Welcome to Matonti Dental

Patient Information

Date_____

❑ Mr. ❑ Mrs. ❑Ms. ❑ Dr. First Name _____ M .I . ___ Last Name_____ Nickname_____

Sex: ❑ Male ❑ Female Birth Date_____ Age_____ Social Sec # _____ E-mail_____

Street_____ Apt #_____ City_____ State_____ Zip_____

Home Tel.(____)_____ Cell Phone (____)_____ Have you ever been a patient of our practice? ❑ Yes ❑ No

Referred By_____ Has a family member ever been a patient of our practice? ❑ Yes ❑No
FIRST NAME LAST NAME

Employer _____ Bus. Tel.(____) _____

In case of emergency, please contact_____ Phone # (____)_____ Relation_____

Who will be responsible for your account

❑ Self (If self, skip this section) ❑ Spouse ❑ Father ❑ Mother ❑ Other _____

Name _____ _____ SSN _____ Birth Date_____ Age _____ Tel.(____)_____
FIRST NAME LASTNAME

Street_____ Apt._____ City_____ State_____ Zip_____

Business Tel.(___)_____ Employer_____

Spouse or Other Guarantor Information (if different from above)

Name_____ _____ Relation_____ SSN_____ Birth Date_____
FIRST NAME LAST NAME

Street_____ Apt._____ City_____ State_____ Zip_____

Tel. (____)_____ Employer_____ Bus. Tel.(_____)_____

Insurance Information

Student: ❑ Full Time ❑ Part Time ❑ Not School Name and Address _____ _____
SCHOOL NAME ADDRESS

Marital Status: ❑ Married ❑ Divorced ❑ Widow ❑ Single ❑ Legally Separated _____ _____ _____
CITY STATE ZIP

Employed: ❑ Full Time ❑ Part Time ❑ Retired ❑ Unemployed Do you belong to a PPO or HMO? ❑ Yes ❑ No

Primary Dental Insurance Company

Employer _____

Bus. Address _____

Bus Tel # _____ Ins. Co. Name _____

_____ ID# _____

Ins. Address _____

_____ Tel # (____)_____
CITY ZIP

Group# _____ Group Name _____

Insured Party _____ Relationship _____

Sex: ❑ M ❑ F Birth Date _____ SSN _____

Street _____ City _____

State, Zip _____Tel# (____)_____

Medical Insurance Information

Employer _____

Bus. Address _____

Bus Tel # _____ Ins. Co. Name _____

_____ ID# _____

Ins. Address _____

_____ Tel # (____)_____
CITY ZIP

Group# _____ Group Name _____

Insured Party _____ Relationship _____

Sex: ❑ M ❑ F Birth Date _____ SSN _____

Street _____ City _____

State, Zip _____Tel# (____)_____

Insurance Benefit Information

Our staff is happy to assist you in determining whether your insurance company will provide benefits toward the cost of your cosmetic dentistry treatment. If benefits are provided for the treatment, we will help you file your claim. Unless other arrangements have been made in advance, we do expect payment at the time of service, and we will ask your insurance company to reimburse you.

Dental Information

Reason for today's visit _____ Are you in pain? ❑ Yes ❑ No, For How Long? _____

Please indicate any of the following problems by checking off the corresponding box:

❑ Discomfort, clicking, or popping in the jaw
❑ Red, swollen, or bleeding gums
❑ A removable dental appliance
❑ Blisters/sores in or around the mouth
❑ Prolonged bleeding from an injury/extraction
❑ Recent infections or sore throat
❑ Lost / broken filling(s)
❑ Teeth grinding/clenching
❑ Ringing in ears
❑ Broken/chipped tooth
❑ Gum disease
❑ Stained teeth
❑ Locking jaw
❑ Bad breath
❑ Burning tongue/lips
❑ Toothache
❑ Difficulty closing jaw
❑ Difficulty opening jaw
❑ Loose/shifting teeth
❑Food caught between teeth
❑ Swelling / lumps in mouth

❑ My teeth are sensitive to: ❑ Hot ❑Cold ❑Sweets ❑ Biting Other _____

Last dental exam _____

How would you rate your smile? (worst) 1 2 3 4 5 6 7 8 9 10 (best) Would you like whiter teeth? ❑ Yes ❑ No

Last dental x–rays _____ Times a day you brush? _____ Times a week you floss? _____

