MONTGOMERY DENTAL ASSOCIATES

Registration

PATIENT INFORMATION

First Name: _____ Last Name: _____ Middle Initial: ___ Preferred Name: _____
Address: _____City:_____State:_____ Zip Code: _____
Date of Birth: ____/____/____ Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed
Social Security Number: _____ Email Address: _____
Employer: _____ Occupation: _____
Cell Phone #: _____ Work Phone #:_____ Ext _____Home #:_____
Emergency Contact: Name: _____ Phone #:_____

How did you find out about our office? _____

PRIMARY DENTAL INSURANCE INFORMATION

Name of Policy Holder: _____ Date of Birth: _____/_____/_____
Policy Holder's SSN: _____ - _____ - _____ Relationship to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other
Employer Name: _____ Insurance Carrier: _____
Insurance Address: _____
Member #: _____ Group #:_____ Insurance Phone #: _____

SECONDARY DENTAL INSURANCE INFORMATION

Name of Policy Holder: _____ Date of Birth: _____/_____/_____
Policy Holder's SSN: _____ - _____ - _____ Relationship to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other
Employer Name: _____ Insurance Carrier: _____
Insurance Address: _____
Member #: _____ Group #:_____ Insurance Phone #: _____

MEDICAL INSURANCE INFORMATION

Name of Policy Holder: _____ Date of Birth: _____/_____/_____
Policy Holder's SSN: _____ - _____ - _____ Relationship to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other
Employer Name: _____ Insurance Carrier: _____
Insurance Address: _____
Member #: _____ Group #:_____ Insurance Phone #: _____

MONTGOMERY DENTAL ASSOCIATES

Medical History

Patient Name: _____

Are you under any physician's care? ☐Yes ☐No Medical conditions: _____
Physician's name: _____ Physician's Phone#: _____ Date of Last visit: _____
Have you ever been hospitalized? ☐Yes ☐No, If yes, for what & when? _____
Have you ever had any surgical procedures? ☐ Yes☐ No Specify: _____
Are you allergic to: ☐Penicillin ☐Codeine ☐Aspirin☐Local Injected Anesthetic ☐Latex ☐Nitrous Oxide☐other, Specify: _____
For Females: Are you pregnant? ☐Yes ☐No if yes, # of weeks: _____ Nursing?☐Yes ☐No, Taking Birth control pills?☐Yes ☐No
Have you ever been told by your physician to take Antibiotics before dental visits? ☐Yes ☐No If yes, why? _____
Do you smoke? ☐ No ☐ Yes If yes, how much and how many years? _____
Do you use any recreational Drug ☐ Yes☐ No If yes, specify: _____ Alcohol? ☐ Yes☐ No If yes, specify: _____
Have you ever taken Bisphosphonate drugs, such as Fosamax, Actonel, Aredia, Boniva, Zometa, and Reclast? ☐Yes ☐No
if yes, please Specify? _____
Are you taking any blood thinner or any cardiovascular medications? ☐ Yes☐ No Which drugs: _____
Are you taking any medications or supplements? ☐Yes ☐No Please list: _____

Do any of these medical conditions apply to you:

Y N Anemia	Y N Epilepsy/Seizure	Y N Kidney Problems	Y N Artificial Heart Valve
Y N Emphysema	Y N Low Blood Pressure	Y N Hay Fever	Y N Glaucoma
Y N Liver Disease	Y N Artificial Bones/Joints	Y N HPV	Y N Mitral Valve Prolapse
Y N Asthma	Y N Heart Attack/Date:	Y N Psychiatric Problems	Y N Abnormal Bleeding
Y N Heart Pacemaker	Y N Reflux	Y N Angina (Chest Pain)	Y N Hepatitis A/B/C
Y N Rheumatic / Scarlett Fever	Y N Arthritis	Y N Heart Murmur	Y N Shingles
Y N Bruise Easily	Y N HIV+/Aids	Y N Sinus Disorder	Y N Cancer/Chemotherapy
Y N Hemophilia	Y N Stroke	Y N Colitis	Y N High Blood Pressure
Y N Tuberculosis	Y N Diabetes	Y N Jaundice	Y N Thyroid Disorder

I confirm that I have read and answered the above questions to the best of my knowledge. Please inform the office of any changes in your medical conditions.

_____ _____
Signature of patient, parent or guardian Date

_____ _____ _____
Signature reviewing medical/dental history Date

Get a healthy, Gorgeous Smile at Montgomery Dental Associates

MONTGOMERY DENTAL ASSOCIATES

Dental History and Patient Treatment Options

What dental issue is your concern in coming to our office today?: _____

When was your last dental visit, & t dental office: _____
Jaw pain: Yes ☐ No ☐ , Teeth or dental fillings breakage: Yes ☐ No ☐ Grinding or clinching: Yes ☐ No ☐
Loose or shifting, teeth: Yes ☐ No ☐ Bleeding or swollen gums: Yes ☐ No ☐ Mouth odor or bad breath: Yes ☐ No ☐
Have you ever had any of the following: Denture, partial denture, or night guard: Please specify: _____
Does food get stuck between your teeth: Yes ☐ No ☐

IF YOU COULD CHANGE YOUR SMILE, WHAT WOULD YOU DO?

