

# MIDTOWN DENTAL CENTER

## PATIENT INFORMATION

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

Name \_\_\_\_\_  
Last First MI Preferred

Sex: Male / Female Martial Status: Married / Single / Child / Other Date of Birth \_\_\_\_\_

Social Security \_\_\_\_\_ Driver License \_\_\_\_\_ E-Mail Address \_\_\_\_\_

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

Phone Number: Home \_\_\_\_\_ Work \_\_\_\_\_ Ext. \_\_\_\_\_ Time to Call \_\_\_\_\_

Fax \_\_\_\_\_ Pager \_\_\_\_\_ Emergency Phone \_\_\_\_\_

Education: grade school / high school / trade or business / college 1 2 3 4 / postgraduate / professional  
School or School District Name \_\_\_\_\_ Place of Employment \_\_\_\_\_

## GENERAL INFORMATION

Number of people in household: \_\_\_\_\_ Number of children in household: \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Is patient available on short notice? yes / no

Who referred you to this dental office? \_\_\_\_\_

## RESPONSIBLE PARTY AND INSURANCE INFORMATION

Name \_\_\_\_\_  
Last First MI Preferred

Sex: Male / Female Martial Status: Married / Single / Child / Other Date of Birth \_\_\_\_\_

Social Security \_\_\_\_\_ Driver License \_\_\_\_\_ E-Mail Address \_\_\_\_\_

Address \_\_\_\_\_  
Street State Zip

Phone Number: Home \_\_\_\_\_ Work \_\_\_\_\_ Ext. \_\_\_\_\_ Time to Call \_\_\_\_\_

Fax \_\_\_\_\_ Pager \_\_\_\_\_ Other \_\_\_\_\_

Employer Name: \_\_\_\_\_ Insurance Company Name: \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_

Insurance Company Phone: \_\_\_\_\_ Group Number: \_\_\_\_\_ Union Local # \_\_\_\_\_

DO YOU HAVE ADDITIONAL DENTAL INSURANCE COVERAGE? yes / no  
IF YES, PLEASE INFORM THE FRONT DESK PERSONNEL.

I authorize and request the performance of dental services for myself (or my minor child) and give my consent for my advisable and necessary dental procedures, medication, anesthetics, or analgesics to be administered by the attending dentist or by his supervised staff for diagnostic purposes or dental treatment.

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

I hereby grant my permission to this dental office to use the diagnostic and treatment photographs, models and records for the purpose of display for scientific articles, seminars and professional presentations.

Signature \_\_\_\_\_

Please turn over to continue

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

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

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

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, c

Are you under a physician's care now?  Yes  No If yes \_\_\_\_\_

Have you ever been hospitalized or had a major operation?  Yes  No If yes \_\_\_\_\_

Have you ever had a serious head or neck injury?  Yes  No If yes \_\_\_\_\_

Are you taking any medications, pills, or drugs?  Yes  No If yes \_\_\_\_\_

Do you take, or have you taken, Phen-Fen or Redux?  Yes  No If yes \_\_\_\_\_

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?  Yes  No If yes \_\_\_\_\_

Are you on a special diet?  Yes  No

Do you use tobacco?  Yes  No

Do you use controlled substances?  Yes  No If yes \_\_\_\_\_

Women: Are you...

Pregnant/Trying to get pregnant?  Nursing?  Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin  Penicillin  Codeine  Acrylic  
 Metal  Latex  Sulfa Drugs  Local Anesthetics

Other?  If yes \_\_\_\_\_

Do you have, or have you had, any of the following?

