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## PATIENT INFORMATION

**NAME:** _____
LAST NAME FIRST NAME MIDDLE

**HOW WOULD YOU LIKE TO BE ADDRESSED?** _____

**ADDRESS:** _____

**DATE OF BIRTH:** _____ **SEX:** M F **SSN:** _____

**PHONE:** (HOME)_____

(WORK)_____ (CELL)_____

**EMAIL:** _____

☐ Check to receive text messages ☐ Check to receive emails

**EMPLOYER:** _____

**PREFERRED PHARMACY:** _____

LOCATION: _____

**EMERGENCY CONTACT:** _____

RELATIONSHIP: _____ PHONE: _____

**PHYSICIAN:** _____

ADDRESS: _____



**Maine Prosthodontics**
1250 Forest Ave
Portland, ME 04103
www.maineprosthodontics.com

Phone: (207) 773-6177
Fax: (207) 773-6552

Email: info@maineprosth.com

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## DENTAL HISTORY

**CURRENT DENTIST:** _____

CITY: _____ STATE: _____

Date of last dental visit: _____Date of last dental x-rays: _____

Reason for today's visit: _____

Whom may we thank for referring you? _____

Have you ever had any complications following a dental visit? YES NO

If so, please explain: _____

_____

**Please Circle:**

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| BAD BREATH | YES | NO | BITE CHANGES | YES | NO | SENSITIVITY TO COLD | YES | NO |
| BLEEDING GUMS | YES | NO | RECEDING GUMS | YES | NO | SENSITIVITY TO HEAT | YES | NO |
| CLICKING/POP JAW | YES | NO | GUM TREATMENT | YES | NO | LOOSE TEETH | YES | NO |
| DRY MOUTH | YES | NO | MOUTH PAIN, BRUSHING | YES | NO | TENDER GUMS | YES | NO |
| SWOLLEN GUMS | YES | NO | ORTHODONTIC TREATMENT | YES | NO | CLENCHING/GRINDING | YES | NO |
| LIP/CHEEK BITING | YES | NO | FOOD TRAPPING | YES | NO | SPACE CHANGES | YES | NO |

How often do you brush? _____ How often do you floss? _____

Are you unhappy with the appearance of your teeth? YES NO

How do you feel about your teeth in general? _____

Do you have any specific concerns? _____



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## MEDICAL HISTORY

**Please circle if you have been treated or are under treatment for any of the following:**

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| HEART DISEASE | YES | NO | RHEUMATIC FEVER | YES | NO | LIVER DISEASE | YES | NO |
| HEART SURGERY | YES | NO | ANEMIA | YES | NO | HEPATITIS (A, B or C) | YES | NO |
| ANGINA PECTORALIS | YES | NO | ABNORMAL BLEEDING | YES | NO | YELLOW JAUNDICE | YES | NO |
| HEART ATTACK | YES | NO | MITRAL VALVE PROLAPSE | YES | NO | THYROID PROBLEMS | YES | NO |
| STROKE | YES | NO | PACEMAKER | YES | NO | DEPRESSION/ANXIETY | YES | NO |
| SHORTNESS OF BREATH | YES | NO | TUBERCULOSIS | YES | NO | SEIZURES | YES | NO |
| HEART MURMUR | YES | NO | ASTHMA | YES | NO | EPILEPSY | YES | NO |
| ARTIFICIAL HEART VALVE | YES | NO | LUNG DISEASE | YES | NO | FAINTING SPELLS | YES | NO |
| OTHER IMPLANT | YES | NO | ARTHRITIS | YES | NO | HEAD INJURY | YES | NO |
| ARTIFICIAL JOINT | YES | NO | KIDNEY PROBLEMS | YES | NO | GERD/ACID REFLUX/GI UPSET | YES | NO |
| CANCER | YES | NO | VENEREAL DISEASE | YES | NO | INFLAMMATORY DISEASE | YES | NO |
| RADIATION THERAPY | YES | NO | DIABETES (TYPE I OR II) | YES | NO | SLEEP PROBLEMS/APNEA | YES | NO |
| CHEMOTHERAPY | YES | NO | PAIN IN JAW JOINTS | YES | NO | ULCERS | YES | NO |
| REACTION TO ANESTHETIC | YES | NO | FEVER BLISTERS | YES | NO | CHOLESTEROL (HIGH/LOW) | YES | NO |
| FREQUENT HEADACHES | YES | NO | HERPES | YES | NO | OTHER (please describe): | | |
| SINUS PROBLEMS | YES | NO | BRUISE EASILY | YES | NO | | | |
| DRUG ABUSE | YES | NO | HIV/AIDS | YES | NO | | | |
| ALCOHOL ABUSE | YES | NO | ALLERGIES | YES | NO | | | |
| GLAUCOMA | YES | NO | HIGH BLOOD PRESSURE | YES | NO | | | |
| PREGNANT/NURSING | YES | NO | LOW BLOOD PRESSURE | YES | NO | | | |