DENTAL HEALTH PRIORITIES

□ Replacing missing teeth
□ Whiter or brighter smile
□ Straighter teeth
□ Repairing worn, chipped, or uneven teeth
□ Managing snoring or sleep apnea
□ Jaw tension or bite discomfort
□ Regular maintenance and cleanings
□ Other: _____

AIRWAY & SLEEP SCREENING

□ Loud or habitual snoring
□ Episodes of stopped breathing during sleep
□ Excessive daytime fatigue or sleepiness
□ Morning headaches or dry mouth
□ Difficulty concentrating or mood changes

Have you ever been diagnosed with:
□ Obstructive Sleep Apnea
□ TMJ Disorder
□ Bruxism (teeth grinding)

Have you used or been prescribed:
□ CPAP Machine
□ Oral Sleep Appliance
□None

Would you be interested in discussing dental solutions for snoring or sleep apnea? □ Yes □ No

COSMETIC DENTISTRY INTEREST

How satisfied are you with your current smile?
□ Very satisfied
□ Somewhat satisfied
□Neutral
□Dissatisfied

Are you interested in any of the following treatments?
□ Smile Makeover
□ Porcelain Veneers
□ Teeth Whitening
□ Full Mouth Reconstruction

Do you have any missing teeth? □ Yes □ No
If yes, how many? _____

Are you interested in options to restore or replace them? □ Yes □ No

Do you have any other questions or concerns that you would like to address during today's appointment?

_____

_____

_____

_____

_____

_____

Medical History

Medical Doctor:_____ Tel. (_____) _____

Are you in good health? ❑ Yes ❑ No • Are you under the care of a physician? ❑ Yes ❑ No

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ❑ Yes ❑ No

Have you had any illness, operation, or been hospitalized in the past five years? ❑ Yes ❑ No

Have you, or a family member, had any unusual or serious reactions to general anesthesia? ❑ Yes ❑ No

Do you have, or have you had, any of the following diseases, medical conditions, or procedures?

Y	N		Y	N		Y	N		Y	N	
❑	❑	Rheumatic fever	❑	❑	Are you immunosuppressed (possibly from transplant sx)	❑	❑	Bleeding tendency	❑	❑	Kidney trouble
❑	❑	Mitral valve prolapse	❑	❑	Hay fever/Sinus problems	❑	❑	Problems w/ immune system *(possibly from med. / surg.)*	❑	❑	Are you on dialysis
❑	❑	Heart murmur	❑	❑	Snoring/Sleep apnea	❑	❑	Jaundice / Liver disease	❑	❑	Arthritis / Joint disease
❑	❑	High blood pressure	❑	❑	Respiratory problems	❑	❑	Hepatitis	❑	❑	Prosthetic joint / Implant
❑	❑	Low blood pressure	❑	❑	Tuberculosis Emphysema	❑	❑	Infectious mononucleosis	❑	❑	Osteoporosis / Osteopenia
❑	❑	Chest pain / Angina Heart attack(s)	❑	❑	Do you smoke	❑	❑	Gallbladder trouble	❑	❑	Osteonecrosis
❑	❑	Irregular heart beat			*if so, # packs a day* ____	❑	❑	Fainting spells	❑	❑	Stomach ulcers
❑	❑	Cardiac pacemaker	❑	❑	Do you use chewing tobacco	❑	❑	Convulsions / Epilepsy Stroke	❑	❑	Contagious diseases
❑	❑	Heart surgery	❑	❑	Blood transfusion	❑	❑	Thyroid trouble	❑	❑	Delay in healing
❑	❑	Pneumonia/Bronchitis/Chronic cough	❑	❑	Blood disorder	❑	❑	Diabetes	❑	❑	Anemia
❑	❑	Chronic fatigue / Night sweats	❑	❑	Bruise easily	❑	❑	A history of alcohol abuse	❑	❑	Tumor or growth
❑	❑	Trouble climbing 1-2 flights of stairs	❑	❑	A history of drug abuse	❑	❑	Sexually transmitted diseases	❑	❑	Cancer/Radiation/Chemotherapy
❑	❑	Mental health problems	❑	❑	Eye disease/Glaucoma	❑	❑	Swollen ankles	❑	❑	Are you on a diet
❑	❑	Damaged heart valves	❑	❑	Abnormal bleeding	❑	❑	Low blood sugar	❑	❑	Contact lenses
❑	❑	Asthma									

Medication & Allergies

Are you now taking, or have you ever taken:

