Date: ______________________

Referral Information

Whom may we thank for referring you to our practice?

- ☐ Friend/Relative
- ☐ Dental office
- ☐ Internet
- ☐ Groupon/Living Social
- ☐ Newspaper/Magazine
- ☐ Mailer
- ☐ School
- ☐ Work
- ☐ Patient

Please Thank: ______________________

☐ Other:

Patient Name: ______________________ *(First, Middle, Last)*

How should we address you? ______________________

H Phone: ______________________

C Phone: ______________________

Email: ______________________

Patient Information

Address: ______________________

City, State, Zip: ______________________

Sex: ☐ Female ☐ Other ☐ Male

Date of Birth: ____________ SS#: ____________

Driver's License Number: ______________________

Driver's License State: ______________________

Marital Status: ☐ Single ☐ Divorced ☐ Married ☐ Widowed ☐ Separated ☐ Partnership

Spouse Name: ______________________

Spouse Phone: ______________________

Responsible Party Information

☐ Self *(disregard rest of section)*

☐ Parent/Guardian *(if patient is a minor/dependent)*

☐ Spouse

Name: ______________________

Gender: ☐ Female ☐ Male

Marital Status: ☐ Single ☐ Divorced ☐ Married ☐ Widowed ☐ Separated ☐ Partnership

Date of Birth: ____________ Age: ______

SS#: ______________________

Address: ______________________

H Phone: ______________________

C Phone: ______________________

W Phone: ______________________

Employer Information

Patient Employed by: ______________________

Occupation: ______________________

W Phone: ______________________

Method of Payment

☐ Self-Pay *(no insurance)*

☐ Dental Insurance *(name of company):* ______________________

Name of Insured: ______________________

Insured's Employer: ______________________

Employer Phone: ______________________

Subscriber ID#: ______________________

Group #: ______________________

Policy #: ______________________

Effective Date: ______________________

Insurance Phone: ______________________

Claims Address: ______________________

Other Dependants Covered by this plan: ______________________

Emergency Contact Information

Contact Name: ______________________

Relationship to Patient: ______________________

Emergency Contact Phone Numbers

Cell: ______________________

Home: ______________________

Work: ______________________

Emergency Contact Email: ______________________

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Please check all that apply:

- ☐ Bad Breath
- ☐ Bleeding Gums
- ☐ Broken Fillings
- ☐ Clench or Grind teeth
- ☐ Clicking/popping of jaw
- ☐ Food collection between teeth
- ☐ Sensitivity to biting
- ☐ Senitivity to hot/cold

Patient Name: ____________________ Birth Date: ____________________

Although dental personnel primariliy treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Dental History

Date of Last Dental Visit: ____________________ Reason for the Visit: ____________________

Former Dentist: ____________________ Date of last dental X-ray: ____________________

Please check if you have/had:

- ☐ Blisters on lips or mouth
- ☐ Burning sensation on tongue
- ☐ Dry Mouth
- ☐ Growths or sore spots in your mouth
- ☐ Gums swollen, tender or bleeding
- ☐ Head, neck, jaw pain, or aches
- ☐ Lip or cheek biting
- ☐ Loose teeth or broken fillings
- ☐ Mouth breathing
- ☐ Orthodontic treatment
- ☐ Nitrious Oxide
- ☐ Periodontal treatment
- ☐ How often do you floss? ____________
- ☐ How often do you brush? ____________
- ☐ Have you ever had an allergic reaction to Novocaine, local, or general anesthetics? If so, explain:

Tobacco History: ☐ Previous Smoker ☐ Current Smoker
☐ Cigarette ☐ Cigars ☐ Pipe
☐ Chew on one side of mouth ☐ Smokeless Tobacco

Please indicate:
_____Years
_____Packs per day

Have you ever had any complications from dental treatment? If yes, please explain:

____

Medical History

Women are you: ☐ Pregnant/Trying to get pregnant? ☐ Taking oral contraceptives ☐ Nursing

Are you allergic to any of the following:

☐ Aspirin ☐ Codeine ☐ Acrylic ☐ Latex ☐ Other, please explain: ____________
☐ Penicillin ☐ Local Anesthetics ☐ Metal ☐ Sulfa Drugs

Please check if you have/had:

