MORGAN
DENTAL CARE

Permission to Release Information

Please list below only the names of the person and/or persons that you wish to give permission for our staff to speak to regarding your medical and/or financial information.

Start date: _____ End date: _____

I, _____ hereby grant the treating doctors and staff of Morgan-

(Patient Name)

Hill Dental Care my permission to speak with the following people regarding my health and dental condition.

1. Name: _____ Relationship: _____
   Telephone: _____ _____ _____
   Home Work Cell
2. Name: _____ Relationship: _____
   Telephone: _____ _____ _____
   Home Work Cell

The following information may be given to the above individual(s)
(please check all applicable boxes)

- ☐ Appointment Time
- ☐ Financial Information
- ☐ Test/Lab Results
- ☐ Medications
- ☐ Procedures
- ☐ Other Information regarding my health

(I understand I may revoke this consent at any time by giving written notice to Morgan-Hill Dental Care

Signed: _____ Date: _____

Printed Name: _____

94 Main Street Gorham, Maine 04038
207-839-2655 207-839-5828 fax
MorganDentalCare.com DrMorgan@gwi.net

MORGAN 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 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 ○ Non-Binary ○

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_____

Do you have or 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	_____	_____	_____	
_____	_____	_____		

	Yes	No	When	
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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MORGAN
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 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 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 and we will provide your insurance company with all 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 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. A $25 service charge will be place for any and all returned checks.

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

- Pre-Payment Discounts: When treatment is paid in full when scheduling the appointment or at least 2 weeks prior to the appointment.
  - 5% courtesy will be given when using cash or check or debit card
  - 3% courtesy will be given for using a credit card.
- 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 appt.

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. 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 instead of the member fee for the appointment.
In return, if we need to reschedule your appointment without giving you a 2 business day notice, we will credit your account $40.

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

Signature _____ Date _____