Medical History Form

Patient Name: _____ **Date of Birth:** _____

Disclaimer

Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive.

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
Have you ever had a joint replacement? If yes, when? Who was the Physician?	Yes No	If yes
Have you had a heart valve replacement? If yes, when? Who was the physicaion?	Yes No	If yes
Do you have a preferred pharmacy? If yes, please list pharmacy name and phone number.	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	
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes No	
Are you on a special diet?	Yes No	
Do you use tobacco?	Yes No	
Do you use controlled substances?	Yes No	

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

Please indicate any allergies not listed above: Yes No If yes

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

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

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

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 my medical status.

Signature of Patient, Parent or Guardian:

X Date:_____

PAYMENT & NO SHOW/CANCELLATION POLICY

In an ongoing effort to better serve our patients, Mitchell Bridge Dental Associates, will use reasonable efforts to obtain benefit information from your insurance carrier for your dental services. Because your insurance carrier typically does not guarantee either the benefits it provides to us on your behalf, or the payment for services rendered to you, your carrier's benefit information which we provide to you may not be completely accurate. We will not know exactly what your coverage of expenses will be until we have received reimbursement from your insurance carrier at which time you are responsible for the balance of all unpaid claims.

Mitchell Bridge Dental Associates wishes to make payment for your account balance as convenient for you as possible. Insurance companies require the separate filing of our professional fees for each date of service. As a courtesy to you, we customarily file your claims with your insurance company. Each patient, however, remains fully responsible for the entire amount of the bill until all claims are paid.

Payment for any deductible, co-insurance, or co-payment is expected at the time services are rendered. If our staff is unable to confirm that you have insurance coverage, payment of your charges in full is requested at the time of service. Any payment due may be paid in cash, personal check, money order, Care Credit, or credit/debit card. If the unpaid balance exceeds 30 days with Mitchell Bridge Dental Associates, the unpaid balance will be subject to a $5.00 billing charge each month.

If you are unable to comply or if you have any questions concerning our payment policy, our Front Office Coordinator will be happy to assist you.

OVERDUE ACCOUNT BALANCES

It is unfortunate when no arrangements for payment can be made or agreed upon arrangements become delinquent. Any account that is 90 days past due may be considered a bad debt risk. When this happens, we may have no recourse but to assign your account to a third party collection agency for collection or place your account with an attorney to obtain judgment or otherwise satisfy payment of your delinquent account. If this occurs, a collection fee of up to 30% of the unpaid balance may be added to your account. We will also charge reasonable attorney fees, court costs, interest, late fees, sheriff's fees and similar fees.

NO SHOW/CANCELLATION POLICY

Twenty-four hours notice is required for all cancellations. Upon a second cancellation occurring less than twenty-four hours from your scheduled appointment time or "no show" appointments will incur a $50.00 broken appointment fee. Three cancellations of less than twenty-four hours prior to appointment time or three "no shows" will result in discharge.

I, the undersigned, have read and understand the
Payment and No Show/Cancellation Policy as outlined above.

_____ _____

Patient or Guardian Signature **Date**

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____ have received a copy of Mitchell Bridge Dental II, LLC's Notice of Privacy Practices and have had the opportunity to ask questions.

* You May Refuse to Sign This Acknowledgment*

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 unencrypted email/text message 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: _____

I have received a copy of Mitchell Bridge Dental II, LLC's Notice of Privacy Practices.

Print Name: _____

Signature: _____ Date: _____

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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
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify) _____

NAME OF PATIENT:

First Name: _____ Middle Initial: _____ Last Name: _____

Patient Is: ____Policy Holder ____Responsible Party Preferred Name: _____

RESPONSIBLE PARTY:

First Name: _____ Middle Initial: _____ Last Name: _____

Mailing Address: _____

Physical Address: _____

City, State, Zip Code: _____

Home Phone: _____ Work Phone: _____ Ext: _____

Cell Phone: _____

Date of Birth: _____ Social Security Number: _____

Sex: ___Male ___Female

Marital Status: ___Married ___Single ___Divorced ___Separated ___Widowed

Email Appointment Reminders: ___Yes ___No If Yes, Email Address: _____

Text Appointment Reminders: ___Yes ___No

___Responsible Party is also Policy Holder

___Primary Dental Insurance Policy Holder ___Secondary Dental Insurance Policy Holder

Employer:_____ Employer Phone number: _____

Employer Address:_____

PATIENT INFORMATION (<u>ONLY FILL OUT IF PATIENT IS NOT RESPONSIBLE PARTY</u>):

Address: _____

City, State, Zip Code: _____

Home Phone: _____ Work Phone: _____ Ext: _____

Cell Phone: _____

Date of Birth: _____ Social Security Number: _____

Sex: ___Male ___Female

Marital Status: ___Married ___Single ___Divorced ___Separated ___Widowed

PLEASE FILL OUT:

Emergency Contact: _____ Phone Number: _____

Primary Care Specialist: _____ Phone Number: _____

Medical Specialist: _____ Phone Number: _____

PRIMARY DENTAL INSURANCE INFORMATION (<u>IF NEW PATIENT OR NEW INSURANCE</u>):

Name of the Insured: _____

Name of Insurance Company: _____

Relationship to Insured: ___Self ___Spouse ___Child ___Other

Date of Birth: _____ Social Security Number: _____

Is this an Individual Policy: ___Yes ___No

Is this through an employer ___Yes ___No If yes, name of employer: _____

Please let us make a copy of your insurance card. Thank you!

SECONDARY DENTAL INSURANCE INFORMATION (<u>IF NEW PATIENT OR NEW INSURANCE</u>):

Name of the Insured: _____

Name of Insurance Company: _____

Relationship to Insured: ___Self ___Spouse ___Child ___Other

Date of Birth: _____ Social Security Number: _____

Is this an Individual Policy: ___Yes ___No

Is this through an employer ___Yes ___No If yes, name of employer: _____

Please let us make a copy of your insurance card. Thank you!