Moonlight Beach Dental

Patient Information Form

Today's Date___________

Patient Name: First:_________________________MI____Last_______________Nickname_______________

Address: Street____________________________ City______________________State______Zip___________

Phone: Home______________________________Work____________________Mobile__________________

E-mail address:____

By providing your email address you agree to receive *(check one or both)* □ Appointment Reminders □Practice Newsletter

What is your preferred method of contact? □ Home □ Work □ Mobile □ E-mail

Social Security Number_________________________________ **Date of Birth**__________________________

Drivers License #______________________________________**State**_________________________________

Employer_____________________________________**Occupation**___________________________________

Address: Street________________________________City____________________State____Zip___________

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

In case of emergency, who should be notified?____

Relationship to Patient____________________**Home Phone**_______________**Mobile Phone**___________

Name of Responsible Party: First_____________________________ Last______________________________

Date of Birth________________ **Relationship to Patient** □ Self □Spouse □Parent □Other__________

Address: *(if different from patient)* Street________________City__________________State_____Zip_________

Phone: Home____________________Work_________________________Mobile_______________________

Employer: *(if different from above)*_________________________**Occupation**____________________________

Dental Benefit Plan Information

Primary Dental Plan Name____**Phone**_________________

Address: Street___________________________ City ____________________State__________ Zip_______

Name of Insured________________ **Date of Birth**________________ **Id number**____________________

Policy Number___________________ **Patient Relationship to Insured**______________________________

Secondary Dental Plan Name____**Phone**__________________

Address: Street___________________________ City ____________________State__________ Zip_______

Moonlight Beach Dental

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__________________________

Moonlight Beach Dental

Dental Health History Form

Today's

Date_______________
Patient Name: First_________________________MI______ Last____________________Nickname____________________

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 for dental treatment due to Heart Conditions, High Blood Pressure? Yes □ No□

If yes, why?____

Have you been anxious about having dental treatment? Yes□ No□

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
□ underbite
□ 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 (deep cleanings, root planning, or periodontal surgery)? □ 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

Confidential Health History Form

Today's Date________

Moonlight Beach Dental

Patient Name: First________________________MI_______Last______________________Date of Birth___________

I. Circle the appropriate answer (leave blank if you do not understand the question)

1. **Yes/No Is your general health good?**
   If NO, explain____
2. **Yes/No Has there been a change in your health within the last year?**
   If YES, explain____
3. **Yes/No Have you gone to the hospital or had a serious illness in the last 3 years?**
   If YES, explain____
4. **Yes/No Are you being treated by a physician now?**
   If YES, explain____
   Date of last medical exam?____________

II. Have you experienced any of the following? *(please circle Yes or No for each)*

Yes/No	chest pain	Yes/No	blood in stools	Yes/No	frequent vomiting
Yes/No	fainting spells	Yes/No	diarrhea or constipation	Yes/No	jaundice
Yes/No	recent weight loss	Yes/No	frequent urination	Yes/No	dry mouth
Yes/No	fever	Yes/No	ringing in ears	Yes/No	excessive thirst
Yes/No	night sweats	Yes/No	headaches	Yes/No	difficulty swallowing
Yes/No	persistent cough	Yes/No	dizziness	Yes/No	swollen ankles
Yes/No	coughing up blood	Yes/No	blurred vision	Yes/No	sinus problems
Yes/No	bleeding problems	Yes/No	bruise easily	Yes/No	shortness of breath

III. Have you had or do you have any of the following? *(please circle Yes or No for each)*

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

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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

IV. Are you allergic to or have you had a reaction to any of the following? *(Please circle Yes or No for each)*

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

Others____

V. Are you taking or have you taken any of the following in the last three months? *(Please circle yes or No for each)*

Yes/No recreational drugs	Yes/No tobacco in any form	Yes/No antibiotics
Yes/No over-the-counter medicines	Yes/No alcohol	Yes/No supplements
Yes/No weight loss medications	Yes/No bisphosphonate (fosamax)	Yes/No aspirin
Yes/No cortico-steroids		

Please list all medications you are currently taking____

VI. Women only *(please circle Yes or No for each)*

Yes/No **Are or could you be pregnant?**   **If YES, what month?**______________________________

Yes/No **Are you nursing?**

Yes/No **Are you taking birth control pills?**

VII. All patients *(please circle Yes or No for each*

Yes/No **Do you have or have any other diseases or medical problems NOT listed on this form? If YES, explain**____
____

Yes/No **Have you ever taken Fen-Phen? 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's name____date_________________________

Physician's Name____phone number_________________________

Moonlight Beach Dental

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. Further, I will not hold my dentist, or any other member of the dental team responsible for any errors or omissions that I have made in the completion of this form.

Signature of Patient (Parent or guardian)	Date	Signature of Dentist	Date
___________________________	___________________________	___________________________	___________________________

Medical Updates

I have reviewed my Heath History and Confirm that it accurately states past and present conditions.

Date	Patient Signature	Changes to Health History	Dentist Initials
___________________________	___________________________	___________________________	___________________________
___________________________	___________________________	___________________________	___________________________
___________________________	___________________________	___________________________	___________________________
___________________________	___________________________	___________________________	___________________________
___________________________	___________________________	___________________________	___________________________
___________________________	___________________________	___________________________	___________________________
___________________________	___________________________	___________________________	

ACKNOWLEDGEMENT OF PRIVACY RIGHTS

Moonlight Beach Dental

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:____DATE:________________________

Patient Signature:____

Provider practice: Moonlight Beach Dental

Relationship to Patient:____

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