Welcome to Metropolitan Dental Care

Personal Information

Date_____
First Name_____Last Name_____Middle Initial_____
Preferred Name_____Address_____
City, State, Zip_____
Home Phone_____Work Phone_____Cell Phone_____
☐Male ☐Female
☐Minor ☐Single ☐Married ☐Domestic Partner Driver's License State & #_____
Birth Date_____Social Security #_____
Employer_____Occupation_____
E-mail Address_____
How do you prefer to be contacted? ☐E-mail ☐Text Message ☐Home # ☐Work # ☐Cell #
Who may we thank for referring you to our office? _____
Emergency Contact_____Phone #_____
Have you seen us on Facebook?☐ Yes ☐No

Responsible Party

Who is responsible for the account?(If other than yourself)_____
Name_____
Relationship to Patient_____Birth Date_____Driver's License #_____
Social Security #_____E-mail Address_____
Address_____
City,State,Zip_____
Employer_____Occupation_____
Method of Payment ☐Cash ☐Check ☐Credit Card

Primary Dental Insurance Information

Name of Insured _____Relationship to Patient_____
Insured's Birth Date_____Insured's Social Security #_____
Group #_____Insured's ID #_____
Employer_____Phone Number_____Occupation_____
Insurance Company_____
Claims/Insurance Company Address_____
City, State, Zip_____
Deductible_____Maximum Annual Benefit_____Amount Used_____

Additional (Secondary) Dental Insurance

Name of Insured _____Relationship to Patient_____
Insured's Birth Date_____Insured's Social Security #_____
Group #_____Insured's ID #_____
Employer_____Phone Number_____Occupation_____
Insurance Company_____
Claims/Insurance Company Address_____
City, State, Zip_____
Deductible_____Maximum Annual Benefit_____Amount Used_____

Consent:

I understand that responsibility for payment of dental services in this office for myself and my dependents is mine, due and payable at the time of services are rendered unless financial arrangements have been made. I understand that I am responsible for all costs of collection including attorney fees, collection fees, and court costs. I understand that any unpaid balance will be assessed interest at the rate of 18.00% (1.5% monthly). **Insurance claims are filed as a courtesy, but it is my responsibility to see that the claims are paid. I fully understand that I am responsible for payment of fees not covered by insurance**. I also assign all benefits to the Dentist. I acknowledge that my signature on this document authorizes the submission of claims without obtaining my signature on each and every claim submitted. I give my authorization and consent for treatment after having a full explanation of proposed treatment, alternatives, and risks by my doctor.

Responsible Party's Signature_____Date_____

Dental History

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

☐Jaw/joint disorder
☐Injury to mouth/face
☐Tooth Removal
☐Orthodontic treatment/Braces
☐Bleeding gums
☐Periodontal surgery
☐Sensitivity to hot/cold/sweets/pressure
☐Nitrous Oxide Gas
☐Dental problems now_____
_____
☐Is there anything you wish you could change about your teeth?_____
☐Have you ever had an unpleasant dental experience?

Do you need to be pre-medicated with antibiotics before dental procedures (i.e. for congenital heart conditions)? ☐Yes ☐No
Previous Dentist_____ Date of last dental visit_____
Why have you come to the dentist today?_____
How would you describe the condition of your teeth and gums? ☐Good ☐Fair ☐Poor
Are you currently in pain or discomfort with your teeth and gums? ☐Yes ☐No
If yes, please explain: _____
If you could wave a magic wand and change anything you could about the appearance of your smile, what would you like to do?
_____
If you could easily and safely whiten your teeth, would you be interested? ☐Yes ☐No
How often do you brush your teeth? _____ Floss your teeth? _____
Do your gums bleed when you brush? ☐Yes ☐No Floss? ☐Yes ☐No
Have you ever experienced pain in your jaw joint? ☐Yes ☐No Do you grind your teeth? ☐Yes ☐No Do you snore? ☐Yes ☐No
Have you ever been treated for TMJ symptoms? ☐Yes ☐No If yes, please explain: _____

Medical History

Although dental personnel primarily treat the area in an around your mouth, your mouth is a part of your entire body. Health problems that you may have or medication that you may be taking could have an important interrelationship with the dentistry you will receive.

