MALLERY FAMILY DENTAL

Patient Last Name:_____ First Name:_____ MI:_____

(❑ Single ❑ Married ❑ Divorced ❑ Widowed) (❑ Male ❑ Female) DOB

Address

City State Zip

Telephone (Home) (Work) (Mobile)

E-Mail Employer Insured Name:

Social Security #: Dental Insurance Co.

Group #: Member ID #: Drivers License #: Exp:

How did you hear about our practice? Patient / Friend: Staff Member: Doctor:

Insurance Company Search Engine: Facebook Twitter Blog Other:

RESPONSIBLE PARTY

Last Name First MI

Address City Zip

DOB Social Security #

Home Phone Work Phone Mobile Phone

EMERGENCY CONTACT

Last Name First Phone #

Address

AUTHORIZATION- *Please Read This Carefully & Initial Each Topic*

_____ Mallery Family Dental provides insurance company billing as a courtesy to our patients. The patient portion of your services are estimated and due at the time of service. Any amount that is not paid by your insurance company is due by you. In addition, certain insurance companies have annual limitations which can be reimbursed within each plan year. If you or your family exceed these annual limitations in any plan year, you will be responsible for these charges in full.

_____ The claims we submit to insurance companies indicate that you have assigned these benefits to Mallery Family Dental. However, if you are paid by the insurance company instead of Mallery Family Dental, you then become responsible for the total account balance and payment would be expected immediately. You as a patient are always responsible for any charges that are not covered by your insurance company.

_____ We understand that emergencies arise that preclude you from keeping an appointment, but ***PLEASE*** remember that we have reserved an appointment time especially for you. We request that you give us at least a 48 hour notice to reschedule an appointment. Therefore a missed appointment fee of $52.00 may be assessed if 48 hour notice is not given for changing or cancelling a reserved appointment.

Signature_____ Date _____

HEALTH HISTORY

PATIENT NAME: _____ DATE OF BIRTH: _____

Although dental personnel primarily treat the area in and 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 Dr. Name/Number? _____

Have you ever been hospitalized/or major surgery? ☐ Yes ☐ No Why & Date? _____

Are you taking any medications, pills, or drugs? ☐ Yes ☐ No ***IF "YES" FILL OUT BACK OF SHEET***

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ☐ Yes ☐ No What medication & when? _____

Are you on a special diet? ☐ Yes ☐ No

Do you use tobacco? ☐ Yes ☐ No

Do you use controlled substances? ☐ Yes ☐ No

Women: Are you: ☐ Pregnant ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following? CHECK FOR YES

☐ Aspirin ☐ Penicillin ☐ Amoxicillin ☐ Erythromycin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics

☐ Sulfa Drugs ☐ Advil ☐ Tylenol ☐ Food Allergies ☐ Other _____

PLEASE CHECK ANY OF THE BELOW CONDITIONS YOU HAVE EVER HAD OR HAVE NOW

☐ AIDS/HIV Positive
☐ Alzheimer's Disease
☐ Anaphylaxis
☐ Anemia
☐ Angina/Chest Pains
☐ Arthritis / Gout
☐ Artificial Heart Valve
☐ **Artificial Joint **
*** PRE-MEDICATION MAY BE NECESSARY ****
WHERE? _____
WHEN? _____
DR.: _____
PHONE #: _____
We will need to contact your Dr to get your Pre-Med regimen.
☐ Asthma

☐ Blood Disease
☐ Blood Transfusion
☐ Breathing Problems
☐ Bruise Easily
☐ Cancer
☐ Chemotherapy
☐ Cold Sores / Fever Blisters
☐ Congenital Heart Disorder
☐ Convulsions
☐ Cortisone Medicine
☐ Diabetes
☐ Drug Addiction
☐ Easily Winded
☐ Emphysema/COPD
☐ Epilepsy or Seizures
☐ Excessive Bleeding
☐ Excessive Thirst
☐ Fainting Spells/ Dizziness
☐ Frequent Cough
☐ Frequent Diarrhea
☐ Frequent Headaches
☐ Frequent Tonsillitis

☐ Glaucoma
☐ Heart Attack / Heart Failure
☐ Heart Murmur
☐ Heart Pacemaker
☐ Heart Trouble / Disease
☐ Hemophilia
☐ Hepatitis A
☐ Hepatitis B or C
☐ Herpes
☐ High Blood Pressure
☐ High Cholesterol
☐ Hives or Rash
☐ Hypoglycemia
☐ Irregular Heartbeat
☐ Kidney Problems
☐ Leukemia
☐ Liver Disease
☐ Low Blood Pressure
☐ Lung Disease
☐ Mitral Valve Prolapse
☐ Osteoporosis
☐ Parkinson's Disease