Y	N		Y	N		Y	N		Y	N	
❑	❑	Nerve pills	❑	❑	Pain killers (including aspirin) Tranquilizers	❑	❑	Muscle relaxers	❑	❑	Stimulants
❑	❑	Diet pills				❑	❑	Insulin	❑	❑	Antidepressants
❑	❑	Blood thinners (Coumadin, Aspirin, Advil)									
❑	❑	Any bone density medication or Bisphosphonates (Aredia, Zometa, Fosamax, Actonel)									

Please list any other medication(s) you are taking (including natural, herbal, or homeopathic products):

MEDICATION & DOSAGE FREQUENCY

Are you allergic to, or had a reaction to:

Y	N		Y	N		Y	N		Y	N	
❑	❑	Penicillin	❑	❑	Sulfa drugs	❑	❑	Local anesthetic (numbing med)	❑	❑	Amoxicillin
❑	❑	Sodium pentothal/Valium/other tranq	❑	❑	Aspirin Eggs /	❑	❑	Codeine or other narcotics	❑	❑	Latex
❑	❑	Soy	❑	❑	Yolk	❑	❑	Sulfites	❑	❑	I have no known allergies

Please list any other medication or antibiotic you are allergic to:

Please list any allergies other than drug allergies:

1-4 below for women only: *(Women note: antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician or gynecologist for assistance regarding additional methods of birth control.)*

1) Is there a possibility of pregnancy? ❑ Yes ❑ No

2) Expected delivery date: _____

3) Are you nursing? ❑ Yes ❑ No

4) Are you taking birth control pills: ❑ Yes ❑ No

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of his / her staff, responsible for any errors or omissions that I have made in the completion of this form.

X _____ X _____ X _____

Signature of patient ***(Parent or Guardian if Minor)*** **Reviewed by** **Date**

FEES & PAYMENTS

We make every effort to keep down the cost of your care. You can help by paying upon completion of each visit. Other arrangements can be made with our office manager depending upon special circumstances. An estimate of the charge for any procedure or surgery you may require will be given to you upon request. If you have any dental and/or medical insurance, we will be glad to fill out the proper forms, but please complete the identifying information on this form.

Please note that insurance is considered a method of reimbursing patients for fees paid to doctors and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance company.** You will be responsible for all collection costs, attorneys' fees, and court costs.

X _____ X _____

Signature of patient ***(Parent or Guardian if Minor)*** **Date**

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

X _____ X _____

Signature of patient ***(Parent or Guardian if Minor)*** **Date**

_____

THIS NOTICE DESCRIBES TO WHOM MEDICAL INFORMATION ABOUT YOU MAY BE DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY

_____

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides privacy protections to your medical records. Our benefits office (or other third party designated by our office) may sometimes need to disclose medical information or payment information protected by HIPAA in relation to our group health plans to your family members or close friends involved in your health care. For example, your spouse may need to contact us if you are in the hospital to determine a particular procedure is covered under our group health plan or may need assistance filing a claim for medical services. Under HIPAA, unless you specifically object we are allowed to use our professional judgment in deciding whether to discuss your medical and payment information with your family members or close friends. However, we would like to provide you with the opportunity to tell us with whom we may discuss your medical or payment information under our group health plans. You may communicate with the following individuals relating to my medical or payment information:

_____

_____

_____

COMPLAINTS:

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services and/or the Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to Matonti Dental. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION:

If you want more information about our privacy practices, call or visit Matonti Dental.

ACKNOWLEDGEMENT OF RECEIPT: I acknowledge that I have received a copy of the HIPAA Consent form.

Signature of patient/parent/or guardian: _____

Date: _____

AUTHORIZATION FOR RELEASE OF IDENTIYING HEALTH INFORMATION

I authorize Matonti Dental to release health information identifying me (including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services) under the following terms and conditions:

1. Detailed description of the information to be released:
2.To whom may the information be released [name(s), or class(es) of recipients]:
3. The purpose(s) for the release (if the authorization is initiated by the individual, it is permissible to state “at the request of the individual” as the purpose, if desired by the individual)
4. Expiration date or event relating to the individual or purpose for the release:

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization. If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to the office listed at the top of this form. When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.
[For marketing authorizations, include, as applicable: We will receive direct or indirect remuneration from a third party for disclosing your identifiable health information in accordance with this authorization.]

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Signature of Patient/Parent/Guardian: _____

Date: _____