____

DENTAL HISTORY:

Reason for this visit:

Date of your last dental visit: What was done:

How often do you visit the dentist: Last complete series of dental film (x-rays)

Previous Dentist information:

How often do you brush: Floss:

Do you use an electric toothbrush: ☐ **Yes** ☐ **No** Water pick: ☐ **Yes** ☐ **No** Fluoride toothpaste: ☐ **Yes** ☐ **No**

Do you have TMJ/Jaw joint problems/pain: ☐ **Yes** ☐ **No** Do you clench or grind: ☐ **Yes** ☐ **No**

Do you wear a nightguard: ☐ **Yes** ☐ **No** Do You smoke or chew tobacco? ☐ **Yes** ☐ **No**

Do you have history of trauma to the teeth or jaw: ☐ **Yes** ☐ **No**

If yes, please explain:

BISPHOSPHONATES (USED FOR Osteoporosis, Paget's Disease, Bone Metastasis) :

Are you taking or have you taken in the past any oral or IV Bisphosphonates? ☐ **Yes** ☐ **No**

☐ **Didronel** (Etidronate) ☐ **Skelid** (Tiludronate) ☐ **Fosamax** (Alendronate) ☐ **Actonel** (Risedronate)

☐ **Boniva** (Ibandronate) ☐ **Aredia** (Pamidronate) ☐ **Zometa** (Zoledronate)

List any additional Bisphosphonates you are taking:

HEALTH HISTORY

REVIEW OF SYMPTOMS: Please check any current or past symptoms you have/have had:

☐ *AIDS*	☐ *Anemia*	☐ *Arthritis*	☐ *Artificial Joints*	☐ *Asthma*
☐ *Allergies*	☐ *Blood Disease*	☐ *Cancer*	☐ *Diabetes*	☐ *Dizziness*
☐ *Epilepsy*	☐ *Excessive Bleeding*	☐ *Fainting*	☐ *Glaucoma*	☐ *Growths/Tumors*
☐ *Smoker*	☐ *Head Injuries*	☐ *Heart Disease*	☐ *Heart Murmur*	☐ *Hepatitis*
☐ *Jaundice*	☐ *Kidney Disease*	☐ *Liver Disease*	☐ *Mental Disorders*	☐ *High Blood Pressure*
☐ *Pace Maker*	☐ *Radiation*	☐ *Tumors*	☐ *Venereal Disease*	☐ *Respiratory Problems*
☐ *Rheumatism*	☐ *Stomach Problems*	☐ *Stroke*	☐ *Tuberculosis*	☐ *Nervous Disorders*
☐ *Thyroid*	☐ *Sinus Problems*	☐ *Ulcers*	☐ *High Cholesterol*	☐ *Rheumatic Fever*

Are you allergic to any medications: ☐ Codeine ☐ Penicillin ☐ Sulfa Drugs ☐ Latex Allergy ☐ Other

MEDICATIONS:

Please list any medications you are currently taking:

Do you take aspirin daily: ☐ Yes ☐ No ***Are you Pregnant***: ☐ Yes ☐ No ***Have you been told to Pre Med***: ☐ Yes ☐ No

Have you ever had complications following dental treatment? ☐ **Yes** ☐ **No** If Yes, Please Explain:

Have you been admitted to a hospital/emergency care during the past two years? ☐ **Yes** ☐ **No** If yes, Please explain:

Are you currently under the care of a physician? ☐ **Yes** ☐ **No** If Yes, Please explain:

Physicians name: Phone:

Do you have any health conditions that need further clarification? ☐ **Yes** ☐ **No** If Yes, Please explain:

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any changes in my health, I will inform the doctors at my next appointment with fail. I am aware that failure to disclose all of my health conditions could result in complications with potential dental treatment.

Signature of patient Date:

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

I, _____ have received a copy of Mint Dental of

Bradenton Notice of Privacy Practices to read.

_____

Please Print Name

_____

Signature _____ Date _____

* You May Refuse to Sign This Acknowledgement*

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:
Individual refused to sign
Communications barriers prohibited obtaining the acknowledgement
An emergency situation prevented us from obtaining acknowledgement
Other (Please Specify)

_____

FINANCIAL POLICY and CANCELLATION POLICY

* **FULL PAYMENT IS DUE AT TIME OF SERVICE**
* **WE ACCEPT CASH, CHECK, VISA, MASTERCARD, AND DISCOVER**
* **PAYMENT PLANS AVAILABLE**

Your insurance policy is a contract between you and your insurance carrier. We are not a party to that contract. We CANNOT bill your insurance company unless you bring us all the accurate insurance information. Please be aware that some services may not be covered under your insurance policy. Some procedures have restricted frequencies as to how often they can be performed. You are required to pay your annual deductible and the percent that the insurance does not cover each visit. As a courtesy to you, we will file your insurance claim to your insurance company. When you receive the monthly statement, monitor the balance. If your insurance company has not paid within **45 days**, you must pay the balance. You are responsible for payment regardless of your insurance company's arbitrary determination of our Usual and Customary Fees (UCR).

As a courtesy, we will call your insurance company so that we can ESTIMATE the insurance portion and the patient portion of charges to the best of our expertise. **THIS INFORMATION IS AN APPROXIMATE COMPUTATION OF PROBABLE COST AND DOES NOT GUARANTEE PAYMENT FROM YOUR INSURANCE COMPANY. YOU ARE ULTIMATELY RESPONSIBLE FOR THE PAYMENT IN FULL.**

Once we notify you about your balance, you will have 30 days to pay your balance in full, without incurring any penalty. Unless further agreement is made to pay for dental services after 30 days, the account will go into collections and you will be responsible for the collection agency's fees and 10% incurred interest on unpaid amount till balance is paid in full. Also, there is a penalty of $50 for returned checks, and you will have 7 days to pay the balance.

If you have to cancel an appointment, we ask you give our office 48 hours notice. We reserve that time for you and the Doctor. There may be a broken appointment fee charged for any appointment not kept with our Doctor.

I have read the financial and cancellation policies. I understand and agree to the terms of the policies.

Signature of Responsible Party: _____ Date _____