☐ Pain in Jaw Joints
☐ Psychiatric Care
☐ Radiation Treatments
☐ Recent Weight Loss
☐ Reflux/GERD
☐ Renal Dialysis
☐ Rheumatic Fever
☐ Rheumatoid Arthritis
☐ Scarlet Fever
☐ Seasonal Allergies
☐ Shingles
☐ Sickle Cell Disease
☐ Sinus Trouble
☐ Spina Bifida
☐ Stomach / Intestinal Disease
☐ Stroke
☐ Swelling of Limbs
☐ Thyroid Disease
☐ Tonsillitis
☐ Tuberculosis
☐ Tumors or Growths
☐ Ulcers
☐ Yellow Jaundice

Have you ever had any serious illness not listed above? ☐ Yes ☐ No If Yes: _____

I ACKNOWLEDGE THAT I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT BY NOT DOING SO IT CAN BE DANGEROUS TO MY (OR PATIENT'S) HEALTH. IT IS MY RESPONSIBILITY TO INFORM THE OFFICE AND DR OF ANY CHANGES IN MY MEDICAL STATUS PRIOR TO ANY TREATMENT.

_____ _____

Signature of Patient, Parent, or Guardian Date

PLEASE MARK ANY OF THE FOLLOWING MEDICATIONS THAT YOU ARE TAKING:

☐ *I TAKE NO MEDICATIONS EITHER PRESCRIBED OR OVER THE COUNTER AT THIS TIME*

ACCUPRIL - QUINAPRIL	GLUCOTROL - GLIPIZIDE	RECLAST – ZOLEDRONIC ACID
ACTONEL – RISEDRONIC ACID		RESTORIL – TEMAZEPAM
ADDERALL – AMPHETAMINE	HUMALOG – INSULIN LISPRO	REQUIP – ROPINIROLE
ADIPEX – PHENTERMINE	HUMULIN - INSULIN	
ADVAIR – FLUTICASONE	HUMIRA – ADALIMUMAB	SEROQUEL - QUETIAPINE
AMBIEN – ZOLPIDEM	HYDROCODONE	SOMA - CARISOPRODOL
ASPIRIN	HYZAAR – LOSARTAN	SPIRIVA – TIOTROPIUM
ATIVAN – LORAZEPAM		STRATTERA - ATOMOXETINE
ATROVENT – IPRATROPIUM	IMITREX – SUMATRIPTAN	SYMBICORT – BUDESONIDE
AVANDIA – ROSIGLITAZONE		SYNTHROID - LEVOTHYROXINE
AVODART – DATASTERIDE	JANUVIA – SITAGLIPTIN	
		TAGAMET – CIMETIDINE
BENICAR – OLMESTARTAN	LABETALOL – TRANDATE	TEGRETOL - CARBAMAZEPINE
BENTYL – DICYCLOMINE	LANTUS – GLARGINE	THYROLAR – LIOTRIX
BONIVA – IBANDRONIC ACID	LASIX - FUROSEMIDE	TOPAMAX – TOPIRAMATE
BYSTOLIC – NEBIVOLOL	LEVOXYL – LEVOTHYROXINE	
	LEVEMIR – INSULIN DETEMIR	TRICOR – FENOFIBRATE
CALAN – VERAPAMIL	LEXAPRO – ESCITALOPRAM	
CAPOTEN – CAPTOPRIL	LIPITOR – ATORVASTATIN	ULTRAM – TRAMADOL
CARDIZEM – DILTIAZEM	LOPRESSOR - METOPROLOL	
CELEBREX – CELOCOXIB	LYRICA – PREGABALIN	VALIUM – DIAZEPAM
CELEXA – CITALOPRAM		VASOTEC - ENALAPRIL
COMBIVENT – IPRATROPIUM	METFORMIN GLUCOPHAGE	VENTOLIN - ALBUTEROL
COREG – CARVEDILOL	MEVACOR – LOVOSTATIN	VESICARE – SOLIFENACIN
CORGARD – NADOLOL	MICARDIS – TELMISARTAN	VICTOZA – LIRAGLUTIDE
COUMADIN – WARFARIN	MIDAMOR – AMILORIDE	VOLTAREN – DICLOFENAC
COZAAR – LOSARTAN	MIRAPEX - PRAMIPEXOLE	
CRESTOR - ROSUVASTATIN	MOBIC - MELOXICAM	WELLBUTRIN - BUPROPION
CYMBALTA - DULOXETINE	MONOPRIL - FOSINOPRIL	WELCHOL - COLESEVELAM
CYTOMEL - LIOTHYRONINE		
	NORVASC - AMLODIPINE	XANAX – ALPRAZOLAM
DETROL LA – TOLTERODINE	NOVOLOG – INSULIN ASPART	
DIGOXIN – LANOXIN		ZANTAC – RANITIDINE
DILANTIN – PHENYTOIN	ONGLYZA - SAXAGLIPTIN	ZESTRIL – LISINOPRIL
DIOVAN – VALSARTAN		ZOCOR – SIMVASTATIN
	PAXIL - PAROXETINE	ZOLOFT - SERTRALINE
EFFEXOR - VENLAFAXINE	PHENEGRAN - PROMAZINE	ZOVIRAX - ACYCLOVIR
ENALAPRIL - VASERETIC	PLAVIX - CLOPIDOGREL	
EVISTA - RALOXIFENE	PRAVACHOL – PRAVASTATIN	
	PREMARIN – ESTROGEN	***OTHER:***
FARXIGA - DAPAGLIFOZIN	PREVACID – LANSOPRAZOLE	
FLEXERIL - CYCLOBENZAPRINE	PRILOSEC – OMEPRAZOLE	
FLOMAX - TAMSULOSIN	PRISTIQ - DESVENLAFAXINE	
FLONASE	PROCARDIA - NIFEDIPINE	
FLOVENT - FLUTICASONE	PROVENTIL - ALBUTEROL	
FOSAMAX - ALENDRONATE	PROZAC – FLUOXETINE	

