Moonlight Beach Dental

Dr. Nicole Vane

Patient Information Form

Date:_______________________

Patient Name:Last______________________________First____________________________MI______Preferred:________________________

Address: Street____City/State/Zip:____

Phone:Home_____________________________________Mobile_____________________________Work_____________________________

Email Address:____

By providing your Email address you agree to receive: (circle one or both) **Appointment Reminders** **Practice Newsletter**

What is your preferred method of contact? **Home** **Work** **Mobile** **Email**

Who may we thank for referring you to our office?____

Social Security Number: ____ Date of Birth:_____________________________________

Drivers License Number:____ State:______________________________

Employer:____Occupation:____

Employer Address: Street____City/State/Zip:______________________________________

Sex: **Male** **Female** Marital Status: **Married** **Single** **Divorced** **Separated** **Widowed**

In case of emergency, who should we notify? ____

Relationship to Patient:__________________________Phone: Home__________________________Mobile:_________________________

Name of Responsible Party: Last____First:____

Relationship to Patient:____Employer/Occupation:_____________________________________

Home Address: Street____City/State/Zip____

Phone: Home_____________________________________Mobile_______________________________Work____________________________

Primary Dental Insurance Carier:____Phone:____________________________________

Name of Insured:________________________________Date of Birth:___________________Policy ID#:_______________________________

Group Number:____Employer:____

Secondary Dental Insurance Carier:____Phone:_____________________________________

Name of Insured:_______________________Date of Birth:_____________________Policy ID#:_____________________________________

Group Number:____Employer:____

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Responsibilities: We are committed to providing you with the best possible care and helping you achieve you optimum oral health. Toward these goals, we would like to explain your financial and scheduling responsibilities.
Payment is due at the time services are rendered. Financial agreements are discussed during the initial visit and a financial agreement is completed in advance of performing any treatment with our practice. We accept all major credit cards, checks, cash and Care Credit.
Dental Benefit Plans: Your dental benefit is a contract between you and your employer and the dental benefit plan. Benefits and payments received are based on the terms of the contract negotiated between you or your employer and the plan. We are happy to help our patients with dental benefit plans to understand and maximize their coverage.
If we are a contracted provider with your plan, you are responsible only for your portion of the approved fee as determined by your plan. We may accept assignment of insurance benefits from your primary carrier after your second visit. We are required to collect the patient's portion (deductible, co-insurance, co-pay, or any amount not covered by your dental benefit plan) in full at time of service. If our estimate of your portion is less than the amount determined by your plan, the amount billed to you will be adjusted to reflect this. Your co-insurance or co-payment is calculated on the information provided by your carrier at the time of the estimate. Please note that your insurance policy is a contract between you and your insurance company; we are not a party to that contract. We accept assignment of benefits as a courtesy to our patients. Any claim not paid by your insurance carrier within 90- days will be billed to the patient.
Scheduling of appointments:
We reserve the doctor and hygienist's time on the schedule for each patient procedure and are diligent about being on time. Because of this courtesy, when a patient cancels an appointment it impacts the overall quality of service we are able to provide. To maintain the utmost service and care, we do require 48-hour notice to reschedule an appointment. With less than 48-hour notice, a fee of $50 or deposit to reserve the appointment time again, may be required. To serve all patients in a timely manner, we may need to reschedule an appointment if a patient is 15 minutes (or more) late upon arriving to our practice.
Delinquent Accounts: In the event payments are not received upon agreed dates, a late charge will be added to the delinquent account. Attorney's fees and collection fees incurred to settle any outstanding balance are the responsibility of the patient. There will be a $25.00 fee for any returned check and additional bank fee's.

Authorizations: I understand that the information I have given today is correct to the best of my knowledge. I authorize Moonlight Beach Dental to perform any necessary dental services that I may need and have consented to during diagnosis and treatment ________ (initial)

Methods of Payment: Payment of services is expected at the time of treatment unless prior arrangements have been made. For your convenience we accept: □ **Cash** □ **Check** □ **Credit Card** □ **Care credit** (financing program)

I have read the above and agree to the financial and scheduling terms._________ (initial)

I authorize the release of necessary information to process my dental benefit claims. I hereby authorize payment directly to Dr. Vane. ___________ (initial)

I hereby acknowledge that a copy of this practice's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice. ______ (initial)

I hereby acknowledge that a copy of this practice's Dental Materials Fact Sheet has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Fact Sheet._____ (initial)

Signature:____ Date:___________________

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Patient Name: Last ________________________________First____________________________________MI______

What is important to you in a dentist or dental practice? ____

Date of last x-rays and exam ________________________Date of last cleaning__________________________________

Have you had problems with prior dental treatment?____

Are you experiencing any discomfort now?____

Have you ever been pre-medicated prior to dental treatment? **YES** **NO**

If yes, why?____

1. Have you been anxious about having dental treatment? **YES** **NO**
2. Have you ever had nitrous or considered having nitrous at during your dental appointment? **YES** **NO**
3. Have you ever had sedation dentistry or considered being sedated at your dental appointment? **YES** **NO**

