Patient Information
(please print)

Patient's name_______________________________________ Middle Initial_____ Short Name______________________

Date of Birth___________________ Sex_____

Home address____ City _______________State _______Zip_______________

Home phone_______________________ Work phone_______________________ Cell phone______________________

E-mail_____________________________________ Driver's license_________________________ State______

Patient's Employer_________________________________ ____________ Patient SS#________________________

Name of Parent or Spouse______________________________________ Date of birth_____________________

Parent or Spouse Employer _____________________________________ Soc. Sec. No: ____________________

Preferred method of contact(circle one): e-mail home phone work phone cell phone

In Case of Emergency

Contact Name ____ Phone___________________________

Has any member of your family been treated at this office? ( )yes ( )no ( ) don't know

I plan to make payment of my dental expenses as follows: ( ) cash/check ( ) credit card

How did you hear about us? ( ) Employer ( ) Insurance ( ) Phone book/ Internet

Family/Friend *[Name]* ______________________________ ( ) Other

Dental Insurance Information

Subscriber's name____ Soc. Sec. No._____________________________

Relationship to patient____________________________________ Work phone_______________________________

Insurance Company Name__________________________________ Group number____________________________

Employer name and full address____

Subscriber DOB:________________

Do you have other Dental coverage? ( ) no ( ) yes, please complete the following:

Subscriber's name____ Soc. Sec. No._____________________________

Relationship to patient_____________________________________ Work phone______________________________

Insurance Company Name___________________________________ Group number___________________________

Employer name and full address____

Subscriber DOB:__________________

Patient Medical History:

Dental History

Name: ____

Date of Last Dental Visit:_______________ Last Dental Cleaning:___________________
What was done at your last dental visit?:____
Previous Dentist's Name:____
Address:____
Phone Number:____
How often do you have dental examinations?:____
How often do you brush your teeth?:_____________________ How often do you floss?:______________
Have you ever used or are currently using topical fluoride? YES NO
What other dental aids do you use? (Interplak, toothpick, etc.?):__________________________________
Do you have any dental problems now?____

Are you happy with your smile? YES NO

Are you interested in Whitening? YES NO

Are you interested in Improving your smile? YES NO

Do any of these apply to you?

Jaw Pain	YES	NO	Sensitivity to Cold/ HOT	YES	NO
Bad Breath	YES	NO	Sensitivity to Biting	YES	NO
Bleeding Gums	YES	NO	Sores or growths in mouth	YES	NO
Clicking or Popping Jaw	YES	NO	Periodontal Treatment	YES	NO
Grinding or clenching teeth	YES	NO			
Loose teeth or broken fillings	YES	NO			

Have you ever had?

Orthodontic Treatment	YES	NO	Serious Facial injuries	YES	NO
Oral Surgery	YES	NO	Nitrous Oxide during dental procedures		
Bite adjustments	YES	NO		YES	NO
Bite Splint	YES	NO			

Medical History

Condition		
Abnormal bleeding	YES	NO
Alcohol Abuse	YES	NO
Allergy to Household Bleach	YES	NO
Anemia	YES	NO
Angina Pectoris	YES	NO
Arthritis	YES	NO
Artificial Joints	YES	NO
Asthma	YES	NO
Blood Transfusion	YES	NO
Cancer	YES	NO
Radiation Date:_______________		
Chemo Date:_________________		
Circulatory Problems	YES	NO
Colitis	YES	NO
Cosmetic Surgery	YES	NO
Diabetes	YES	NO
Diet controlled		
Drug controlled		
Insulin Dependent		
Drug Abuse	YES	NO
Epilepsy-Seizures	YES	NO
Fainting Spells/Dizziness	YES	NO
Fever Blisters	YES	NO
Frequent Headaches	YES	NO
Glaucoma	YES	NO
Growth on Head or Neck	YES	NO
HIV-AIDS	YES	NO
Hay Fever	YES	NO
Heart Problems	YES	NO
Hemophilia	YES	NO
Hepatitis- Type______	YES	NO
High Blood Pressure	YES	NO
Jaundice	YES	NO
Kidney Problems	YES	NO
Liver Disease	YES	NO
Low Blood Pressure	YES	NO
Mitral Valve Prolapse	YES	NO
Pace Maker	YES	NO
Psychiatric Condition	YES	NO
Radiation Therapy	YES	NO
Respiratory Problem	YES	NO
Rheumatic Fever	YES	NO
Scarlet Fever	YES	NO
Sinus Problems	YES	NO
Stroke	YES	NO
Thyroid Problems	YES	NO
Tuberculosis	YES	NO
Ulcers	YES	NO
Venereal Disease	YES	NO

