Mady Dental
Patient Registration

To our Patients:

We are thrilled you have chosen us to provide you with excellent dental care. We understand dentistry can sometimes be expensive, time consuming, and inconvenient. We vow to help in any way we can to make dental care as easy and affordable as possible. Your satisfaction is our #1 goal. If there is ever anything we can do to help you feel more comfortable during your visits, please don't hesitate to let our staff know.

Patient Information:

First Name: _____ Middle Initial: _____ Last Name: _____ Preferred Name:_____

Address: _____ City: _____State: ____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Birth Date: _____ Age: _____ Social Security Number: _____ Sex: Male Female

E-mail Address: _____ How did you hear about our office? _____

Would you like us to contact you via text and/or e-mail to confirm appointments? Yes No

Emergency Contact: _____ Relationship: _____ Phone Number: _____

Please list any individuals with whom we may discuss your treatment and account information:

_____ _____

Dental Insurance Information:

Subscriber for This Policy's First Name: _____ Middle Initial: _____ Last Name: _____

Subscriber's Relationship to Patient: _____ Subscriber's Birth Date: _____

Subscriber's Social Security Number: _____ Insurance Company: _____

Subscriber's Employer: _____ Group Number: _____

Subscriber ID: _____ Insurance Phone Number: _____

Responsible Party (If Someone Other Than Patient):

First Name: _____ Middle Initial: _____ Last Name: _____

Address: _____ City: _____ State/ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Birth Date: _____ Age: _____ Social Security Number: _____

Although dental staff primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have or medications you could be taking could have an important interrelationship with the dental care you will receive. Please answer the following as thoroughly as possible. Thank you!

1. Are you under a physician's care now? ___ Yes ___ No If yes, please explain_____
2. Have you ever been hospitalized or had a major operation? ___ Yes ___ No If yes, please explain_____
3. Have you ever had a serious neck or head injury? ___ Yes ___ No If yes, please explain _____
4. Do you or have you ever taken Fosamax, Boniva, Actonel or any medications containing bisphosphonates? ___ Yes ___ No
   If yes, please explain _____
5. Do you use tobacco? ___ Yes ___ No If yes, please explain _____
6. Do you use controlled substances? ___ Yes ___ No If yes, please explain _____
   Female Patients: Are you pregnant/ trying to get pregnant? ___ Yes ___ No If yes, when is your due date? _____
   Are you taking oral contraceptives? ___ Yes ___ No Nursing? ___ Yes ___ No
7. Are you allergic to any of the following?

___ Aspirin ___ Penicillin ___ Codeine ___ Local Anesthetics ___ Acrylic ___ Metal ___ Latex
___ Sulfa Drugs ___ Insect Bites ___ Other Please Explain Reaction: _____
_____

8. Do you have or have you ever been prescribed an Epi-pen? ___ Yes ___ No If yes, please explain _____
9. What medications, pills, or drugs (prescription or recreational) are you currently taking? _____
_____

Please circle any of the following you have or have had:

AIDS/HIV Positive	Alzheimer's Disease	Anaphylaxis*	Anemia
Angina*	Arthritis/Gout	Artificial Heart Valve	Artificial Joint
Asthma	Blood Disease	Blood Transfusion	Breathing Problem*
Bruise Easily	Cancer	Chemotherapy	Chest Pain
Cold Sores/Fever Blisters	Congenital Heart Disorder	Congestive Heart Failure	Cortisone Medication
Diabetes*	Drug Addiction*	Easily Winded	Emphysema
Epilepsy Seizures*	Excessive Bleeding	Excessive Thirst	Fainting Spells/Dizziness
Frequent Cough	Frequent Diarrhea	Frequent Headaches	Genital Herpes
Glaucoma	Hay Fever	Heart Attack/Failure	Heart Murmur
Heart Pacemaker/Defibrillator	Heart Trouble/Disease	Hemophilia	Hepatitis B
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
Pain in Jaw Joints	Parathyroid Disease	Psychiatric Care	Radiation Treatments
Radical Weight Loss	Renal Dialysis	Rheumatic Fever	Rheumatism
Scarlet Fever	Shingles	Sickle Cell Disease	Sinus Trouble
Spina Bifida	Stomach/Intestinal Disease	Stroke	Swelling Limbs
Thyroid Disease	Tuberculosis	Tumors/Growths	Ulcers
Venereal Disease	Yellow Jaundice		

