Patient Information Form (Please Print)

Today's Date: _____

First Name _____ MI ____ Last Name _____

Social Security # _____ Driver's License Number _____

Address _____

City _____ State _____ Zip _____

Home Phone (___) _____ Work (___) _____

Cell (___) _____ Email _____

Date of Birth _____ Sex: M F □Married □Single □Divorced □Other

Student? Yes No School Name _____

Employer Name _____

Address, City, State, Zip _____

Person Responsible for this account _____

Relationship to Patient: Self Spouse Parent Other _____

Emergency Contact _____

Relationship to Patient: Self Spouse Parent Other _____

Phone (___) _____ Alternate Phone (___) _____

Address, City, State, Zip _____

Primary Insurance Subscriber

First Name _____ MI ____ Last Name _____

Social Security # _____ Driver's License Number _____

Address _____Date of Birth _____

City _____ State _____ Zip _____

Home Phone (___) _____ Work (___) _____

Relationship to Patient: Self Spouse Parent Other _____

Employer Providing Insurance

Employer Name _____

Address, City, State, Zip _____

Patient Information Form Continued (Please Print)

Patient Name: _____

Today's Date: _____

Insurance Information

Primary Dental Insurance Company Name _____

Policy Number _____ Group Number _____

Phone (___) _____

Address, City, State, Zip _____

Secondary Dental Insurance Company Name _____

Policy Number _____ Group Number _____

Phone (___) _____

Address, City, State, Zip _____

Primary Care Physician _____

Phone (___) _____

Address, City, State, Zip _____

Pharmacy _____

Phone (___) _____

Address, City, State, Zip _____

Whom may we thank for referring you to our office? _____

Patient Medical History

Patient Name: _____

Today's Date: _____

Are you under medical treatment now? □Yes □No

Have you been hospitalized for any surgical operation or serious illness within the last 5 years? □Yes □No If yes, please explain: _____

Are you taking any medication(s), over-the-counter or prescribed? □Yes □No

If yes, please list: _____

Have you ever had any joints replaced? □Yes □No

If yes, please explain: _____

Have you ever been advised to take an antibiotic before any dental procedure? □Yes □No

If yes, please explain: _____

Do you use tobacco? □Yes □No

Do you have a cardiac pacemaker? □Yes □No

Do you take any blood thinners like Warfarin or daily aspirin? □Yes □No

Do you use any controlled substances? □Yes □No

Do you wear contact lenses? □Yes □No

For women only:

Are you currently pregnant or think you may be pregnant? □Yes □No

Are you nursing? □Yes □No

Are you taking oral contraceptives? □Yes □No

Do you take any medications for low bone density or osteoporosis? □Yes □No

Are you allergic to any of the following?

□Y □N Local anesthetics

□Y □N Penicillin or any other antibiotics

□Y □N Codeine or other pain medications

□Y □N Sulfa drugs

□Y □N Barbiturates

□Y □N Sedatives

□Y □N Iodine

□Y □N Aspirin

□Y □N Any metals

□Y □N Latex

Other: _____

_____

Patient Medical History Continued

Patient Name: _____

Today's Date: _____

Do you currently or have you ever had any of the following?

□Y □N High blood pressure
□Y □N Low blood pressure
□Y □N Heart murmur
□Y □N Mitral valve prolapsed
□Y □N Angina/ chest pain
□Y □N Heart attack
□Y □N Stroke
□Y □N Cancer
□Y □N Radiation Therapy
□Y □N Glaucoma
□Y □N Recent unintentional weight loss
□Y □N Rheumatic fever
□Y □N Fainting
□Y □N Epilepsy/ Seizures
□Y □N Hay Fever/ Allergies
□Y □N Asthma
□Y □N Emphysema
□Y □N Respiratory problem(s)
□Y □N Leukemia
□Y □N Diabetes
□Y □N Kidney disease
□Y □N Liver disease
□Y □N HIV/ AIDS
□Y □N Sexually Transmitted Disease(s)
□Y □N Hepatitis/ Jaundice
□Y □N Thyroid problem
□Y □N Stomach troubles/ ulcers
Other: _____

Do any of the following apply?

□Y □N Bleeding gums (while flossing or brushing?)
□Y □N Sensitivity to hot or cold foods or liquids
□Y □N Sensitivity to sweet foods or liquids
□Y □N Sores/ lumps in or near mouth
□Y □N Head neck or jaw injuries
□Y □N Difficult tooth extraction(s) in the past
□Y □N Prolonged bleeding following an extraction
□Y □N Current or past dentures or partials
□Y □N Orthodontic treatments (past or present)
□Y □N Frequent biting or lips or cheeks

Problems in your jaw(s):

□Y □N Clicking
□Y □N Pain (joint, ear, side of face)
□Y □N Difficulty opening or closing
□Y □N Difficulty chewing
□Y □N Frequent headaches
□Y □N Clenching or grinding your teeth

Chief complaint:

_____
_____
_____
_____
_____

Dr. Signature: _____

Financial Policy

Our experience has shown us that many questions and/or problems about our financial policies can be avoided by understanding our office policies. As a courtesy, we will be happy to file your primary insurance benefits, though we are not obligated to do so.