- ☐ AIDS/HIV Positive
- ☐ Allergies/Hay Fever/Sinusitis
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Heart Valve
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Transfusions
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Cortisone Treatment
- ☐ Diabetes: **TYPE I II**
- ☐ Emphysema
- ☐ Epilepsy/Seizures
- ☐ Excessive Bleeding
- ☐ Fainting/ Dizzy spells
- ☐ Frequent Headaches
- ☐ Glaucoma
- ☐ Head Injuries
- ☐ Heart Problems
- ☐ Heart Murmur
- ☐ Hepati **A B C**
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low blood pressure
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sickle Cell Disease
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Swelling of limbs
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Tumor or growth on head/neck
- ☐ Ulcers
- ☐ Venereal Disease

Have you been admitted to a hospital or needed emergency care during the past two years?
If yes, please explain: ____________________

Do you have any health problems that need further clarification? ☐ yes ☐ no

____

List any medications you are taking:

____

____

Name of Physician: ____________________

Physician Phone: ____________________

Preferred Pharmacy & Phone: ____________________

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Patient Name: ____________________
As of Date: ____________________

Medical Consent

I certify that I have read, reviewed and understand the information on this questionaire, and it is accurate to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. I also understand that I am responsible for notifying the office if this information changes at any time.

I authorize the practice to release any information including diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers or health practitioners. I authorize the use of this signature on all insurance submissions to ensure payment of services.

I have read and understand the financial policy of the practice and realize that my benefit plan may pay less than the actual bill for services rendered. I understand that I am responsible for the payment of charges on the date of service unless prior arrangements have been made.

Patient, Parent, or Guardian Signature ____________________ Date ____________

Doctor Signature ____________________ Date ____________

HIPPA Consent

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Pricacy Practices before you decide whether to sign this consent. Our notice provides a decription of our treatment, payment activities, and healthcare operations of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our notice accompanies this consent. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain these changes. Those changes may apply to any of your protected health information that we maintain.

Patient, Parent, or Guardian Signature ____________________ Date ____________

Doctor Signature ____________________ Date ____________

CANCELLATION, NO SHOW, AND LATE PATIENT POLICIES

Cancellation of an Appointment
In an effort to be respectful to the dental needs of our community, we request that you call as soon as you know or at least 48 business hours in advance of any appointments with the doctor, hygienist, or dental assistant. Please be courteous and call promptly if you are unable to attend an appointment, so that we have the opportunity to reallocate your appointment to another patient in need of, or desiring dental treatment.

No Show Policy
A "no show" is someone who misses an appointment without canceling it 24 business hours in advance of your scheduled appointment.

> **Example**: If your appointment is at 3 pm on Tuesday. You need to call by 3 pm on Monday.

A failure to be present at the time of a scheduled appointment will be recorded in your chart as a "no show". The first time there is a "no show", a fee of **$75.00** will be billed to your account and sent to your home. This fee covers administrative tasks associated with your appointment. This fee will need to be paid in full before scheduling any further appointments. Three follow-up "no shows" in a 12-month period of time may result in permanent discharge from the practice.

Late Patient Policy
A "late patient" is someone who makes an appointment and for any reason cannot make it to the appointment on time.

> **Example:** Your appointment is at 2 pm and you do not arrive until 4 pm.

Late patients inconvenience the entire practice as a whole. The Doctor, Staff, and all other patients deserve a professional environment. To ensure that this standard is upheld there will be a **$20.00** penalty for each hour that the patient is late. It is up to the Doctor to use his discretion in determining if the late patient can be accommodated into the schedule.

Late Cancellations
Late cancellations will be considered as a "no show".

How to Cancel Your Appointment
To cancel appointments, please call 561.653.1163. If you do not reach the receptionist, you may leave a detailed message on the voicemail.

M Dental appreciates your understanding and cooperation in helping us provide excellent care with the utmost respect to your time spent in our office. We look forward to providing you the highest standard of care.

Please sign here stating that you have read and understand the policies:

Print Name: ______________________________

Signature: ______________________________

Date: ______________________________

425 Greenwich Circle, Suite 101
Jupiter, FL 33458
B: 561.653.1163 F: 561.653.1164
info@mdentaljupiter.com

WRITTEN FINANCIAL POLICY

Thank you for choosing M Cosmetic and Family Dentistry. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

- Cash, Debit Card, Visa, MasterCard, American Express or Discover Card.
  We offer a 3% courtesy accounting adjustment to patients who pay for their treatment with cash prior to completion of care for treatment plans of $1000 or more.
- Convenient Monthly Payment Options[1] from CareCredit Healthcare Credit Card or Springstone Patient Financing allow you to pay over time, some plans with no annual fees or pre-payment penalties.

