

PATIENT LAST NAME: \_\_\_\_\_ FIRST: \_\_\_\_\_ INITIAL: \_\_\_\_\_

How do you wish to be addressed? \_\_\_\_\_ Date of Birth \_\_\_\_\_

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

Telephone (Mobile) \_\_\_\_\_ Work \_\_\_\_\_ Home \_\_\_\_\_

Email \_\_\_\_\_

How did you hear about our practice? \_\_\_\_\_

## INSURANCE INFORMATION

Primary Insurance	Secondary Insurance
Subscriber Name _____	Subscriber Name _____
Subscriber ID _____	Subscriber ID _____
Date of Birth _____	Date of Birth _____
Relationship to Subscriber <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	Relationship to Subscriber <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other
Employer Name _____	Employer Name _____
Employer Phone _____	Employer Phone _____
Insurance Company _____	Insurance Company _____
Insurance Group _____	Insurance Group _____
Insurance Phone _____	Insurance Phone _____

*Please present your insurance card to be photocopied for our records.*

## RESPONSIBLE PARTY (if minor)

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

Address (if different) \_\_\_\_\_ Date of Birth \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Mobile) \_\_\_\_\_

Email \_\_\_\_\_

## EMERGENCY CONTACT

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

Telephone (  Mobile  Work  Home ) \_\_\_\_\_

## AUTHORIZATION

I consent to the diagnostic procedures and dental treatment performed by my dentist, and to the release of information concerning my (or my child's) health care, advice, and treatment to another dentist, or for evaluating and administering any claims for insurance benefits. I consent to the direct payment of my insurance benefits to dentist or dental group and understand that my insurance benefits may pay less than the actual bill for services and that **I am responsible for any services not paid or covered by my insurance benefits and any account balance.**

**ELECTRONIC COMMUNICATIONS.** I consent to receiving HIPAA-compliant electronic communications, such as email and text messages regarding treatment, payment and health care operations. I understand that there is no obligation to receive these electronic communications. Message/data rates may apply.

I attest to the accuracy of the information on this page.

Signature \_\_\_\_\_ Date \_\_\_\_\_

(Responsible Party, if under 18)

PLEASE COMPLETE ALL INFORMATION – THANK YOU

PATIENT LAST NAME: \_\_\_\_\_

PATIENT FIRST NAME: \_\_\_\_\_

## DENTAL HISTORY

Reason for today's visit _____	Date of last dental visit _____
Former dentist _____	Date of last dental x-rays _____
<b>Please check if you have / had:</b>	
<b>Yes No</b>	<b>Yes No</b>
Bad breath <input type="checkbox"/> Yes <input type="checkbox"/> No	Head, neck, jaw pain, or aches <input type="checkbox"/> Yes <input type="checkbox"/> No
Blisters on lips or mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Lip or cheek biting <input type="checkbox"/> Yes <input type="checkbox"/> No
Burning sensation on tongue <input type="checkbox"/> Yes <input type="checkbox"/> No	Loose teeth or broken fillings <input type="checkbox"/> Yes <input type="checkbox"/> No
Chew on one side of mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth breathing <input type="checkbox"/> Yes <input type="checkbox"/> No
Cigarette, pipe, or cigar smoking <input type="checkbox"/> Yes <input type="checkbox"/> No	Orthodontic treatment <input type="checkbox"/> Yes <input type="checkbox"/> No
Smokeless tobacco <input type="checkbox"/> Yes <input type="checkbox"/> No	Nitrous Oxide <input type="checkbox"/> Yes <input type="checkbox"/> No
Dry mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Periodontal treatment <input type="checkbox"/> Yes <input type="checkbox"/> No
Food collection between teeth <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to pressure or irritants <input type="checkbox"/> Yes <input type="checkbox"/> No
Clench or grind teeth <input type="checkbox"/> Yes <input type="checkbox"/> No	(cold, heat, sweets)
Growths or sore spots in your mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	How often do you floss? _____
Gums swollen, tender or bleeding <input type="checkbox"/> Yes <input type="checkbox"/> No	How often do you brush? _____
	Have you ever had an allergic reaction to Novocaine, local, or general anesthetics? <input type="checkbox"/> Yes <input type="checkbox"/> No
	If Yes, please explain _____
	Have you ever had trouble from previous dental care? <input type="checkbox"/> Yes <input type="checkbox"/> No
	If Yes, please explain _____

