MILFORD DENTAL GROUP

To help us meet all your healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us and we will be happy to help.

Patient Information

Name_____ Date_____

Address_____ City_____ State_____ Zip_____

Home Phone_____ Cell Phone _____

E-Mail_____ SS #_____ Birthdate_____

Check Appropriate Box: □ Minor □ Single □ Married □ Separated □ Divorced □ Widowed

If Student, Name of School/College_____ City_____ State_____

Patient's or Parent/Guardian's Employer_____ Work Phone _____

Business Address_____ City_____ State_____ Zip_____

Spouse or Parent/Guardian's Name_____ Employer_____ Work Phone _____

Whom May We Thank for Referring You? _____

Person to Contact in Case of Emergency_____ Phone _____

Responsible Party

Name of Person Responsible for this Account_____ Relationship to Patient _____

Address_____ Home Phone _____

E-Mail_____ Cell Phone _____

Driver's License #_____ Birthdate_____

Employer_____ Work Phone_____ SS # _____

Is this Person Currently a Patient in our Office? □ Yes □ No

Payment is due in full at each appointment. For your convenience, we offer the following payment methods

Cash – CareCredit – All Major Credit Cards

Patient Dental History

Name of Previous Dentist and Location_____ Date of last dental exam? _____

	Yes	No		Yes	No
1. Do your gums bleed while brushing or flossing?	□	□	10. Have you ever had any difficult extractions in the past?	□	□
2. Are your teeth sensitive to hot or cold liquids/foods?	□	□			
3. Are your teeth sensitive to sweet or sour liquids/foods?	□	□	11. Have you ever had any prolonged bleeding following extractions?	□	□
4. Do you feel pain in any of your teeth?	□	□			
5. Do you have any sores or lumps in or near your mouth?	□	□	12. Have you had any orthodontic treatment?	□	□
6. Have you had any head, neck, or jaw injuries?	□	□	13. Do you wear dentures or partials?	□	□
7. Do you have frequent headaches?	□	□	If yes, date of placement _____		
8. Have you ever experienced any of the following problems in your jaw?			14. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	□	□
Clicking	□	□	15. Do you like your smile?	□	□
Pain (joint, ear, side of face)	□	□	16. Do you have dry Mouth?	□	□
Difficulty in opening or closing	□	□			
Difficulty in chewing.	□	□			
Do you clench or grind your teeth?	□	□			
Do you bite your lips or cheeks frequently?	□	□			
9. Are you in pain now?	□	□			

Patient Health History

1. Is your general health good? _____
2. Has there been a change in your health within the last year? _____
3. Have you been hospitalized or had a serious illness in the last three years? _____
4. Are you being treated by a physician now? For What? _____
   Date of last medical exam? _____
5. Have you had problems with prior dental treatment? _____

Have you experienced	Yes	No		Yes	No
Chest pain (angina)?	☐	☐	Headaches?	☐	☐
Shortness of breath?	☐	☐	Fainting spells and/or vertigo?	☐	☐
Recent weight loss?	☐	☐	Blurred vision?	☐	☐
Persistent cough, coughing up blood?	☐	☐	Seizures?	☐	☐
Bleeding problems, bruising easily?	☐	☐	Excessive thirst?	☐	☐
Sinus problems?	☐	☐	Gastrointestinal problems?	☐	☐
Difficulty swallowing?	☐	☐	Jaundice?	☐	☐
Aphthous ulcers/canker sores?	☐	☐	Dizziness?	☐	☐

Do you have:	Yes	No		Yes	No
Heart disease/heart defects?	☐	☐	Hepatitis, other liver disease?	☐	☐
Congenital heart problems?	☐	☐	Stomach problems, ulcers?	☐	☐
Mitral valve prolapses?	☐	☐	Sexually transmitted disease?	☐	☐
Prosthetic heart valve?	☐	☐	AIDS/HIV infection?	☐	☐
Rheumatic fever?	☐	☐	Herpes/cold sores?	☐	☐
Stroke, hardening of arteries?	☐	☐	Tumors, cancer?	☐	☐
Artificial joint/metal?	☐	☐	Arthritis, rheumatism?	☐	☐
High blood pressure?	☐	☐	Eye diseases?	☐	☐
Low blood pressure?	☐	☐	Skin diseases?	☐	☐
Hypoglycemia?	☐	☐	Anemia?	☐	☐
Diabetes?	☐	☐	Kidney, bladder disease?	☐	☐
Asthma?	☐	☐	Thyroid, adrenal disease?	☐	☐
TB, emphysema, other lung diseases, or persistent cough?	☐	☐	Eating disorders?	☐	☐