PRINTED PATIENT NAME _____

DATE _____

CANCELLATION POLICY / INSURANCE AND PAYMENT AGREEMENT

FOR ALL PATIENTS: (Please initial and sign)

_____ Payment is due at the time of service. If you need assistance in planning for the cost of treatment, we offer third party financing through Care Credit. Payment arrangements must be made before the treatment is performed.

_____ CANCELLATION POLICY: It has always been our contention that your time is valuable and you deserve our undivided attention. Please remember that we reserved the time required to allow quality dentistry to be delivered, and we ask that you respect the time allotted to you. Although we understand that emergencies arise, we ask that you give us a 48 hour notice to reschedule an appointment. A missed appointment fee of $52.00 may be assessed if a 48 hour notice is not given for cancelling or not showing up for a reserved appointment.

I have read, understand and agree to the terms set forth in this Agreement as indicated by my signature below.

_____
Patient Printed Name

_____ _____
Patient or Guardian Signature Date

FOR PATIENTS WITH INSURANCE:

Dental insurance is designed to help pay part of the cost of dental treatment. Your employer has made this coverage available to you, and we will do our best to help you maximize your benefits. Dental insurance will not pay all of the cost of treatment. The benefits you receive are dependent upon what your employer has negotiated with the insurance company, which are detailed and outlined in their policy handbook.

It is our policy to help you afford optimum dental care by accepting assignment of your insurance benefits so that you will not be out of pocket for the full amount of services provided. In order for us to do this, we ask that you initial and sign below to indicate your understanding of the following conditions under which we will file your insurance.

1. Your co-payment is due at the time of service. Payment arrangements must be made before the treatment is performed. _____ (Initial)
2. Please give the front desk any NEW insurance information prior to your appointment so we can verify your benefits. _____ (Initial)
3. We can generally estimate insurance coverage with reasonable accuracy. Treatment plans are estimated based off of the information we are given when verifying your benefits. However, you will be fully responsible for any amount that the insurance company does not pay, regardless of the reason that they refuse payment or pays less than expected. _____ (Initial)

I have read, understand and agree to the terms set forth in this Agreement as indicated by my signature below.

_____
Patient Printed Name

_____ _____
Patient or Guardian Signature Date

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.

Patient Name: _____ 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.

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

_____
Patient Printed Name

_____ _____
Signature Relationship to Patient (For a minor or Legal Representative)

THIS RELEASE OF INFORMATION WILL REMAIN IN EFFECT UNLESS REVOKED IN WRITING BY THE PATIENT:

□ Yes, I agree □ No, I wish to update yearly

□ I authorize the release of information regarding my appointments, treatment, health, and billing to:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

□ Information is not to be released to anyone

I authorize contact from this office for my appointments, treatment, health information, or billing information via:

□ Home Phone: _____ □ Cell Phone: _____ □ Check for Text Message

□ Work Phone: _____ □ E-Mail: _____

If you are unable to reach me:

□ Leave a detailed message

□ Leave a message asking me to return your call

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.

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Office Use Only:

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

It was emergency treatment. _____
The patient refused to sign. _____
The patient was unable to sign _____
Other: _____ _____

_____ _____
Signature of Privacy Officer Date