Are you under a physician's care now? ☐Yes ☐No If yes, please explain _____
Have you ever been hospitalized or had a major operation? ☐Yes ☐No If yes, please explain_____
Have you ever had a serious head or neck injury? ☐Yes ☐No If yes, please explain_____
Are you taking any medications, pills, or drugs? ☐Yes ☐No If yes, please explain_____
Do you take or have you taken Phen-Fen or Redux? ☐Yes ☐No
Are you on a special diet? ☐Yes ☐No
Do you use tobacco? ☐Yes ☐No
Do you use controlled substances? ☐Yes ☐No
Do you take or have you taken oral or I.V. bisphosphonates or any drugs for osteoporosis? ☐Yes ☐No

Women: Are you Pregnant/Trying to get pregnant? ☐Yes ☐No Taking oral contraceptives? ☐Yes ☐No Nursing? ☐Yes ☐No

Are you allergic to any of the following?
☐Aspirin ☐Penicillin ☐Codeine ☐Acrylic ☐Metal ☐Latex ☐Local Anesthetics ☐Other_____

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

☐AIDS/HIV positive	☐Congenital Heart Disorder	☐Heart Attack/Failure	☐Mitral Valve Prolapse	☐Tonsillitis
☐Alzheimer's Disease	☐Convulsions	☐Heart Murmur	☐Pain in Jaw Joints	☐Tuberculosis
☐Anaphylaxis	☐Cortisone Medicine	☐Heart Pace Maker	☐Parathyroid Disease	☐Tumors or Growths
☐Anemia	☐Diabetes	☐Heart Trouble/Disease	☐Radiation Treatment	☐Ulcers
☐Angina	☐Drug Addiction	☐Hemophilia	☐Recent Weight Loss/Gain	☐STD's
☐Arthritis/Gout	☐Easily Winded	☐Hepatitis A	☐Renal Dialysis	☐Yellow Jaundice
☐Artificial Heart Valve	☐Emphysema	☐Hepatitis B or C	☐Rheumatic Fever	☐High Cholesterol
☐Artificial Joint	☐Epilepsy/Seizures	☐Herpes	☐Rheumatism	☐Osteoporosis
☐Asthma	☐Excessive Bleeding	☐High Blood Pressure	☐Scarlet Fever	☐Eating Disorder
☐Blood Disease	☐Excessive Thirst	☐Hives or Rash	☐Shingles	☐Prostate Issues
☐Blood Transfusion	☐Fainting Spell/Dizziness	☐Hypoglycemia	☐Sickle Cell Disease	☐HPV
☐Breathing Problem	☐Frequent Cough	☐Irregular Heartbeat	☐Sinus Trouble	☐Other not listed _____
☐Bruise Easily	☐Frequent Diarrhea	☐Kidney Problems	☐Spina Bifida	
☐Cancer	☐Frequent Headaches	☐Leukemia	☐Stomach/Intestinal Disease	☐ NONE OF THE ABOVE
☐Chemotherapy	☐Genital Herpes	☐Liver Disease	☐Stroke	Current Height _____
☐Chest Pains	☐Glaucoma	☐Low Blood Pressure	☐Swelling of Limbs	Current Weight _____
☐Cold Sores/Fever Blisters	☐Hay Fever	☐Lung Disease	☐Thyroid Disease	(used for prescription dosage)

Physician_____ Phone_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.
SIGNATURE OF PATIENT, PARENT, OR GUARDIAN_____ DATE_____

Metropolitan Dental Care

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:
☐ First Name Only ☐ Proper Surname ☐ Other _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):
Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

☐ Phone Message
☐ Text Message
☐ Email
☐ **Any of the Above**
☐ **None of the above** (opt out)

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

_____ _____
Please ***print*** name of Patient Please ***sign*** for Patient / Guardian of Patient

_____ _____
Legal Representative / Guardian Relationship of Legal Representative / Guardian

Your comments regarding Acknowledgements or Consents: _____

_____

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment ☐
I could not communicate with the patient ☐
The patient refused to sign ☐
The patient was unable to sign because ☐
Other (please describe) ☐

_____
Signature of Privacy Officer