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PATIENT INFORMATION

NAME_____
Last First Middle How do you wish to be addressed?

ADDRESS_____CITY_____STATE_____ZIP_____

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

TELEPHONE (H)_____(W)_____(C) _____

EMAIL_____ ○ **Check to receive text messages**

○ **Check to receive emails**

EMPLOYER_____ PREFERRED PHARMACY_____

EMERGENCY CONTACT_____RELATIONSHIP_____PHONE _____

PHYSICIAN_____ADDRESS_____

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? _____

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Have you ever had any complications following dental treatment? 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

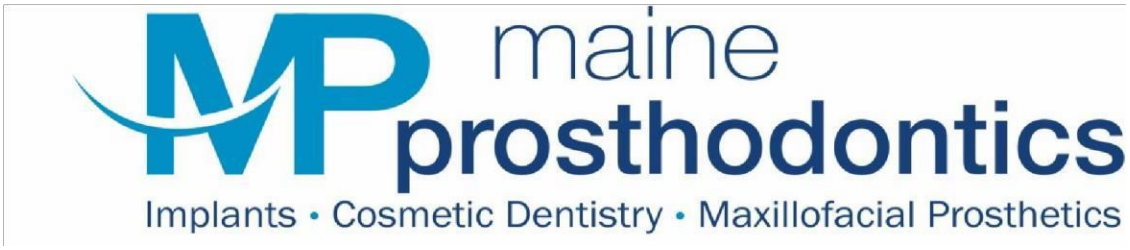
How do you feel about your teeth in general? _____

Do you have any specific concerns? _____

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 OR B)	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	GI/STOMACH DISTURBANCE	YES	NO
SHORTNESS OF BREATH	YES	NO	TUBERCULOSIS	YES	NO	PSYCH/DEPRESSION/ANXIETY	YES	NO
HEART MURMUR	YES	NO	ASTHMA	YES	NO	SEIZURES	YES	NO
ARTIFICIAL HEART VALVE	YES	NO	LUNG DISEASE	YES	NO	EPILEPSY	YES	NO
OTHER IMPLANT	YES	NO	ARTHRITIS	YES	NO	FAINTING SPELLS	YES	NO
ARTIFICIAL JOINT	YES	NO	KIDNEY PROBLEMS	YES	NO	HEAD INJURY	YES	NO
CANCER	YES	NO	VENEREAL DISEASE	YES	NO	GERD/ACID REFLUX	YES	NO
RADIATION THERAPY	YES	NO	DIABETES (TYPE I OR II)	YES	NO	INFLAMMATORY DISEASE	YES	NO
CHEMOTHERAPY	YES	NO	PAIN IN JAW JOINTS	YES	NO	SLEEP PROBLEMS/APNEA	YES	NO
REACTION TO ANESTHETIC	YES	NO	FEVER BLISTERS	YES	NO	ULCERS	YES	NO
FREQUENT HEADACHES	YES	NO	HERPES	YES	NO	CHOLESTEROL (HIGH/LOW)	YES	NO
SINUS PROBLEMS	YES	NO	BRUISE EASILY	YES	NO	OTHER:		
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/wk

Do you need to or have you needed to in the past pre-medicate for dental procedures? YES NO

If so, what antibiotic:

_____

MEDICATIONS: (Please list all medications, including herbal, you are currently taking and dosages or provide us with a separate list.)

_____

_____

_____

_____

A**LLERGIES (PENICILLIN/LATEX)**:

_____

_____

_____

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INSURANCE AND FINANCIAL INFORMATION

Person Responsible for Account - Please Circle 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

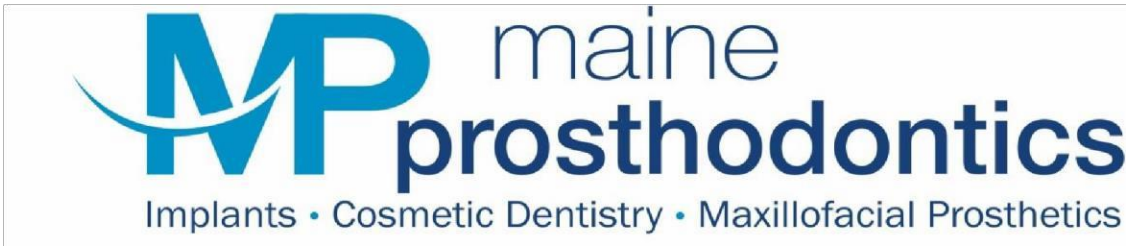
Last Name:		First Name:		DOB:	
Relationship:		Employer:		Ins Co Name:	
ID #		Group #			

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 gladly offer pre-treatment estimates. Of course it is only an estimate and charges may differ depending on the nature of your procedure. Please be aware that your insurance policy is a contract between you and the insurance company, not Maine Prosthodontics. While we will gladly file a claim on your behalf, you are ultimately responsible for charges incurred.

Signature_____Date_____

I ATTEST TO ACCURACY OF INFORMATION ON THIS FORM.



* 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 situation prevented us from obtaining acknowledgement

__Other (Please Specify):

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Patient Financial Policy

Patient Name: _____

Patient Date of Birth: _____

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.

Patient Financial Class Policies:

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. 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 in order 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 has to 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.

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 $25.00 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:_____
(Patient/Guardian)

Date: _____

Consent for Photos:

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.

_____ **DATE:** _____
PATIENT OR LEGAL GUARDIAN SIGNATURE