Morgan–Hill Dental Care

If you have dental insurance you would like us to help you with, please notify us before you are seen for your appointment.
Thank You

ABOUT THE PATIENT

Today's Date _____

Patient Name _____
First Last
Name Prefer To Be Called _____
Male Female
Mailing Address _____
Street/Box #/Apt #
_____
City State Zip
Home Phone _____
Work Phone _____ ext _____
Cell Phone _____
Email _____
Date of Birth _____ - _____ - _____
Social Security # _____ - _____ - _____
Circle Marital Status:
Single Married Widowed Partnered Divorced

Employer Name_____

Employer Address_____
_____

Are you a full time student? _____
If Yes, Name and Address of School _____
_____

Who should we contact in case of an emergency?
_____Relationship to you_____
Phone Number_____

Name of Physician_____
Physician Phone Number_____
Office Location _____

SPOUSE OR PARENT INFORMATION

Name _____
First Last
Relationship to Patient: _____

Address _____
Street/Box #/ Apt. #
_____
City State Zip
Home Phone _____
Cell Phone _____
Employer Name _____
Employer Address _____
_____
Work Number _____ ext _____
Date Of Birth _____-_____-_____
Social Security # _____-_____-_____

DENTAL INFORMATION ON PATIENT

Please check if you have any of the following problems:
__Discomfort, clicking or popping in jaw
__Red, swollen or bleeding gums
__Sensitive tooth, teeth or gums
__Blister/sores in or around mouth
__Broken/chipped tooth or teeth
__Bad Breath __ Locking jaw __ Stained Teeth
__Ringing in ears __ Grinding Teeth
__Unhappy with the appearance of your teeth
If yes, explain what you are unhappy with:
_____
_
_____
_
_____

Name of previous dentist? _____

Do your parents have gum disease or have they lost teeth due to gum disease?_____
Have you ever used a C-PAP? _____
Has C-PAP ever been recommended to you?_____
Ever been told you stop breathing in your sleep?_____
Do you ever wake up gasping?_____
Are you often tired during the day?_____
Fall asleep during the day?_____
Do you have headaches in the morning?_____

HOW DID YOU HEAR ABOUT US?

__ Mailing ___Radio ___Website ____TV

__Yellow Pages ___Sign ___ Patient *

* If someone referred you, please list their name & relationship to you _____

MEDICATIONS & OVER THE COUNTER DRUGS

Check if you are taking any of the following:
__Stimulants __Muscle Relaxers __Blood Thinners __ Insulin
__Aspirin __Recreational Drugs __Herbal Supplements __Tylenol __Vitamins
__Tranquilizers __Tagamet (Cimetidine) __ Diuretic
__Grapefruit juice or grapefruit extract __Antacids
List all current medications, dosages, and reason for taking medication:
_____ _____
_____ _____
_____ _____

ALLERGIES

Are you allergic to any of the following?

__Aspirin
__Food Allergies
__Latex
__Jewelry
__Sulfa Meds
__No Allergies
__Tetracycline
__Penicillin/ Amoxicillin
__Dental Anesthetics
Other:_____

MEDICAL INFORMATION

Are you presently under a physician's care? ____ If yes, what are you being treated for?_____
Name of Physician _____ Physician Address_____
Have you ever had any surgeries or hospitalizations? If so what? _____
Do you require an antibiotic before dental visits? __yes __no __don't know. Name of the antibiotic?
_____ Are you pregnant?_____ If yes, estimated due date_____

Have You Ever Had any of the following?
Yes | No | When

Asthma _____ _____ _____
Arthritis/rheumatism _____ _____ _____
Anemia _____ _____ _____
Alcohol abuse _____ _____ _____
Artificial joints/bones _____ _____ _____
Bleeding problems _____ _____ _____
Back problems _____ _____ _____
Bruise easily _____ _____ _____
Bulimia _____ _____ _____
Chemotherapy _____ _____ _____
Congenital heart defect _____ _____ _____
Chest pains _____ _____ _____
Cancer _____ _____ _____ Type_____
Difficulty breathing _____ _____ _____
Diabetes _____ _____ _____
Depression _____ _____ _____
Emphysema _____ _____ _____
Fainting _____ _____ _____
Frequent Headaches _____ _____ _____
Glaucoma _____ _____ _____ Type_____
HIV/AIDS _____ _____ _____
High/Low blood pressure_____ _____ _____

