WELCOME!

We would like to welcome you to our office. Our goal is to make everyone's visit pleasant and educational. We strive to teach exceptional oral care that will enable you to have a beautiful smile that lasts a lifetime!

1. Patient Information

Today's Date: _____

First Name: _____

Last Name: _____

Birthdate: _____ Age: _____

SS#: _____

☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

Address: _____

_____

Home #: _____ Cell #: _____

Employer _____ Work #: _____

Occupation: _____

Email: _____

Referred By: _____

Emergency Contact Full Name: _____

Emergency Contact Phone#: _____

2. Responsible Party

First Name: _____ MI: _____

Last Name: _____

Birthdate: _____ Age: _____

SS#: _____

Employer: _____ Work #: _____

Occupation: _____

Address: _____

_____

3. Dental Insurance

Insurance Co. Name: _____

Insurance Co. Phone #: _____

Plan: _____ Group #: _____ Policy: _____

Policy Holder's Name: _____

Relationship to Patient: _____

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's DOB: _____ SS#: _____

4. Secondary Dental Insurance

Sec. Insurance Co. Name: _____

Sec. Insurance Co. Phone #: _____

Plan: _____ Group #: _____ Policy: _____

5. Dental History

Purpose of today's visit: _____

Previous Dentist: _____

Date of last visit: _____

What was done: _____

Last Cleaning: _____

How often do you brush _____ Gum Bleed? ☐ YES ☐ NO

Any ☐ Sensitive Teeth ☐ Loose Teeth ☐ Broken Fillings

☐ Jaw Pain ☐ Injuries to Tooth ☐ Other

Explain: _____

Unpleasant Dental Experience ☐ YES ☐ NO

Explain: _____

Have you ever had...

☐ Orthodontics ☐ Gum Treatment ☐ Implants ☐ Root Canal

☐ Oral Surgery ☐ Crowns ☐ Veeners

Are you happy with the appearance of your teeth?

☐ YES ☐ NO ☐ Color ☐ Position ☐ Smile

Have you ever had tooth whitening? ☐ YES ☐ NO

Are you interested in replacing any missing teeth? ☐ YES ☐ NO

Which method ☐ With Dentures ☐ Bridges ☐ Implant

6. Medical History

I authorize the doctor to perform all recommended treatment agreed upon by me and to use the appropriate medication and therapy for such treatment in connection with. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and give consent to the doctor to use and employ such assistant as deemed to provide recommended treatment.

Initials _____

Physicians Name: _____

Office Address: _____

_____

Office Telephone #: _____

Are you currently under the care of a physician? ☐ YES ☐ NO

Explain: _____

Has there been any changes in your health? ☐ YES ☐ NO

Explain: _____

Are you currently taking any prescription, over the counter or recreational drugs? ☐ YES ☐ NO

Explain: _____

_____

Have you been hospitalized or had a serious illness within the past five years? ☐ YES ☐ NO

Explain: _____

Have you been treated now or in the past with Bisphosphonates for Osteoporosis or Cancer? ☐ YES ☐ NO

Explain: _____

Are you Pregnant or is it likely that you could be pregnant at this time? ☐ YES ☐ NO

Explain: _____

Do you?

☐ Smoke Packs per day? _____ How Long? _____

☐ Chew Tobacco

☐ Drink Per week? _____ Per Month? _____

☐ Wear Contact Lenses

☐ Take Herbal Supplements ☐ Take Diet Pills

Circle if you have or ever had

Y N	Artificial Limb/Joint/Hip	Y N	Chronic Diarrhea
Y N	High/Low Blood Pressure	Y N	Stroke TIA
Y N	Organ Transplant	Y N	Cancer/Chemotherapy
Y N	Sinus Problems	Y N	Blood Disorder
Y N	Migraines	Y N	Increased Frequent Urination
Y N	Frequent Headaches	Y N	Bell's Palsy
Y N	Claustrophobia	Y N	Heart Disease
Y N	Artificial Heart Valve	Y N	Diabetes
Y N	Prolonged Bleeding	Y N	Asthma
Y N	Ulcers/Colitis	Y N	Kidney Problems
Y N	Hay Fever (Seasonal Allergies)	Y N	Night sweat
Y N	Head Injury	Y N	Psychiatric/Emotional
Y N	Venereal Disease	Y N	Recurrent Infections
Y N	Mitral Valve Prolapse	Y N	Angina
Y N	Acid Reflux	Y N	Kidney Problems
Y N	Arthritis	Y N	Bronchitis
Y N	Epilepsy	Y N	Addictions
Y N	STD	Y N	Pace Maker
Y N	Treated for AID,HIV,ARC	Y N	Liver Problems
Y N	Rheumatic Fever	Y N	Emphysema
Y N	Rheumatic Therapy	Y N	TMJ Problems
Y N	Stomach Problems	Y N	Shortness of Breath
Y N	Glaucoma	Y N	Hepatitis: A or B or C
Y N	Dizziness/Fainting Spells	Y N	Tuberculosis
Y N	Heart Murmur	Y N	Unexplained Weight Loss
Y N	Thyroid Problems	Y N	Mouth Ulcers
Y N	Used Diet Drug Fen-Phen	Y N	Aspirin Daily
Y N	Anemia	Y N	Joint Surgery