PLEASE NOTE:

- M Cosmetic and Family Dentistry, P.A. requires payment prior to the completion of your treatment. If you choose to discontinue care before treatment is complete, you will receive a refund less the cost of care received.
- We accept payment in thirds for treatments over $1000. For plans requiring more than 3 appointments, alternative payment arrangements may be provided. For larger, more comprehensive treatment plans of $500 or more, a 50% deposit is required to secure your initial treatment appointment.
- For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.[2]
- A fee of $75 is charged for patients who miss or cancel more than 2 times in a calendar year without 48-hour notice. A late fee penalty of $20 will be charged for each hour a patient is late.
- M Cosmetic and Family Dentistry charges $30 for returned checks.
- If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want and/or need.

____

Patient, Parent or Guardian Signature   Date

____

Patient Name (Please Print)

[1]Subject to credit approval

[2]However, if we do not receive payment from your insurance carrier within 30 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.

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TREATMENT CONSENT

As of Date: ______________________

Patient Name: ______________________ DOB: ______________________

Please read and initial the items checked below. Then read and sign the section at the bottom of form.

☐ 1.) **WORK TO BE DONE**

I understand that I am having the following work done.

☐ Fillings ______________________
☐ Bridges ______________________
☐ Crowns ______________________
☐ Extractions ______________________
☐ Impacted Teeth removed ______________________
☐ General Anesthesia ______________________
☐ Root Canals ______________________
☐ Other ______________________

Pt. Initials: __________

☐ 2.) **DRUGS AND MEDICATIONS**

I understand that antibiotics and other medications can cause allergic reactions causing redness and swelling of the tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction)

Pt. Initials: __________

☐ 3.) **CHANGES IN TREATMENT PLAN**

I understand that during treatment it may be necessary to change or add procedures because of conditions found while woring on the teeth that were not dicovered during examination, the most common being root canal therapy following the routine restorative procedures. I give my permission to the Dentist to make any/all changes and additons as necessary.

Pt. Initials: __________

☐ 4.) **REMOVAL OF TEETH**

Alternative to removal have been explained to me (root canal therapy, crowns, and periodontal surgery, etc.) and I authorize the Dentist to remove the following teeth ____________________ and any others necessary for reasons in paragraph #3. I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks incolved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, l,ips, toungue and surrounding tissue (Parasthesia) that can last for an indefinite period of time (Days or months) or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility,

Pt. Initials: __________

☐ 5.) **CROWN, BRIDGES, AND CAPS**

I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize that final opportunity to make changes in my new crown, bridge or cap (including shape, fit, size, and color) will be before cementation.

Pt. Initials: __________

☐ 6.) **DENTURES, COMPLETE OR PARTIAL**

I realize that full or partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The problems of wearing these appliances have been explained to me, including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new dentures (including shape, fit, size, placement, and color) will be at the "teeth in wax" try-in visit. I understand that most dentures require refining approximately three to 12 months after initial placement. The cost for this procedure is not included in the initial denture fee.

Pt. Initials: __________

☐ 7.) **ENDODONTIC TREATMENT (ROOT CANAL)**

I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment, and that occasionally metal objects are cemented in the tooth or extend through the root, which does not necessarily affect the success of the treatment, I understand that occassionally additional surgical procedures may be necesasry following root canal treatment (apicoectomy).

Pt. Initials: __________

☐ 8.) **PERIODONTAL LOSS (TISSUE & BONE)**

I understand that I have a serious condition, causing gum and bone infection or loss and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including gum surgery, replacements and/or extractions. I understand that undertaking any dental procedures may have a future adverse effect on my periodontal condition.

Pt. Initials: __________

I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot guarentee results. I acknowledge that no guarantee or assurance has been made to me by anyone regarding the dental treatment that I have requested and authorized for myself or my minor child. I have had full opporunity to discuss and ask questions regarding the dental treatment, and all questions have been answered to my satisfaction.

____
Signature of Patient, Parent, Guardian or Personal Representative

____
Date

____
Printed name of Patient, Parent, Guardian or Personal Representative

____
Relationship to Patient