AIDS/HIV Positive <input type="radio"/> Yes <input type="radio"/> No	Corticone Medicine <input type="radio"/> Yes <input type="radio"/> No	Hemophilia <input type="radio"/> Yes <input type="radio"/> No	Radiation Treatments <input type="radio"/> Yes <input type="radio"/> No
Alzheimer's Disease <input type="radio"/> Yes <input type="radio"/> No	Diabetes <input type="radio"/> Yes <input type="radio"/> No	Hepatitis A <input type="radio"/> Yes <input type="radio"/> No	Recent Weight Loss <input type="radio"/> Yes <input type="radio"/> No
Anaphylaxis <input type="radio"/> Yes <input type="radio"/> No	Drug Addiction <input type="radio"/> Yes <input type="radio"/> No	Hepatitis B or C <input type="radio"/> Yes <input type="radio"/> No	Renal Dialysis <input type="radio"/> Yes <input type="radio"/> No
Anemia <input type="radio"/> Yes <input type="radio"/> No	Easily Winded <input type="radio"/> Yes <input type="radio"/> No	Herpes <input type="radio"/> Yes <input type="radio"/> No	Rheumatic Fever <input type="radio"/> Yes <input type="radio"/> No
Angina <input type="radio"/> Yes <input type="radio"/> No	Emphysema <input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Rheumatism <input type="radio"/> Yes <input type="radio"/> No
Arthritis/Gout <input type="radio"/> Yes <input type="radio"/> No	Epilepsy or Seizures <input type="radio"/> Yes <input type="radio"/> No	High Cholesterol <input type="radio"/> Yes <input type="radio"/> No	Scarlet Fever <input type="radio"/> Yes <input type="radio"/> No
Artificial Heart Valve <input type="radio"/> Yes <input type="radio"/> No	Excessive Bleeding <input type="radio"/> Yes <input type="radio"/> No	Hives or Rash <input type="radio"/> Yes <input type="radio"/> No	Shingles <input type="radio"/> Yes <input type="radio"/> No
Artificial Joint <input type="radio"/> Yes <input type="radio"/> No	Excessive Thirst <input type="radio"/> Yes <input type="radio"/> No	Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No	Sickle Cell Disease <input type="radio"/> Yes <input type="radio"/> No
Asthma <input type="radio"/> Yes <input type="radio"/> No	Fainting Spells/Dizziness <input type="radio"/> Yes <input type="radio"/> No	Irregular Heartbeat <input type="radio"/> Yes <input type="radio"/> No	Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No
Blood Disease <input type="radio"/> Yes <input type="radio"/> No	Frequent Cough <input type="radio"/> Yes <input type="radio"/> No	Kidney Problems <input type="radio"/> Yes <input type="radio"/> No	Spina Bifida <input type="radio"/> Yes <input type="radio"/> No
Blood Transfusion <input type="radio"/> Yes <input type="radio"/> No	Frequent Diarrhea <input type="radio"/> Yes <input type="radio"/> No	Leukemia <input type="radio"/> Yes <input type="radio"/> No	Stomach/Intestinal Disease <input type="radio"/> Yes <input type="radio"/> No
Breathing Problems <input type="radio"/> Yes <input type="radio"/> No	Frequent Headaches <input type="radio"/> Yes <input type="radio"/> No	Liver Disease <input type="radio"/> Yes <input type="radio"/> No	Stroke <input type="radio"/> Yes <input type="radio"/> No
Bruise Easily <input type="radio"/> Yes <input type="radio"/> No	Genital Herpes <input type="radio"/> Yes <input type="radio"/> No	Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Swelling of Limbs <input type="radio"/> Yes <input type="radio"/> No
Cancer <input type="radio"/> Yes <input type="radio"/> No	Glaucoma <input type="radio"/> Yes <input type="radio"/> No	Lung Disease <input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No
Chemotherapy <input type="radio"/> Yes <input type="radio"/> No	Hay Fever <input type="radio"/> Yes <input type="radio"/> No	Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No	Tonsillitis <input type="radio"/> Yes <input type="radio"/> No
Chest Pains <input type="radio"/> Yes <input type="radio"/> No	Heart Attack/Failure <input type="radio"/> Yes <input type="radio"/> No	Osteoporosis <input type="radio"/> Yes <input type="radio"/> No	Tuberculosis <input type="radio"/> Yes <input type="radio"/> No
Cold Sores/Fever Blisters <input type="radio"/> Yes <input type="radio"/> No	Heart Murmur <input type="radio"/> Yes <input type="radio"/> No	Pain in Jaw Joints <input type="radio"/> Yes <input type="radio"/> No	Tumors or Growths <input type="radio"/> Yes <input type="radio"/> No
Congenital Heart Disorder <input type="radio"/> Yes <input type="radio"/> No	Heart Pacemaker <input type="radio"/> Yes <input type="radio"/> No	Parathyroid Disease <input type="radio"/> Yes <input type="radio"/> No	Ulcers <input type="radio"/> Yes <input type="radio"/> No
Convulsions <input type="radio"/> Yes <input type="radio"/> No	Heart Trouble/Disease <input type="radio"/> Yes <input type="radio"/> No	Psychiatric Care <input type="radio"/> Yes <input type="radio"/> No	Veneral Disease <input type="radio"/> Yes <input type="radio"/> No
			Yellow Jaundice <input type="radio"/> Yes <input type="radio"/> No

