Welcome to Metropolitan Dental Care

Personal Information					
Date					
First Name	Last Name	Mic	ddle Initial		
	Address				
City, State, Zip					
Home Phone	Work Phone	Cell Phone			
Male Female		D.:			
	Married Domestic Partner				
E 1	Social Security	' #			
Employer_	Occ	upation			
E-mail Address	contacted? E-mail Text Message	Hama # Warls # Call #			
Who may we thank for re	contacted? E-mail Text Message	Home # Work # Cell #			
Emergency Contact	eletting you to our office?	Phone #			
Have you seen us on Fac	ebook? Yes No	I none #			
-	Responsi	ble Party			
Who is responsible for the	e account?(If other than yourself)				
3.7					
Relationship to Patient	Birth Date	Driver's License #			
Social Security #		E-mail Address			
Address			.		
City,State,Zip					
Employer	000	upation			
Method of Payment Ca	ash Check Credit Card				
	Primary Dental Ins	urance Information			
Name of Insured		Relationship to Patient			
Insured's Birth Date	Insured's Social S	Security #			
Group #					
Employer	Phone Number	Occupation			
Insurance Company					
Claims/Insurance Compa	nny Address				
City, State, Zip	Maximum Annual Benefit				
Deductible		Amount Used_			
	Additional (Seconda:	ry) Dental Insurance			
Name of Insured		Relationship to Patient			
Insured's Birth Date	Insured's Social S	Relationship to Patient Security #			
Group #	Insured's ID #	Occupation_			
Employer	Phone Number	Occupation			
Insurance Company	A J J				
City State 7	any Address				
City, State, Lip	Maximum Annual Danass	Amount Used			
Consent:	waximum Annual Benefit	Amount Usea			
	payment of dental services in this office for myself and	I my dependents is mine, due and payable at the time of servi	ices 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.

Dental History

Do you have or have you had any of the following? Ialawjoint disorder Injury to mouth/face Tools Removal Orthodontic treatment/Parces Is there anything you wish you could change about your tech? Periodonal surgery Periodonal surgery Periodonal surgery Periodonal surgery Periodonal surgery Do you need to be pre-medicated with antibiotics before dental procedures (i.e. for congenital heart conditions)? Ves No Periodonal surgery Why have you come to the dentals today? Do you need to be pre-medicated with autibiotics before dental procedures (i.e. for congenital heart conditions)? Ves No Periodon Dentals: Why have you come to the dentals today? If yes, please explain: If you could sucker the the condition of 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 stutle, what would you like to do? If yes, please explain: If you could wave a magic wand and change anything you could about the appearance of your stutle, what would you like to do? If yes, please explain: If you could wave a magic wand and change anything you could about the appearance of your stutle, what would you like to do? If yes, please explain: If you could wave a magic wand and change anything you could about the appearance of your stutle, what would you like to do? If yes, please explain: Floss your teeth? Floss your			Dental Histor	y	
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Do you need to be pre-medicated with antibiotics before dental procedures (i.e. for congenital heart conditions)? 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? Food Are you currently in pain or discomfort with your teeth and gums? Food Fair Poor No Fair Poor No Food Fair Poor No Food Fair Poor No Rey you currently in pain or discomfort with your teeth and gums? Food which your teeth; Food which your teeth; Food which you could about the appearance of your smile, what would you like to do? Food which you was a magic wand and change anything you could about the appearance of your smile, what would you like to do? Food which you was a safely which your teeth? Food which you brush your teeth? Food which you wand have the ward of your smile, what would you like to do? Food which you brush your teeth? Food which you brush your teeth? Food which you brush your teeth? Food which you wand have the prevented of your smile, what would you wand you wand you wand you wand your mouth is a part of your entire body. Health problems that you may have or medication 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 physiciant's care now? Yes No If yes, please explain Have you ever had a serious head or neck injury? Yes No If yes, please explain Have you ever had a serious head or neck injury? Yes No If yes, please explain Have you ever had a serious head or neck injury? Yes No If yes, please explain Have you wand have you that on the you taken and your wand your			Have you ever had an un	pleasant dental experience?	
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Figure 1 Figure 2 Figure 3	If you could wave a magic	wand and change anything	you could about the appear	rance of your smile, what wo	ould you like to do?
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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 healthcare facility. A copy of this signed	ot of a copy of the currently effective Notice of Privacy Practices for this d, dated document shall be as effective as the original.		
	SED WHEN SUMMONED FROM THE RECEPTION AREA: ame □ Other		
	VHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION: ts and any care takers who can have access to this patient's records): Relationship:		
Name:	Relationship:		
	OFFICE TO CONFIRM MY APPOINTMENTS, TREATMENT & BILLING		
□ Cell Phone Confirmation□ Home Phone Confirmation□ Work Phone Confirmation			
I AUTHORIZE INFORMATION ABOUT	MY HEALTH BE CONVEYED VIA:		
□ Cell Phone Confirmation□ Home Phone Confirmation□ Work Phone Confirmation			
I APPROVE BEING CONTACTED ABO HEALTH INFO on behalf of this Healtho	UT SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW are Facility via:		
□ Phone Message□ Text Message□ Email	☐ Any of the Above☐ None of the above (opt out)		
In signing this HIPAA Patient Acknowledgement promote your improved health. This office may or Omnibus Rule, provide you this information with you	Form, you acknowledge and authorize, that this office may recommend products or services to may not receive third party remuneration from these affiliated companies. We, under current HIPAA ur knowledge and consent.		
	AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR ATTENDING DOCTOR / FACILITIES IN THE FUTURE.		
Please <i>print</i> name of Patient	Please <u>sign</u> for Patient / Guardian of Patient		
Legal Representative / Guardian	Relationship of Legal Representative / Guardian		
Your comments regarding Acknowledgement	ts or Consents:		
Office Use Only As Privacy Officer, I attempted to obtain the patient' It was emergency treatment I could not communicate with the patien The patient refused to sign The patient was unable to sign because Other (please describe)			
	- 3		