**ILFORD**

**DENTAL GROUP**

To help us meet all your healthcare needs, please fill outthis 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-AII 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? ....................
2. Are your teeth sensitive to hot or cold liquids/foods? ................
3. Are your teeth sensitive to sweet or sour liquids/foods? ............ .
4. Do you feel pain in any of your teeth? ............................
5. Do you have any sores or lumps in or near your mouth? ............ .
6. Have you had any head, neck, or jaw injuries? ..................... .
7. Do you have frequent headaches? ...............................
8. Have you ever experienced any of the following problems in your jaw?

**Clicking** ...............................................

Pain (joint, ear, side of face) ..............................

Difficulty in opening or closing ........................... .

□ □ 10. Have you ever had any difficult extractions in the

□ □ **past?** .................................................. □ □

□ □ 11H.ave you ever had any prolonged bleeding

□ □ following extractions? ..................................... □ □

□ □ 12H.ave you had any orthodontic treatment? ................. □ □

□ □ 13D.o you wear dentures or partials? ....................... □ □

□ □ Ifyes, date of placement

14. Have you ever received oral hygiene instructions

regarding the care of your teeth and gums? ................... □ □

□ □ 15D.o you like your smile? ................................. □ □

□ □ 16D.o you have dry Mouth? ............................... □ □

□ □

Difficulty in chewing..................................... □ □

Do you clench or grind your teeth? ........................ □ □

Do you bite your lips or cheeks frequently? ................. □ □

1. A**re you** .**1n pa**.**in 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?-------------------------------------

4A.re you being treated by a physician now? For What? ­

Date of last medical exam?

5. Have you had problems with prior dental treatment?---------------------------------------------

##### Women only: Yes No All patients: Yes No

Are you or could you be pregnant? ............................. □ □

Taking birth control pills? .................................... . □ □

Breast-feeding? ............................................ . □ □

**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 payers 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

##### Do you have or have you had any other diseases or medical problems NOT listed on this form? (Example, ADHD, Depression,

**Learning Disabilities)** If so, please explain: □ □

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Have you experienced** | **Yes** | **No** |  | **Yes** | **No** |
| Chest pain (angina)? ......................................... | □ | □ | Headaches? .............................................. | □ | □ |
| Shortness of breath? ........................................ . | □ | □ | Fainting spells and/or vertigo? .............................. | □ | □ |
| Recent weight Ioss? .......................................... | □ | □ | Blurred vision? ........................................... . | □ | □ |
| Persistent cough, coughing up blood? .......................... | □ | □ | Se1. zures?................................................. | □ | □ |
| Bleeding problems, bruising easily? ............................ | □ | □ | Excess•1vet h.1rst?.......................................... . | □ | □ |
| Sinus problems? ........................................... . | □ | □ | Gastrointestinal problems? ................................. | □ | □ |
| Difficulty swallowing? ....................................... . | □ | □ | Jaundice? ................................................ | □ | □ |
| Aphthous ulcers/canker sores? ................................ | □ | □ | D1. zz.1ness?................................................. | □ | □ |
| [ **Do you have:** | **Yes** | **No** |  | **Yes** | **No** |
| Heart disease/heart defects? .................................. | □ | □ | Hepat1•t1•s, ot her 11· ver d1. sease?................................ | □ | □ |
| Congenital heart problems? ................................... | □ | □ | Stomach problems, ulcers? ................................ . | □ | □ |
| MitraI valve prolapses? ....................................... | □ | □ | Sexually transmitted disease? ............................... | □ | □ |
| Prosthetic heart valve? ...................................... . | □ | □ | AIDS/HIV infection? ........................................ | □ | □ |
| Rheumatic fever? ........................................... | □ | □ | Herpes/cold sores? ........................................ | □ | □ |
| Stroke, hardening of arteries? ................................. | □ | □ | Tumors, cancer? .......................................... | □ | □ |
| Art1.f.1c1•aI J• o•int/ metaI?........................................ . | □ | □ | Art hr .It .I s, rh eum at .Ism?. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . | □ | □ |
| High blood pressure? ........................................ | □ | □ | Eye diseases? ............................................. | □ | □ |
| Low blood pressure? ......................................... | □ | □ | Skin diseases? ............................................ | □ | □ |
| Hypoglycemia? ............................................. | □ | □ | Anemia? ................................................. | □ | □ |
| Diabet es? ................................................. . | □ | □ | Kidney, bladder disease? .................................. . | □ | □ |
| Asthma ? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . | □ | □ | Thyroid, adrenaI disease? ................................... | □ | □ |
| TB, emphysema, other lung diseases, or persistent cough? .......... | □ | □ | Eating disorders? .......................................... | □ | □ |
| **Doyouhaveorhaveyoueverhad:**Psych1. atr1.c care?............................................. | **Yes**□ | **No**□ | Blood transfusions? ....................................... . | **Yes**□ | **No**□ |
| Rad1. at.1on treatments?........................................ | □ | □ | Surger1.es?................................................ . | □ | □ |
| Chemotherapy? ............................................. | □ | □ | Contact lenses? ........................................... | □ | □ |
| Pacemaker? ............................................... .Hosp1•ta11• zat1• on?.............................................. | □□ | □□ | **Have you ever taken Fosamax, Boniva, Actonel, or any****me**d**1**•**cat**•**1onconta1**•**n1**•**ng b"1sph osph onates**-**.**,.................... . | □ | □ |
| **Are you allergic to any of the following:** | **Yes** | **No** | **Are you taking:** | **Yes** | **No** |
| LocaI Anesthetics (e.g., Novocain)? ............................. | □ | □ | Recreational drugs? ........................................ | □ | □ |
| Ant1.b.1ot1.cs?................................................ . | □ | □ | Controlled substances? ..................................... | □ | □ |
| Ifso, which ones? ------------------- Sulfa Drugs? ................................................ | □ | □ | Drugs, medications, over-the-counter medicines(including Aspirin), natural remedies? ........................ | □ | □ |
| Barbiturates? .............................................. . | □ | □ | Blood thinners (such as Coumadin or Warfarin)? ............... | □ | □ |
| Sedatives? ................................................. | □ | □ | Medications for opiate dependency? .......................... | □ | □ |
| Iodine? ....................................................Asp1..r1n?.................................................... | □□ | □□ | Tobacco in any form? ..................................... .Alcohol? ................................................. | □□ | □□ |
| Any Metals (e.g., nickel, mercury, etc.)? .........................Latex Rubber? ............................................. . | □□ | □□ | **PLEASE LIST ALL MEDICATIONS** -------------- |  |  |
| Other?  |  |  |   |  |  |

# ILFORD DENTAL GROUP

**OFFICE POLICIES**

## 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

## 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

## INSURANCE NETWORK

I have been informed by Milford Dental Group if they are contracted with my dental plan. I understand that 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

## 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

## 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

## 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 \_**

# ILFORD DENTAL GROUP

**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:

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

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