Have you ever had any serious illness not listed above?  Yes  No If yes \_\_\_\_\_

Comments:

\_\_\_\_\_

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

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

# Midtown Dental Center, PLLC

*Your Privacy Is Important to Us*

## Acknowledgement of Receipt of Notice of Privacy Policies

I have received a copy of the Notice of Privacy Practices of Midtown Dental Center, PLLC. I hereby authorize, as indicated by my signature below, Midtown Dental Center, PLLC to use and to disclose my protected health information for any necessary clinical, financial, and insurance purpose, as authorized in the Patient Consent form.

Print Name \_\_\_\_\_

Address \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

Please check your preferred means of communication:

- You may contact me at my home telephone number \_\_\_\_\_
- You may contact me on my mobile telephone number \_\_\_\_\_
- You may contact me on my work telephone number \_\_\_\_\_
- You may send me an email at: \_\_\_\_\_
- Other \_\_\_\_\_

Please list authorized persons with whom we may discuss your Protected Health Information (PHI) in addition to custodial parents and legal guardians:

1. \_\_\_\_\_ Date Added / Removed: \_\_\_\_\_
2. \_\_\_\_\_ Date Added / Removed: \_\_\_\_\_
3. \_\_\_\_\_ Date Added / Removed: \_\_\_\_\_
4. \_\_\_\_\_ Date Added / Removed: \_\_\_\_\_
5. \_\_\_\_\_ Date Added / Removed: \_\_\_\_\_

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### 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 the acknowledgement
- Other (Please Specify) \_\_\_\_\_

# PATIENT CONSENT

## Clinical

1. I authorize Midtown Dental Center, PLLC to perform all recommended treatment.
2. I authorize the Practice to take radiographs, study models, photos, and other diagnostic aids or materials (collectively, "Diagnostic Material") as needed to make a thorough diagnosis. I authorize that such Diagnostic Material may be released to third-party payors and/or other health professionals.
3. I authorize the use of anesthetics, sedatives, and other medication, as needed, and am fully aware that using anesthetic agents involves certain risks, including but not limited to redness and swelling of tissues, pain, itching, vomiting, dizziness, miscarriage, cardiac arrest, drowsiness, and/or lack of coordination.

## Financial

4. I am responsible for payment for all services rendered on my behalf. I understand that payment is due when services are rendered. I am aware that a 1.5% MPR or 18% APR automatically tabulated into my account if my balance is 30 days old or older. Should my account become delinquent, I will be responsible for all additional collection costs, including reasonable attorney fees.
5. A \$50 missed appointment fee will be charged to my account for all missed appointments or last minute cancellations by me. I am aware that to hold down operating costs, 24 hours notice of cancellation is required.

## Insurance

6. I authorize the Practice to release to staff, hospitals, health care service plans, insurance companies, self-insurers or their representatives, any and all information, records, and other Diagnostic Material about my medical history, services rendered, or recommended treatment.
7. I authorize the Practice to submit claims for payment for services rendered or pre-authorizations necessary to my insurance company, on my behalf and in my name listed as "signature on file" and assign to the Practice the insurance benefits providing assignment is accepted. I am responsible for payment regardless of coverage provided.

I have read this Patient Consent and agree to all terms and conditions herein.

Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Patient's Address: \_\_\_\_\_