Do you smoke or use tobacco? YES NO If yes, how much? _____ packs per day

Do you consume alcoholic beverages? YES NO If yes, how much? _____ per day/week

Do you currently, or have you previously, needed to pre-medicate for dental procedures? YES NO

If so, what antibiotic? _____



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**MEDICATIONS:** (Please list all current medications, including herbal, with dosages or provide a separate list.)

_____

_____

_____

_____

**ALLERGIES:** (PENICILLIN/LATEX/ETC.)

_____

_____

_____

_____

**ANYTHING ELSE WE SHOULD KNOW?** (DENTAL ANXIETY/DENTAL TRAUMA/ETC.)

_____

_____

_____

_____

_____



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# INSURANCE AND FINANCIAL INFORMATION

**Person responsible for your account** (circle one): SELF / GUARDIAN / SPOUSE / FATHER / MOTHER

## PRIMARY DENTAL INSURANCE

| | | | | | |
|---|---|---|---|---|---|
| LAST NAME: | _____ | FIRST NAME: | _____ | DOB: | _____ |
| RELATIONSHIP: | _____ | EMPLOYER: | _____ | INS. CO. NAME: | _____ |
| ID # | _____ | GROUP # | _____ | | _____ |

## SECONDARY DENTAL INSURANCE

| | | | | | |
|---|---|---|---|---|---|
| LAST NAME: | _____ | FIRST NAME: | _____ | DOB: | _____ |
| RELATIONSHIP: | _____ | EMPLOYER: | _____ | INS. CO. NAME: | _____ |
| ID # | _____ | GROUP # | _____ | | _____ |

## PRIMARY MEDICAL INSURANCE

| | | | | | |
|---|---|---|---|---|---|
| LAST NAME: | _____ | FIRST NAME: | _____ | DOB: | _____ |
| RELATIONSHIP: | _____ | EMPLOYER: | _____ | INS. CO. NAME: | _____ |
| ID # | _____ | GROUP # | _____ | | _____ |

## SECONDARY MEDICAL INSURANCE

| | | | | | |
|---|---|---|---|---|---|
| LAST NAME: | _____ | FIRST NAME: | _____ | DOB: | _____ |
| RELATIONSHIP: | _____ | EMPLOYER: | _____ | INS. CO. NAME: | _____ |
| ID # | _____ | GROUP # | _____ | | _____ |

***Payment is due in full at the time of service.*** *We will file an insurance claim on your behalf, we kindly request that you provide your insurance information in advance of your appointment.*

*We offer pre-treatment estimates, though final charges may vary based on your procedure. Please note, your insurance policy is a contract between you and the insurer, not Maine Prosthodontics. While we'll file claims for you, you are responsible for any charges.*

**Signature:** _____ **Date:** _____
*I attest to the accuracy of information on this form.*



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*You May Refuse to Sign This Acknowledgment*