Allergies

Allergy		
Aspirin	YES	NO
Codeine	YES	NO
Dental Anesthetics	YES	NO
Erythromycin	YES	NO
Jewelry	YES	NO
Latex	YES	NO
Metals	YES	NO
Penicillin	YES	NO
Tetracycline	YES	NO

Others:_______________________

____

For Women Only:

Are you taking Birth Control? YES NO

Are you pregnant? YES NO

Are you nursing? YES NO

Medications you are currently taking (prescription, over-the-counter, vitamins)___________________

____

Are you currently under the care of a Physician? YES NO

Physician’s name/ Phone Number: ____

Have you been hospitalized in the past 2 years? YES NO

If yes, for what reason?____

Do you smoke or use Tobacco? YES NO

Frequency:____

Patients Signature:_____________________________ Date:_________________

Doctor Signature: _____________________________ Date:_________________

HIPAA PRIVACY PRACTICES

I acknowledge that Mailloux Dentistry "Notice of Privacy Practices" has been made available to me. I understand I have the right to review Mailloux Dentistry's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of healthcare operations at Mailloux Dentistry.

The Notice of Privacy Practice is also provided upon request at the main administration desk of this practice. This Notice of Privacy Practice also describes my rights and Mailloux Dentistry's duties with respect to my protected health information.

Mailloux Dentistry, reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or by asking for one at the time of my next appointment.

____ _______________________

Signature of Patient or Personal Representative *Date*

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Description of Personal Representative's Authority (Parent/ legal guardian)

Please list below the names of person(s) authorized to gain access to patient account information:

____

____

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Patient Communication

In general, the HIPAA privacy rule gives individuals the right to request confidential communications or that a communication of private health information can be made by alternative means, such as sending correspondence to the patient's office instead of their home. Occasionally our office will send out greeting cards, reminder postcards, call you regarding an appointment, etc. Written communication will be sent to the address specified on your patient intake unless you request otherwise.

I would like Appointment Reminders by:

- Text – Cell phone number _______________________________
- Home phone number __________________________________
- Work phone number __________________________________
- Email ____

Email Communication:

- I give my permission to send occasional emails with birthday gifts, news, specials, and events. (*We will not sell or give your address to third parties)*

By signing this form, I am acknowledging that I have been notified of the Privacy Practices utilized in this office.

____ ____________________________

Signature of Patient of Personal Representative *Date*

Written Financial Policy

Thank you for choosing Mailloux Dentistry. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

- Cash, Check, Visa, MasterCard, American Express or Discover Card

  We offer a 5% courtesy accounting adjustment to patients who pay for their treatment with cash or check prior to completion of care for treatment plans of $500 or more.

- Convenient Monthly Payment Options[1] from CareCredit Healthcare Credit Card
  - Allow you to pay over time
  - No annual fees or pre-payment penalties

Please note:

Mailloux Dentistry requires payment prior to the completion of your treatment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.[2] All co-pays are due at time of treatment.

A fee of $50 is charged for patients who cancel 2 times or more in a calendar year without 24-hour notice.

A fee of $50 is charged for any MISSED appointment.

Mailloux Dentistry charges $25 per returned check.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

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Patient, Parent or Guardian Signature   Date

____

Patient Name (Please Print)

[1]Subject to credit approval

[2]However, if we do not receive payment from your insurance carrier within 30 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.