Do you have or have you ever had :	Yes	No		Yes	No
Psychiatric care?	☐	☐	Blood transfusions?	☐	☐
Radiation treatments?	☐	☐	Surgeries?	☐	☐
Chemotherapy?	☐	☐	Contact lenses?	☐	☐
Pacemaker?	☐	☐	**Have you ever taken Fosamax, Boniva, Actonel, or any**		
Hospitalization?	☐	☐	**medicationcontaining bisphosphonates?**	☐	☐

Are you allergic to any of the following:	Yes	No	Are you taking:	Yes	No
Local Anesthetics (e.g., Novocain)?	☐	☐	Recreational drugs?	☐	☐
Antibiotics?	☐	☐	Controlled substances?	☐	☐
If so, which ones? _____			Drugs, medications, over-the-counter medicines		
Sulfa Drugs?	☐	☐	(including Aspirin), natural remedies?	☐	☐
Barbiturates?	☐	☐	Blood thinners (such as Coumadin or Warfarin)?	☐	☐
Sedatives?	☐	☐	Medications for opiate dependency?	☐	☐
Iodine?	☐	☐	Tobacco in any form?	☐	☐
Aspirin?	☐	☐	Alcohol?	☐	☐
Any Metals (e.g., nickel, mercury, etc.)?	☐	☐	**PLEASE LIST ALL MEDICATIONS** _____		
Latex Rubber?	☐	☐	_____		
Other? _____			_____		
			_____		

Women only:	Yes	No	All patients:	Yes	No
Are you or could you be pregnant?	☐	☐	**Do you have or have you had any other diseases or medical**		
Taking birth control pills?	☐	☐	**problems** NOT **listed on this form? (Example, ADHD, Depression,**		
Breast-feeding?	☐	☐	**Learning Disabilities)** If so, please explain:	☐	☐
			_____		
			_____		
			_____		
			_____		

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X_____Date _____

Hygienist or Doctor Comments :

_____

_____

_____

Doctor Signature_____Date_____

Hygienist Signature_____Date_____

OFFICE POLICIES

1.) GENERAL TREATMENT CONSENT

Direct Authorization for general treatment (Preventative, Restorative, Prophylaxis, and X-rays) by Milford Dental Group. I authorize Milford Dental Group for myself /parent/guardian or on behalf of the Minor Patient. _____Initial

2.) FINANCIAL AGREEMENT

Payment is due at the time of service. As a courtesy to you, we will submit all charges to your insurance company. Insurance is designed to cover a portion of our fees only; your estimated co-pay will be collected at each appointment. I authorize my insurance company to make direct payments to MilfordDental Group. In addition, I acknowledge that I have been informed of an estimated out-of-pocket expense and will be given the opportunity to ask questions about my insurance coverage. _____Initial

3.) INSURANCE NETWORK

I have been informed by Milford Dental Group if they are contracted with my dental plan. I understandthat if Milford Dental Group is contracted with my plan, I am responsible for my co-payment as determined by my insurance. However, if Milford Dental Group is NOT contracted or is out-of-networkwith my plan, I am responsible of all unpaid balances for services rendered _____Initial

- I have been informed Milford Dental Group is in-network with my dental plan, OR
- I have been informed Milford Dental Group is out-of-network with my dental plan

4.) CANCELLATION AND FAILURE TO KEEP APPOINTMENT

We understand that circumstances do arise that can keep you from your scheduled appointment:

- We require a 48 hours' notice to change/cancel a General/Hygiene/Specialist appointment.
- If we don't receive a verbal or written confirmation in 24 hours, your appointment can be removed fromthe schedule.

As a result of this policy, the following charges will apply.

- General /Hygiene/Specialist two (2) days' notice $100.00. _____Initial

5.) APPOINTMENT REMINDER CARDS /COURTESY CONFIRMATION CALLS /TEXTING/ E-MAIL

I give Milford Dental Group permission to send a reminder postcard by U.S. postal service, via the internet/telecommunication. _____Initial

6.) COLLECTIONS

Failure to pay your balance within 90 days; your account will be sent to a collection agency. There will bea $50.00 charge to process the collections account and a 20% collection cost added. _____Initial

By signing below, I understand and agree to the above listed General Consent for Treatment and Office Policies, for treatment and services rendered.

Patient/Parent/Guardian_____**Date**_____

ACKNOWLEDGEMENT OF RECEIPT OFNOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I,_____, have reviewed a copy of this office's Notice of Privacy Practices.

_____
{Please Print Name}

_____
{Signature}

_____
Date}

_____
{Person Authorized to Release Information to (ex. Spouse, Parent, Guardian, or Sibling)}

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Other (Please Specify)

_____

_____

This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).