## MEDICAL HISTORY

Physician's name _____	Date of last visit _____
Physician's address _____	Blood Pressure _____
Have you had any serious illnesses or operations <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please describe _____
Have you ever had a blood transfusion <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, give approximate dates _____
(Female) Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No	Due date _____
Nursing? <input type="checkbox"/> Yes <input type="checkbox"/> No	Taking birth control pills? <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Please check if you have / had:</b>	
<b>Yes No</b>	<b>Yes No</b>
Allergies, hay fever, sinusitis <input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches <input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No	Heart murmur <input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis, Rheumatism <input type="checkbox"/> Yes <input type="checkbox"/> No	Heart problems <input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial heart valves <input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis type _____ <input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial joints <input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes <input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No	High blood pressure <input type="checkbox"/> Yes <input type="checkbox"/> No
Required Hospitalization <input type="checkbox"/> Yes <input type="checkbox"/> No	Any immune deficiency <input type="checkbox"/> Yes <input type="checkbox"/> No
Have you used steroids <input type="checkbox"/> Yes <input type="checkbox"/> No	Jaundice <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last episode _____ <input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney disease <input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding abnormally with operations <input type="checkbox"/> Yes <input type="checkbox"/> No	Low blood pressure <input type="checkbox"/> Yes <input type="checkbox"/> No
or surgery <input type="checkbox"/> Yes <input type="checkbox"/> No	Mitral valve prolapse <input type="checkbox"/> Yes <input type="checkbox"/> No
Blood disease, clotting disorders <input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis <input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No	Osteopenia <input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical dependency <input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No
Chemotherapy <input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation treatments <input type="checkbox"/> Yes <input type="checkbox"/> No
Circulatory problems <input type="checkbox"/> Yes <input type="checkbox"/> No	Respiratory disease <input type="checkbox"/> Yes <input type="checkbox"/> No
Cortisone treatments <input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic fever <input type="checkbox"/> Yes <input type="checkbox"/> No
Cough, persistent or bloody <input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet fever <input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of breath <input type="checkbox"/> Yes <input type="checkbox"/> No
Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus trouble <input type="checkbox"/> Yes <input type="checkbox"/> No
Epilepsy <input type="checkbox"/> Yes <input type="checkbox"/> No	Sickle cell anemia <input type="checkbox"/> Yes <input type="checkbox"/> No
Fainting <input type="checkbox"/> Yes <input type="checkbox"/> No	Skin rash <input type="checkbox"/> Yes <input type="checkbox"/> No
Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No	Slow healing wounds <input type="checkbox"/> Yes <input type="checkbox"/> No
	Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No
	Swelling of feet or ankles <input type="checkbox"/> Yes <input type="checkbox"/> No
	Thyroid problems <input type="checkbox"/> Yes <input type="checkbox"/> No
	Tonsillitis <input type="checkbox"/> Yes <input type="checkbox"/> No
	Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No
	Tumor or growth on head/neck <input type="checkbox"/> Yes <input type="checkbox"/> No
	Ulcer <input type="checkbox"/> Yes <input type="checkbox"/> No
	Venereal disease <input type="checkbox"/> Yes <input type="checkbox"/> No
	Weight loss, unexplained <input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you wear contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you consume alcoholic beverages? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Are you currently under the care of a Physician? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Are you allergic/sensitive to Latex? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Allergic to Penicillin, Aspirin, or other drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No
	If Yes, please specify _____
	List any medications that you are taking: _____

## AUTHORIZATION AND RELEASE

I have read and answered the above questions to the best of my knowledge.

Patient/Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_

Reviewed by: \_\_\_\_\_

Date \_\_\_\_\_



**SECTION A: PATIENT GIVING CONSENT**

Patient Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Telephone: \_\_\_\_\_ E-mail: \_\_\_\_\_  
Patient Number: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

**SECTION B: TO THE PATIENT - PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY**

**Purpose of Consent:** By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

**Notice of Privacy Practices:** You have the right to read the Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

**Compliance Officer:** Tammy Ellis  
**Telephone:** (302) 998-9594 Fax: (302) 998-8207  
**Address:** 2601 Annand Drive, Suite #18, Wilmington, DE 19808

**Right to Revoke:** You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation.

**SECTION C: SIGNATURE**

I, \_\_\_\_\_ have had full opportunity to read and consider the contents of this Consent form and the Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