Our office policy requires that payment is due in full at the time your dental treatment is rendered. In addition to cash, we accept check, Visa, Mastercard, Discover, and American Express with proper identification. Should you be interested in financing, our office accepts Care Credit 6 month and 12 month interest-free financing. If you are unfamiliar with Care Credit healthcare financing, please ask for details.

Your dental insurance plan is a contract between you, your employer, and the insurance company. Our office does not determine or guideline your benefits. As a courtesy to our patients with dental insurance, our doctors may agree to accept a patient's insurance assignment. If our front desk staff is able to determine the expected coverage of your insurance plan, our office will submit you claim to your insurance company. However, it is your responsibility to be familiar with your insurance policy, including knowledge of your deductibles, yearly maximums, co-payments, and non-covered services. Remaining benefits for pre-treatment estimates are generated on information obtained from your insurance company at the time of inquiry. Moore Dental Care is not responsible for misinformation obtained from your insurance company, including the amount of remaining benefits. We will wait up to 60 (sixty) days for the insurance payment to be received and applied to your account. The responsible party for the account must pay any deductible, co-payments, non-covered services, or difference between the insurance company fees and the office fees at the time services are completed. It is your responsibility to notify the office staff if there are any changes in your insurance coverage.

If, for any reason, your insurance company does not pay the insurance claim or does not pay the full amount of the expected benefit within 60 (sixty) days from the date of service, the balance will be transferred from an insurance balance to a personal balance. A statement will be sent to the responsible party and payment will be expected within 10 (ten) days. Any unpaid balance will be subject to a 1.5% interest rate per month. There will be a $25 service charge on any returned checks. If your account is turned over to a collection agency, you are responsible for any cost incurred in collection of said balance(s), which may include collection agency fees up to 35% of your outstanding balance, court cost, and attorney fees.

An important issue to remember is that the doctor will prescribe dental treatment on the bases of their patient's needs, not on the dental treatment the insurance will or will not cover.

Please sign only after you have read our policy in its entirety and are comfortable with the terms. If you would like a copy of our financial policy, please request one from the front desk after signing. Thank you.

_____ _____

Patient or Guardian Signature Date

Cancellation Policy:

Our office requires notification of at least 1 (one) business day if you need to cancel or reschedule an appointment. Tardiness in excess of 15 minutes may result in a failed appointment if the doctor or hygienist cannot accomodate you in the schedule. Failure to contact our office in advance will result in a $50.00 per half hour fee assessed to your account. The amount of hours is determined by the length of time your appointment was booked for based on your recommended treatment. As a courtesy, your first missed appointment will receive a warning letter since we understand that unforeseen circumstances may arise. Thereafter, the $50.00 per half hour fee will apply.

_____ _____

Signature Date

Authorization and Release:

I certify that I have read and answered the questions on the Patient Information Form and Patient Medical History accurately to the best of my knowledge. I understand the information given to me regarding the office's Financial and Cancellation Policies. I understand that withholding or providing incorrect information can be dangerous to my health. I hereby authorize and request the performance of dental services for my child or myself.

I authorize the dentist to release any information, including the diagnosis and records of any treatment or examination rendered to my child or myself during the period of such dental care, to third party payors and/or other health practitioners (i.e. endodontist).

If applicable, I authorize and request my insurance company to pay directly to the dentist or dental group such insurance benefits otherwise payable to me. I understand that I am financially responsible for any deductible, co-payments, non-covered services, differences between the insurance company fees and the office fees, or balances unpaid by my insurance company.

I understand that in the event I default on my payment for completed services, I can be charged an amount to cover collection, court, and attorney fees.

_____ _____

Patient or Guardian Signature Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

_____

Please print your name here

_____

Signature

_____

Date

We cannot discuss your protected health information (PHI) with anyone other than yourself unless you authorize us to do so. Please list below names(s) of the individual(s) you authorize our office to discuss care with. Your PHI may be disclosed to the individual(s) listed below until you notify us otherwise in writing.

_____ _____

_____ _____

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement.
- ☐ We weren't able to communicate with the patient.
- ☐ Other *(Please provide specific details)*

_____

_____

_____

_____ _____

Employee signature *Date*