Please mark any allergies/adverse reactions

Y N	Penicillin	Y N	NSAID (Advil/Motrin)
Y N	Tetracycline	Y N	Latex
Y N	Erythromycin	Y N	Aspirin
Y N	Sulfa	Y N	Iodine
Y N	Local Anesthesia	Y N	Household Bleach
Y N	Codeine	**Other**	_____

_____ _____

Patient or Guardian Signature Date

_____ _____

Dentist Signature Date

Patient Consent to Receive Mail, E-mail, and/or Telephone Messages

Please Print (Last Name) (First Name) (M.I.)

I agree that the practice may communicate with me electronically at the following address:

Phone Number E-mail Address *(please print)*

I consent to receive calls and text messages related to my protected healthcare and other services at the phone number(s) above, including my wireless number provided. I understand I may be charged for such calls by my wireless carrier and that such calls may be generated by an automated dialing system.

Do we have your permission to:

Send a recall appointment reminder to your home? Y____ N____

Leave appointment, billing or dental information on your answering machine/voice mail/e-mail: Y____ N____

I give permission to share appointment, billing or dental information with the person named below:

Name: _____

Signature of Patient/Parent or Legal Guardian Date

If signed by other than patient, specify relationship to patient: _____

Acknowledgment of Receipt of Notice of Privacy Practices

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

Signature of Patient / Parent or Legal Guardian Date

If signed by other than patient, specify relationship to patient: _____

FOR OFFICE USE ONLY

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

- ☐ Patient / Parent or Legal Guardian refused to sign form
- ☐ Other

Signature of Office Manager Date

APPOINTMENT POLICY

CONFIRMATIONS

All appointments must confirmed 24 hours in advance. We will make a courtesy call the day before your appointment. If we are unable to speak with you, we reserve the right to double-book your appointment. PLEASE CONTACT US 24 HOURS IN ADVANCE TO CONFIRM YOUR APPOINTMENT.

CANCELLATIONS

If you cannot come to a dental appointment, please call the dental office one day before your scheduled appointment time. This helps our office to fill the time with someone who has been waiting for care. Failure to cancel an appointment will result in $30.00 fee charge to your account.

MISSED APPOINTMENT

If you cannot come to a dental appointment, please call our office to schedule a new one. Failure to cancel an appointment or cancelling with less than 24 hours will result in a $30.00 fee charge to your account. If you fail to come two times, we will no longer pre-schedule any of your appointment and you may be seen on a space available only.

LATE ARRIVALS

If you arrive for your appointment more than 15 minutes late, there is a chance that we will not be able to accommodate you, and you might have to reschedule your appointment.

I have read and understood the about mentioned policies.

Patient signature

Date

Understanding Your Insurance Benefits and Financial Responsibilities

We have prepared this letter to help you better understand the complexities of dental insurance; we realize how confusing it can be. First and foremost, we would like to highlight a common misconception most patients have. Dental Insurance is NOT designed to cover all costs of your dental treatment. Most contracts have various limits and/or various degrees of co-payments; that is expected at the time services are rendered.

All levels of payment by insurance companies, including the allowable fees, known as usual and customary (UCR), are governed by the premiums paid. There is no affiliation with the actual charges. Our fees are based upon a combination of our costs, our time, and our constant dedication to our patients, with the highest quality of dental care. The treatment recommended by our office is never based on what your insurance company will cover; your treatment should not be governed by your dental insurance contract.

However, it should be understood that the dental insurance contract is between the insurance company and the patient, whom ultimately bears the financial responsibility. We strongly encourage our patients to become familiar with your dental plan benefits.

We are happy to file an insurance claim for you, but we require a copy of your insurance card, and verification at each appointment. We also require the social security number of the policy holder for claim filing purposes. If you do not provide the necessary information for filing the claims; we reserve the right to bill you at full cost. Payment of any co-pays or non-covered services is expected at the time of your visit. If any insurance claim is filed for you, we will wait 60 days for reimbursement. If we do not receive payment, you will be billed and prompt payment is expected. Any disputes regarding coverage should be handled between you and your insurance company. We will do our best to provide the insurance company with the appropriate information to process the claim.