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

**Print Name:** _____

**Signature:** _____ **Date:** _____

## 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 prevented us from obtaining acknowledgement
- ☐ Other: _____

_____

_____





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# PATIENT FINANCIAL POLICY

**Patient Name:** _____ **D.O.B.:** _____

*Patient agrees to pay for all portions of services, due in full, at the time services are provided by our office.* We work for you and are committed to providing the best dental and medical care possible. Our Financial Coordinator will do everything possible to maximize benefits for your specific needs, which aren't always what your insurance company agrees to cover and/or determines that they will reimburse you. **You are required to present a valid insurance card at every visit and as needed throughout your care.**

**Medical Commercial Insurance Carriers:** We do not participate with or accept payment from any insurance company. *We ask that you pay us in full at the time of service.* We will assist you by filing a claim and any necessary documentation with your carrier and they will determine the reimbursement allowed for services based on your insurance policy's language**. *It is your responsibility to ensure all authorizations/referrals are in place prior to the start of treatment.***

**Medicare Part B:** Our office is a non-participating Medicare provider. We will file all of the necessary paperwork on your behalf; however, we ask that you pay us in full at the time of services. Medicare will reimburse you directly.

**MaineCare (Medicaid):** Our office is a MaineCare participating provider for pre-approved medical visits, only. We will bill MaineCare for you. ***All services that are NOT covered by MaineCare are the patient's responsibility and payment in full at the time of service is expected.***

**Worker's Compensation:** If you visit to our office is work related, please provide your case number and the carrier's name prior to your visit for us to bill the worker's compensation company*. **We require written approval of procedures and the amount to be paid prior to the start of treatment.***

**Dental Insurance:** We do not participate with or accept payment directly from Dental Insurance Providers. We ask that you pay us in full at the time of service. We will assist you by filing a claim with your carrier and they will determine the reimbursement allowed for services based on your insurance policy provisions.

**Cancellation Policy:** You will be charged for failed or cancelled appointments without prior notification of 48 hours. This fee covers only a portion of the overhead such as salaries, electric, heat, etc., which still must be paid whether you are present or not. Once an appointment has been made, please remember this time has been reserved for you.



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## ACCEPTED METHODS OF PAYMENT FOR SERVICES

**For your convenience we accept:** Cash, Personal Checks*, Credit cards (MasterCard, Visa, Discover and American Express) as well as Debit cards. For any payments $1000 and above made with a credit or debit card, a 3% processing fee will be assessed.

If not paid according to the terms as outlined above; the patient (or person with financial responsibility) understands that outstanding balances will be sent to Collections after 90 days delinquent unless *prior to treatment* other arrangements have been made with our Financial Coordinator. In the event your account is turned over for collections, you agree to pay all additional fees accessed in the collection of the debt. These fees include collection agency and/or attorney fees incurred by our office.

*Returned checks are assessed a $35.00 NSF charge.

*The patient is ultimately responsible for all fees for services.* I have read, understood and agree to the above financial policy for payment of professional fees.

**Signature:** _____ **Date:** _____
*(Patient or Parent/Guardian)*

## CONSENT FOR PHOTOS (Optional)

**Patient Name:** _____ **DOB:** _____

I consent to have photographs taken to be used for educational or research purposes, or to be published in scientific journals provided my name is not used in connection herewith.

**Signature:** _____ **Date:** _____
*(Patient or Parent/Guardian)*



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# AUTHORIZATION FOR RELEASE OF INFORMATION TO FAMILY MEMBERS

**Patient Name:** _____ **D.O.B.:** _____

Many of our patients allow family members such as their spouse, parents, or others to call and request medical/dental or billing information. Under the requirements of HIPAA, we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical/dental or billing information released to family members you must sign this form.

Signing this form will only give information to family members indicated below.

I authorize Maine Prosthodontics to release my medical/dental and/or billing information to the following individual(s):

**Full Name:** _____ **Relationship to Patient:** _____

**Full Name:** _____ **Relationship to Patient:** _____

**Full Name:** _____ **Relationship to Patient:** _____

## Patient Information

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed.

I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to redisclosure by the above recipient.

You have the right to revoke this consent in writing at any time.

**Signature of Patient:** _____ **Date:** _____



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