Hepatitis _____ _____ _____ Type_____
Heart disease _____ _____ _____
Heart surgery _____ _____ _____
Hemophilia _____ _____ _____
Heart attack _____ _____ _____
Kidney problems _____ _____ _____
Liver problems _____ _____ _____
Leukemia _____ _____ _____
Osteoporosis _____ _____ _____
Pacemaker _____ _____ _____
Psychiatric problems _____ _____ _____
Respiratory problems _____ _____ _____
Rheumatic fever _____ _____ _____
Radiation therapy _____ _____ _____
Sleep apnea _____ _____ _____
Scarlet fever _____ _____ _____
Sinus problems _____ _____ _____
Seizures/Epilepsy _____ _____ _____
Stroke _____ _____ _____
Tobacco use _____ ____Frequency_____
Tuberculosis _____ _____ _____
Ulcers _____ _____ _____
Joint Replacement _____ _____ _____

I understand the above and certify the information given on this history is complete and accurate and I understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature_____ Date _____ BP_____/_____ Pulse ___
Print Name_____

Date__/___/___ BP___/___ P___ Changes to above:_____ Pt:_____ Dr:_____
Date__/___/___ BP___/___ P___ Changes to above:_____ Pt:_____ Dr:_____
Date__/___/___ BP___/___ P___ Changes to above:_____ Pt:_____ Dr:_____
Date__/___/___ BP___/___ P___ Changes to above:_____ Pt:_____ Dr:_____
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Date__/___/___ BP___/___ P___ Changes to above:_____ Pt:_____ Dr:_____

MORGAN-HILL DENTAL CARE

INSURANCE INFORMATION

To enable us to help you with your insurance, please provide us with the following information:

Name of the employee: _____

Name of the Employer you have the insurance through: _____

Name of the Insurance Company: _____

Insurance Company Telephone Number: _____

Insurance Company mailing address for claims: _____

Insurance Company payor ID number for electronic claims: _____

Special ID number for the employee: _____

Group Number: _____

Social Security number of the Employee: _____

Benefit Year: _____ Maximum: _____ Deductible: _____

Waiting Periods: _____

Coverage for Preventive: Preventive: _____ % Basic: _____ % Major: _____ %

MORGAN-HILL DENTAL CARE

Financial and Scheduling Responsibilities

Dental Treatment is an excellent investment in an individual's medical and psychological well-being. To provide you with the highest quality dental care on a sound business basis, we provide our patients with an estimate of fees and arrange for a payment schedule. The purpose of this agreement is to clarify the financial and scheduling responsibilities so we can devote our efforts to helping you achieve and maintain the healthy smile you deserve.

Insurance: All professional services rendered are the responsibility of the patient. As a courtesy to you, we will file your insurance claim, although you are responsible for all charges incurred, not your insurance company. Your claim will be filed the day of service. We provide your insurance company with all of the information necessary for them to process your claim. If insurance denies your claim or takes longer than 60 days to pay, we ask that you pay your balance in full and collect the money due from your insurance company.

Billing: We do not bill, we ask for payment at the time of service. We ask that our patients not have an outstanding balance. With the only exception being form a pending insurance claim for up to 60 days. Any account balance over 60 days will be subject to interest charges of 1.5% per month, plus any legal or collection fees.

Financial Arrangements: In order to help you obtain the dental health you desire, we have several payment options, as outlined below:

- Pre-Payment Discounts: These are given for treatment plans in excess for $250 when they are paid in full when making the appointment at least 2 weeks prior to your scheduled appointment.
    - 5% courtesy will be given when using cash or check or debit card. A $25 service charge will be placed for any and all returned checks
    - 3% courtesy will be given for using a credit card. We accept MasterCard, Visa, Discover, and American Express.
- Extended payment plans:
    - CareCredit: Deferred interest plans for up to 12 months depending on the amount charged. 24-60 month payment plans with interest depending on the amount financed. Quick approvals. DenVantage savings cannot be applied when using CareCredit.
    - Personal Credit Cards: See above pre-payment discount section. By using your own credit card, you can save money and budget your payments as you wish
- Installments: Make payments on your account and when treatment is paid for, schedule your appointment.

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MORGAN-HILL DENTAL CARE

PATIENT CONSENT FORM HIPAA

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among the multiple Healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment form third party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you and your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent.

I understand that the organization has the right to change its Notice of Privacy Practices form time to time and that I may contact the organizations at any time 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. I also understand you are not required to agree to my requested restrictions, but if you agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____

MORGAN-HILL DENTAL CARE

Appointment Guarantee: When you schedule an appointment, this time has been reserved exclusively for you. We ask that all rescheduling requests are made at least 2 business days prior to the appointment. Any and all appointments rescheduled without proper notice will incur a $40 rescheduling fee. For appointments scheduled that have been made with one of the doctors and are longer than 3 hours will incur a $125/hr fee. DenVantage members will also be required to pay the regular fee schedule, losing member benefits for the scheduled appointment.

In return, if we need to reschedule your appointment without giving proper notice, we will credit your account $40.

I have read and understand the payment and financial responsibilities as outlined in this form:

Signature:_____

Date:_____