

Patient Health Form for Dental Group of Meriden Wallingford

Complete and return the questionnaire to the receptionist. **All information will be considered confidential.**

I GENERAL INFORMATION

PHYSICIAN'S NAME _____

PATIENT NAME _____ HOW DID YOU HEAR ABOUT THIS OFFICE _____

ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

TELEPHONE _____ CELL _____ DATE OF BIRTH _____ SOCIAL SEC. # _____ EMAIL _____

EMPLOYER _____ DRIVER'S LIC. # _____

ADDRESS _____ TELEPHONE _____ LICENSE PLATE# _____

PARENT OR SPOUSE'S NAME _____ WHOM MAY WE CONTACT IN AN EMERGENCY? _____

ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

TELEPHONE _____ DATE OF BIRTH _____ SOCIAL SEC. # _____

EMPLOYER _____ CITY _____ TELEPHONE _____

II INSURANCE INFORMATION

DO YOU HAVE DENTAL INSURANCE? _____

DO YOU HAVE A SECONDARY INSURANCE? _____

IF YES, NAME OF INSURANCE CARRIER _____

POLICY # & SOC. SEC. # OF CARRIER _____

PERSON RESPONSIBLE FOR PAYMENT OF THIS ACCOUNT? _____

III CREDIT INFORMATION

DO YOU HAVE VISA/MASTERCARD? _____

CARD# _____ EXP. DATE _____

WILL YOU REQUIRE CREDIT FINANCING BY OUR OFFICE? Yes - No

MY CREDIT IS: GOOD - FAIR - POOR

You will be pre-approved for CareCredit, our dental credit card

IV HEALTH INFORMATION

PLEASE ANSWER THE FOLLOWING QUESTIONS

YES NO

- | PLEASE ANSWER THE FOLLOWING QUESTIONS | YES | NO |
|---|-----|----|
| 1. ARE YOU PRESENTLY UNDER A PHYSICIAN'S CARE? | | |
| 2. HAVE YOU BEEN EXAMINED BY YOUR PHYSICIAN WITHIN THE PAST YEAR? | | |
| 3. HAVE YOU CONSULTED SPECIALISTS WITHIN THE PAST YEAR? | | |
| 4. ARE YOU TAKING ANY MEDICATION? PLEASE LIST IN ADJACENT BOX. | | |
| 5. DO YOU HAVE ANY MEDICAL PROBLEMS? PLEASE EXPLAIN IN ADJACENT BOX. | | |
| 6. HAVE YOU EVER BEEN SERIOUSLY ILL? | | |
| 7. HAVE YOU EVER HAD A MAJOR OPERATION? | | |
| 8. HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR SYMPTOMS: | | |
| A. RHEUMATIC/SCARLET FEVER OR RHEUMATIC HEART DISEASE? | | |
| B. HEART ATTACK/DISEASE, MITRAL VALVE PROLAPSE, HEART MURMUR? | | |
| C. CORONARY SURGERY, BYPASS, VALVE REPLACEMENT, PACEMAKER? | | |
| D. LIVER OR KIDNEY DISEASE, HEPATITIS, JAUNDICE? | | |
| E. SURGICAL REPAIR OF BONE/JOINT WITH SCREWS, PLATES OR RODS? | | |
| F. ARM, LEG, HIP PROSTHESIS? ORGAN TRANSPLANT? | | |
| 9. DO YOU NEED ANTIBIOTICS BEFORE DENTAL TREATMENT? | | |
| 10. CHEST PAINS OR SHORTNESS OF BREATH ON MILD EXERTION? | | |
| 11. HIGH BLOOD PRESSURE, SWOLLEN ANKLES? | | |
| 12. STROKE, EPILEPSY, SEIZURE? TENDENCY TO FAINT? | | |
| 13. BLOOD DISORDERS, ANEMIA, PROLONGED BLEEDING? | | |
| 14. HIV, AIDS, VENEREAL DISEASE? | | |
| 15. ENDOCRINE DISORDERS, DIABETES, THYROID? | | |
| 16. CANCER? | | |
| 17. ASTHMA, EMPHYSEMA, T.B., RHEUMATISM, ARTHRITIS, ULCERS? | | |
| 18. ARE YOU PREGNANT? DO YOU TAKE BIRTH CONTROL PILLS? | | |
| 19. DO YOU USE COCAINE OR SIMILAR DRUGS? | | |
| 20. DO YOU SMOKE OR CHEW TOBACCO? | | |
| 21. HAVE YOU EVER HAD RADIATION THERAPY, CHEMOTHERAPY, OR CORTISONE THERAPY? | | |
| 22. HAVE YOU EVER EXPERIENCED ANY REACTION OR ALLERGY TO THE FOLLOWING DRUGS: | | |
| A. ASPIRIN? B. CODEINE? C. PENICILLIN? D. LOCAL ANESTHETICS? E. LATEX RUBBER? F. IODINE? G. SULFUR? | | |

V OFFICE POLICY

Patients with Insurance: Copayment for service is due at the time of service. I authorize my insurance to send payment directly to the Dental Group of Meriden-Wallingford.

Patients without Insurance: Payment IN FULL as services rendered. All denture services are to be paid when treatment begins regardless of insurance plans.

You are encouraged to read your insurance policy to determine the annual maximum allowed; and the percentage paid by your carrier.

As a guide: Most insurances pay—

100% Preventive: Exams, x-rays, prophylaxis

80% Fillings; except posterior composites which are paid at 40%

50%-80% for endodontic treatment 0%-50% for crowns and bridges

These estimates are a guide. The actual monies owed will be determined once your insurance company processes the claims.

There will be a \$75 charge for each broken appointment.

I give permission to the Dental Group of Meriden to perform dental treatment with my full knowledge and consent. **I WILL BE RESPONSIBLE FOR ALL CHARGES AND AGREE TO MAKE PROMPT PAYMENT FOR TREATMENT. ACCOUNTS NOT PAID WITHIN 90 DAYS WILL BE AUTOMATICALLY CHARGED TO MY VISA/MASTERCARD/CareCredit.** In the event of default your account will be subject to finance charges of 18% annually. You and/or your guardian are liable for all collection costs and attorney fees. I consent to the release of information contained in my dental records.

I have had full opportunity to read and consider the contents of the HIPPA Consent form and your Notice of Privacy Practices. I understand that, by signing this form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

SIGNATURE _____ Date: _____

Personal Representative's Name: _____

If this Consent is signed by a personal representative on behalf of the patient.

Relationship to Patient: _____

AT SUBSEQUENT APPOINTMENTS PLEASE INFORM US OF ANY CHANGES IN YOUR HEALTH

PLEASE EXPLAIN ANY MEDICAL PROBLEMS HERE