_____Making it whiter or Straight
_____Closing the gaps
_____Repairing Chipped teeth
_____Replacing missing teeth
_____Replacing old silver fillings with tooth-colored fillings or crowns
_____Replacing old crowns which are not fitting or not matching with new cosmetic crowns
_____Having a beautiful Smile Makeover

ON A SCALE 1 TO 10, 10 TO BEING THE HIGHEST:

_____How important is your dental health to you?
_____How would you rate your current dental health?
_____How important is to you to have a beautiful smile?
_____How do you rate your current smile?

Would you be interested to have a complimentary consultation with our dentist providing you a treatment solution that can give you a more beautiful smile and improving your dentition's function? Yes ☐ No ☐

PATIENT TREATMENT DESIRE

While we strive to help each patient achieve the highest level of dental care, we recognize that not all patients have the same level of aspiration and desire about treating the causes of dental disease, please check off the level of care you feel most appropriate for you at this time:

☐ **Urgent care only:** People with emergency issues such as pain, swelling, or bleeding that need our immediate help are at this level.

☐ **Proactive care:** Patients who choose this level of care want a thorough examination and take an active part in the treatment and prevention of present and future disease problems. However, they usually choose solutions that can be achieved in several stages

☐ **Complete care:** Similar to proactive care, patients in this level choose to have a thorough examination. However, they decide on a **MASTER PLAN** to formulate a long-term treatment plan for health and function. These patients seek dental treatments that can be completed in the most lasting fashion possible.

Consent:
The undersigned herby authorize this office to take x-rays, 3D scans, photographs and study models or any required diagnostic aids which deemed appropriate by our dentists to perform the required treatment and as indicated in the treatment plans. I also understand that use of dental anesthetic agents embodies a certain risks.

Patient Signature: _____ **Date:** _____

MONTGOMERY DENTAL ASSOCIATES

Financial Policy

Thank you for choosing our office as your dental healthcare provider. We are committed in providing you the highest quality and lifetime dental care to attain optimal oral health. The following is a statement of our financial policy, which we require that you read, agree to, and sign prior to your treatment. Please note that payment of your bill is considered part of your treatment. Payment is due prior to scheduling. Our office accepts cash, credit cards and certified checks. Third party financing is also available.

As a courtesy to you, we will help you process all your insurance claims. **Please understand that we will provide an insurance estimate to you, however it is not a guarantee that your insurance will pay exactly as estimated**. Your insurance company and your plan benefits ultimately determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible.

All charges you incur are your responsibility regardless of your insurance coverage. **We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company. Our office is not a party to that contract.** Our practice is committed to providing the best treatment for our patients. In general, for services not covered by your dental insurance we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Please sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office. **We ask that you pay the deductible and co-payment, which is the estimated amount, not covered by your insurance company, by cash, MasterCard, Visa, Discover, American Express or available financing prior to scheduling.**

Insurance payments are ordinarily received within 30-60 days from the time of filing. If your insurance company has not made payment within 60 days, **you will be responsible for paying the full amount at that time.**

We will cooperate fully with the regulations and requests of your insurance company that may assist in the claims being paid. Our office will not, however, enter into a dispute with your insurance company over any claim. We thank you for the opportunity to serve your dental health care needs and welcome any questions you may have concerning your care or our financial policy.

Consent to assignment of benefits:

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO MY DENTAL OFFICE. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable prior to scheduling unless financial arrangements have been made. I further understand that a finance, rebilling, collection charge and/or attorney fee will be added to any overdue balance. By signing below, you are authorizing us to call you at any number you provide including calls to mobile phone for any lawful purpose. You agree to pay for any fees or charges that you may incur for an incoming call from us. To avoid any additional cost and inconvenience, should the insurance company forward payment to me, I authorize this office to facilitate payment utilizing the credit card number on file to resolve the balance. A photocopy of this Assignment shall be considered as effective and valid as the original.

X_____ _____

Signature of patient or parent/guardian if minor Date

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

MONTGOMERY DENTAL ASSOCIATES

I have been informed of and given the right to receive a copy of this office's Notice of Privacy Practices.
I, _____, have received a copy of this office's Notice of Privacy Practice.

_____
Signature of Patient, Parent or Guardian

_____
Date

Note: To cancel your appointment, it is necessary that you call and notify us at least 48 hours in advance before your appointment date to prevent a $50 cancellation fee. Thank you for your cooperation.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 04/15/03 and will remain in effect until we replace it We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.
You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION:

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:
Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.
Payment: We may use and disclose your health information to obtain payment for services we provide to you.
Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.
Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.
To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.
Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.
Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.
Required by Law: We may use or disclose your health information when we are required to do so by law.
Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.
National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorize federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.
Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, text, email, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $50.00 for each set of copies, and postage if you want the copies mailed to you. We can also email them to you. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure. **Restriction:** You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).**Amendment:** You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.