Have you ever had any serious illness not listed above? ___Yes ___ No If yes, please explain _____
_____

Comments: _____
_____
_____
_____
_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient/Parent or Guardian _____ Date _____

FINANCIAL AND INSURANCE INFORMATION

Financial Information

We will collect estimated co-payments and deductibles on the day services are rendered. A finance charge may be added to your account after 90 days of no account/payment activity, or your account could be turned over to an outside collection agency. **Patients are expected to pay in full by cash, check, or major credit card the day services are rendered, unless financial arrangements have been made prior to treatment beginning.** For your convenience, we do offer information for financing your dental visits from 2 months to 5 years. Please feel free to ask someone about this service.

Insurance Information

We perform a complimentary insurance benefit check for those patients who have dental insurance coverage to better understand your coverage. It is ultimately **your responsibility** to be aware of your own dental coverage and provide us with as much information as possible in order to better assist you. We will estimate as closely as possible what portion your insurance will cover, but be aware that all plans differ in coverage.

- Your dental benefits are **based upon a contract made between your employer and your insurance company**. If you have any questions regarding your dental benefits, please contact your employer or your insurance company directly.
- **Dental benefits differ greatly from medical benefits**. Dental benefit plans will never pay for completion of your dental care. It is only meant to assist you.
- Many people receive notification from their insurance company that dental fees are "above usual and customary." An insurance company determines their reimbursement level by surveying a geographical area, calculating the average fee, then determines that 80% of the average fee is customary. Included in the survey are discount dental clinics and managed care facilities, which have several reduced dental fees that bring down the average. Any doctor in private practice will have fees that insurance companies define as "higher than usual and customary."
- Many dental benefit plans tell their participants that they will be covered "up to 50%, 80% or 100%," but do not clearly specify the plan fee schedule allowance, annual maximums, or limitations. It is more realistic to expect dental benefits to cover between 25%-60% of dental services.
- Often, Insurance Companies do not recognize many routine dental services such as composite (tooth colored) fillings, porcelain (tooth colored) crowns and occlusal guards.
- Many plans try to confuse participants by giving the in-network as opposed to the out-of-network benefits. Before deciding on going to an in-network provider of your insurance, you need to evaluate the level of treatment and patient care you will be receiving. **Our office participates with Delta Dental, meaning we are in-network.**

If you understand and agree to the above guidelines for our office, please sign below.

Patient/Guardian Signature: _____ Date: _____

APPOINTMENT AND CANCELLATION POLICIES

MADY DENTAL

Appointments

We will make every effort to provide dental service in a timely manner. We understand that your time is valuable and want your visit to be as convenient as possible. In order to give you the most effective care, we work within an appointment system and your appointment times are reserved exclusively for you. Our office hours are: Monday & Wednesday: 8:20AM-7:00PM, Tuesday & Thursday: 8:20AM-2:00PM, Friday & Saturday*: 8:20AM-1:00PM, alternating Thursdays & Saturdays.
We make every effort to honor all time commitments and expect that patients extend the same courtesy to us. We aim to give you the time and attention you need when in our office. Please help us achieve this goal by being punctual for your appointment**. If you are more than 15 minutes late for your appointment we may need to reschedule you to allow enough time for your treatment. For many appointments scheduled, a scheduling deposit will be required. This deposit will go towards your out of pocket cost on the day of treatment.**

Cancellation Policy

I understand that if I am unable to keep my scheduled appointment for any reason I will notify the office at least 48 business hours in advance of my scheduled appointment time. **For appointments requiring deposits cancelled within 48 business hours of the scheduled appointment time, the deposit will be lost. If a deposit was not provided for the next appointment, the cancellation fee is $50.**

If you understand and agree to the above guidelines for our office, please sign below.