(Questions 1-3) Please Explain: ____

What concerns do you currently have with your oral health or smile? *(Check all that apply)*

□ jaw joint pain
□ clenching or grinding of teeth
□ discolored teeth
□ crowding/crooked teeth
□ missing teeth
□ spaces in between teeth
□ loose tooth/teeth
□ tooth shape or size
□ unhappy with appearance of teeth
□ overbite
□ under bite
□ uncomfortable bite
□ old fillings
□ old crowns
□ speech problems
□ too much gum tissue when I smile
□tooth sensitivity to hot/cold or biting
□ food gets caught in between teeth
□ difficulty chewing
□ bad breath
□other________________________

Have you ever had orthodontic treatment? **YES** **NO** If yes, when?__________________________________

Have you ever had periodontal treatment? **YES** **NO** If yes, When?_________________________________

Have you ever whitened your teeth in the past? **YES** **NO**

Are you interested in learning more about the following? *(Check all that apply)*

□ teeth whitening
□ clear aligners (Invisalign)
□ veneers/porcelain crowns
□ tooth colored fillings
□ dental implants
□ how to prevent periodontal disease
□ at home oral hygiene care
□ replacing mercury fillings
□ tooth replacement options

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Confidential Health History

Patient Name: Last ________________________________First____________________________________MI______

Is your general health good? **YES** **NO**
If No, please explain: ____

Has there been a change in your health within the last year? **YES** **NO**
If yes, please explain: ____

Have you gone to the hospital or had a serious illness in the last 3 years? **YES** **NO**
If yes, please explain: ____

Are you being treated by a physician now? **YES** **NO**
If yes, please explain: ____

Date of last medical exam__________________________

Have you experienced any of the following?

Yes/No chest pain
Yes/No persistent cough
Yes/No difficulty swallowing
Yes/No fainting spells
Yes/No sinus problems
Yes/No dizziness
Yes/No dry mouth
Yes/No bleeding problems
Yes/No bruise easily
Yes/No fever
Yes/No diarrhea or constipation
Yes/No excessive thirst
Yes/No headaches
Yes/No ringing in ears
Yes/No shortness of breath

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

Yes/No Heart Disease
Yes/No stomach problems
Yes/No heart attack
Yes/No artificial joint
Yes/No heart defects
Yes/No heart murmurs
Yes/No rheumatic fever
Yes/No skin disease
Yes/No hardening of arteries
Yes/No high blood pressure
Yes/No tuberculosis
Yes/No surgeries
Yes/No Hospitalization
Yes/No diabetes
Yes/No family history of diabetes
Yes/No tumors or cancer
Yes/No stroke
Yes/No radiation
Yes/No arthritis, rheumatism
Yes/No emphysema or
Yes/No eating disorders
Yes/No osteoporosis
Yes/No thyroid disease
Yes/No asthma
Yes/No hepatitis
Yes/No sexual transmitted disease
Yes/No herpes
Yes/No canker or cold sores
Yes/No anemia
Yes/No liver disease

This information will not be released unless specifically authorized by patient

Yes/No AIDS/HIV
Yes/No anxiety
Yes/No depression
Yes/No treatment for emotional condition

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Are you allergic to or have you had a reaction to any of the following?

Yes/No Aspirin	**Yes/No** Valium	**Yes/No** Tetracycline
Yes/No Darvon	**Yes/No** Demerol	**Yes/No** Vicodin
Yes/No Codeine	**Yes/No** Penicillin	**Yes/No** Percodan
Yes/No latex	**Yes/No** food	**Yes/No** Nitrous oxide
Yes/No local anesthetic	**Yes/No** Erythromycin	**Yes/No** Metal

Do you have any other allergies?____

Are you taking or have you taken any of the following in the last three months?

Yes/No recreational drugs	**Yes/No** tobacco	**Yes/No** antibiotics
Yes/No OTC medicines	**Yes/No** alcohol	**Yes/No** supplements
Yes/No weight loss medications	**Yes/No** corticosteroid	**Yes/No** aspirin

Please list all medications you are currently taking: ____

Women Only:

Yes/No Are or could you be pregnant? If yes, when are you Due? ____________________

Yes/No Are you nursing?

Yes/No Are you taking birth control pills?

Do you have or have any other diseases or medical problems NOT listed on this form? **YES** **NO**

If YES, explain: ____

Have you ever taken Fen-Phen? **YES** **NO**

If YES, when? ____________________________

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially Medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment. I authorize the dentist to contact my physician.

Patient Signature: ____ Date:__________________________

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My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers for my health care services
- Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of my dental provider's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review such Notice of Privacy Practices. I understand that my dental provider has the right to change the Notice of Privacy Practices and that I may contact this office at the address above to obtain a current copy of the Notice of Privacy Practices.
I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name:____

Patient/Guardian Signature:____Date:__________________

Provider practice: Moonlight Beach Dental

For Office Use Only

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Rights due to the following reason:

- The patient refused to sign
- Emergency situation
- Communication barriers
- Other