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

*If this Consent is signed by a personal representative (parent/guardian) on behalf of the patient, complete the following:*

Personal Representative's Name: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_

**SECTION D: 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
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (please specify) \_\_\_\_\_

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

You are entitled to a copy of this consent after you sign it

**SECTION E: REVOCATION OF CONSENT**

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

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

*If this Revocation of Consent is signed by a personal representative (parent/guardian) on behalf of the patient, complete the following:*

Personal Representative's Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

**SECTION F: PATIENT / RELATIVE HIPAA CONSENT**

I, \_\_\_\_\_, understand that by signing this Consent form, I am giving my consent to Milltown Dental LLC to disclose and discuss my protected health information to carry out treatment, payment activities and health care operations with the following family member

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

**Right to Revoke:** You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Compliance Officer listed on Section B.

\_\_\_\_\_  
Date: \_\_\_\_\_

Patient's Signature (Legal Guardian, if Patient is a minor)

**SECTION G: RESTRICTION OF PROTECTED HEALTH INFORMATION (PHI)**

I request Milltown Dental LLC restrict the disclosure of my PHI to those specified below:

Name: \_\_\_\_\_

Name: \_\_\_\_\_

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

*If this Restriction of PHI is signed by a personal representative (parent/guardian) on behalf of the patient, complete the following:*

Personal Representative's Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

Milltown Dental LLC and affiliated companies, collectively known as “MD”, are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy, or your responsibility

- \* ALL PATIENTS MUST COMPLETE OUR “PATIENT INFORMATION FORM” BEFORE SEEING THE DENTAL PROFESSIONAL.
- \* FULL PAYMENT IS DUE AT TIME OF SERVICE.
- \* WE ACCEPT CASH, CHECKS, VISA, MASTER CARD, DISCOVER AND CARE CREDIT.
- \* MD PROVIDES INSURANCE COMPANY BILLING AS A COURTESY TO OUR PATIENTS. THE PATIENT PORTION OF PARTICULAR DENTAL SERVICE(S) IS ESTIMATED AND DUE AT THE TIME OF SERVICE.

### ADULT PATIENTS

Adult patients are responsible for full payment at time of service

### MINORS ACCOMPANIED BY AN ADULT

The adult accompanying a minor, his/her parents or guardians, are responsible for full payment at time of service.

### UNACCOMPANIED MINORS

The parents or guardians are responsible for full payment at time of service. Non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, or to Visa, Master Card or Discover. We do not accept American Express payments.

### INSURANCE

MD provides insurance company billing as a courtesy to our patients. The patient portion of particular dental service(s) is estimated and due at the time of service. This amount may be subject to adjustment when the dental service(s) claim(s) are adjudicated by the insurance company. In addition, certain insurance companies have annual limitation for the amount of dental services that can be reimbursed within each plan year. If you or your family exceed these annual limitations in any plan year, you will be responsible for the full amount of dental services that exceed the particular plan’s limitations. The patient is responsible for monitoring the amount of his/her remaining benefits for any annual benefit period. The patient may not rely upon any information provided by MD staff regarding his/her remaining benefit in any such benefit period.

The claims we submit to insurance companies indicate that you have assigned those benefits to MD. However, if you are paid by the insurance company instead of MD, you then become responsible for the total account balance and payment would be expected immediately

If you or your family has more than one dental insurance program, we will assist you in obtaining the maximum benefits available.

You as a patient are always responsible for any charges that are not covered by your insurance.

### MEDICARE/ MEDICAID/ CHAMPUS/ WORKER’S COMPENSATION

If you are covered by Medicare, Medicaid, Champus, Worker’s Compensation or any other government sponsored program, please discuss your payment situation with our office staff prior to arriving at the MD office on the date of service

### DELINQUENT PAYMENTS

It is our policy to charge finance fees at 1.5% for outstanding patient balances after the balance has been outstanding 30 days. In addition, all payments returned due to non-sufficient funds will be subject to a NSF fee of \$35.00.

### MISSED APPOINTMENTS

Unless cancelled at least 48 hours in advance, our policy is to charge for missed appointments at the rate of \$55.00 per appointment. Please help us service you better by keeping scheduled appointments.

***Thank you for understanding and accepting our Financial Policy. Please let us know if you have any questions or concerns.***

Responsible Party Signature \_\_\_\_\_ Date \_\_\_\_\_