Patient/ Guardian Signature: _____ Date: _____

HIPAA/PRIVACY PRACTICES

I understand that my healthcare information concerning my diagnosis, treatment, payment, and insurance will be disclosed when necessary for filing my insurance and in communication with other health care professionals in the course of treatment of their offices. Limited information will also be disclosed to businesses supporting operations of this office such as dental or medical labs, hospitals, accountants, billing personnel, customer support, answering service, and consultants.

Their businesses are restricted in uses and disclosure of your information by contract. Disclosure may also occur for any necessary legal purposes or appropriate governmental authorities. If a family member or person is paying for your healthcare with your knowledge, we may disclose to that family member or person.

I understand that my files are stored on a computer database. Only staff and janitorial personnel may have access to this office during non-business hours. I understand that this office will make every effort to keep my information secure and correct any violation of my privacy if this should occur.

I understand that I have the right to access, copy, or inspect my healthcare information; the right to restrict disclosures, and obtain an accounting of disclosures. I have the right to voice my concerns about privacy to the practice and/or The Secretary of Health and Human Services within 180 days of my discovery of a disclosure violation without fear of retaliatory acts by the office. I may correct my records in the form of a letter signed by me. I also have the right to revoke my authorization for disclosure. A minimal fee of $.25 per page will be charged to me for copies of records that I request.

I understand that I will receive communication in the form of phone calls, e-mails, text messages, and/or post cards to remind me of an existing appointment, or that it is time to schedule an appointment. I may receive mail containing financial information. Communication may also be sent to me in the form of fax, e-mail, or other electronic means. I understand that if a message is left for me to return a call, the message will contain the doctor's name and phone number. Complete messages concerning my health information may be left on my personal home or work voicemail.

I have read and understand this office policy. I understand that by signing this agreement, I give permission for the use and disclosure of my personal and health information in order to carry out treatment, payment, insurance claims, and healthcare operations. This office retains the right to revise this privacy policy.

Patient/Guardian Signature: _____Date: _____

I have read this form and do not wish to sign (Initial) _____

SMILE EVALUATION

How long has it been since you were last at the dentist? ____6 months ____1-2 years ____3-5 years _____ 5+ years

What is your main concern today?

___Tooth Pain ___Sensitivity ___Broken/Cracked Teeth ___Cavities/Decay ___Cosmetic Dentistry ___Cleaning

___Missing Teeth/Implants ___Old Dentistry ___Gum Disease ___Orthodontics ___Dentures ___Whitening

___Sedation Dentistry ___Gum Recession ___Other, please list:
_____

If our doctors find an issue that should be addressed immediately, are you interested in having treatment done today? _____

Do you have any anxiety, fear or bad experiences associated with the dentist office? ___yes ___no. If yes would you say that you have ___Low Anxiety ___Moderate Anxiety ___High Anxiety

Do you like the appearance of your smile and look of your teeth? ___yes ___no. If no, what would you most like to change about your smile?
_____

What is most important to you when seeking dental treatment?

___Quality of Service ___Technology ___Comfort ___Fear/Sedation ___Cost ___Convenient Office Hours

___Friendliness of Staff ___Cleanliness of Office ___Other, please list: _____

Are you aware of clenching/grinding your teeth? ___yes ___no

Have you ever had periodontal gum treatment (deep cleaning or gum grafting)? ___yes ___no

Have you ever had orthodontic treatment (braces)? ___yes ___no

Have you had your wisdom teeth removed? ___yes ___no

How many times a day do you brush? _____ **How many times a week do you floss?** _____

Have you ever had sedation dentistry before? ___yes ___no

Are you concerned about bad breath? ___yes ___no

May we take the necessary dental x-rays in order to provide you with an accurate diagnosis? ___yes ___no

Is there anything else you would like for us to know about you? _____

_____