We hope this information has been helpful. Please take the time to review your dental contract thoroughly so we may best serve you. As always, you may feel free to ask any member of our staff for clarification on services, billing and insurance. We thank you for choosing our dental office, and will strive to obtain the benefits you deserve.

Please sign the form below. We will keep one copy in your file, and give you one copy for your records if requested.

I hereby authorize payment directly to the dental office of the insurance benefits otherwise payable to me

I understand that I am ultimately responsible for ALL costs of dental treatment for myself and my dependents. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payers.

_____ _____

Please Print Your Full Name Date

_____

Signature of Patient or Parent/Guardian

****If you would wish to keep a credit card on file with us for unpaid services or co-payments, please ask Staff for the form to fill out and keep on file. We will not process payments without your acknowledgement. Thank you.****

FINANCIAL POLICY

Thank you for choosing our practice to serve your dental needs.
Please take the time to read the following, *initial each section*, and *sign and date* the bottom of this form.

Initial:

____ Full payment is due at the time of service unless arrangements have been made prior to the start of treatment.

____ Insurance balances are ultimately the patient's obligation. We will file most primary insurances at no cost to you as a courtesy. However, insurance balances which are not paid within *60 days* may be billed to you. Please keep your walk-out statements and follow up with your insurance carrier to ensure prompt payment.

____ Some of your treatment **may not** be covered by your insurance carrier. The cost for such charges will be your responsibility.

____ Major services may require a deposit equal to at least one half of the estimated patient portion at the time the appointment is made.

____ Patients are asked to confirm their appointments at least *24 hours* in advance by directly contacting our office or by responding to our confirmation contact. Failure to confirm your appointment may result in a charge for the time reserved.

____ There will be a fee of $30.00 for any checks returned as Non-Sufficient Funds (NSF)

____ Patients balances that go unpaid for 30 days or more may incur one or more of the following charges:

Interest charges of 1.5% per month
18% APR collections fees (up to 25% of the full balance)

_____ _____

Print Name Date

_____ _____

Signature of Patient or Guardian Witnessed By

MJ COSMECTIC DENTISTRY

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have read, understood, and received a copy of MJ Cosmetic Dentistry's Notice of Privacy Practices.

Name (Print):_____

Signature:_____

Date: _____

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 NPP
	Communication barriers prohibited obtaining the acknowledgement
	An emergency situation prevented us from obtaining the acknowledgement
	Other (Please specify):

MJ COSMETIC DENTISTRY

Effective Date: 05/18/2017-05/18/23

Notice of Dental Privacy Practice

This notice gives a description on how your health information may be used and disclosed. Also it provides content on how you can get access to this information. Please review it carefully.

Legal Duty: We are required by federal and state law to maintain the privacy of our patient's general protected health information. We are also required to see you've received this Notice about our privacy's practices, our legal duties as a business, and your rights concerning your general protected health information. We will follow the privacy practices that are described in this Notice while it is still in effect. This Notice will take action on effective date listed above until a replacement Notice.

We have the right to change and/or alter our privacy's practices and the terms of this Notice at any time, as long as the changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and provide the new Notice at our practice's location, and will distribute it upon request.

You may request a copy of our Notice at any time. For more information about our privacy's practice, or additional copies of this Notice, please contact us with the information provided to you at the end of this Notice.

Uses and Disclosures of Health Information

We use and disclose your health information without authorization for the purposes of treatments, payments, and healthcare operations.

Treatment: We may use or disclose your health information for your treatment. For example, we may disclose your health information with another provider/doctor providing treatment for you.

Payment: We may use and disclose your health information to obtain payment for services we provide for you.

Healthcare Operations: We may use and disclose your protected health information with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, and certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for the following purposes, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us authorization, you may revoke the authorization at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose any information for any reason except those described in this Notice.

Person Involved in Care: We may use your general protected health information to notify, or assist in the notification of a family member, your personal representative or another person responsible for your personal care, of your location, your general condition, or death. If you are present, then prior to use or disclose of your health information, we will provide you with an opportunity to object to such uses and disclosures. In the event of your absence or incapacity or in emergency circumstances, we will disclose health information based on a determination using our professional judgement disclosing only health information that is directly relevant to the person's involvement in your healthcare.

Marketing or Sale: We will not use your protected health information in any way for marketing communications, nor disclose your health information in exchange for remuneration, without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Public Health and Public Health Benefit: We may use or disclose your health information to report abuse, neglect, or any domestic violence; to report disease, injury, and vital statistics; to report information to the Food and Drug Administration (FDA); to alert someone who may be at risk of contracting or spreading a disease; for health oversight activities; for certain