New Patient Form

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

Patient Information

First Name ______ M.I. ______ Last Name ______ Birthdate ______

SSN ______ Phone ______ Email ______

Address ______ City ______ State ______ Zip ______

Patient's Employer ______ Work Phone ______

Address ______ City ______ State ______ Zip ______

Male Female Minor Single Married Divorced Separated

Name of Pharmacy ______ Whom may we thank for referring you? ______

Emergency Contact ______ Relationship ______ Cell Phone ______ Work Phone ______

Spouse

First Name ______ M.I. ______ Last Name ______

Birthdate ______

SSN ______

Phone ______ Email ______

Address ______

City ______ State ______ Zip ______

Employer ______

Work Phone ______

Address ______

City ______ State ______ Zip ______

Person Responsible for Account

First Name ______ M.I. ______ Last Name ______

Birthdate ______

SSN ______

Phone ______ Email ______

Address ______

City ______ State ______ Zip ______

Employer ______

Work Phone ______

Address ______

City ______ State ______ Zip ______

Parental Information (For those under the age of 18)

Marital Status Single Married Divorced Separated

Mother Stepmother Guardian

First Name ______ M.I. ______ Last Name ______

Birthdate ______

SSN ______

Phone ______ Email ______

Address ______

City ______ State ______ Zip ______

Employer ______

Work Phone ______

Address ______

City ______ State ______ Zip ______

Father Stepfather Guardian

First Name ______ M.I. ______ Last Name ______

Birthdate ______

SSN ______

Phone ______ Email ______

Address ______

City ______ State ______ Zip ______

Employer ______

Work Phone ______

Address ______

City ______ State ______ Zip ______

HIPAA - (Health Insurance Portability and Accountability Act)

Patient Agreement For Authorization and Release Of Records, Insurance and Financial Responsibility, Medical Information Disclosure, and Privacy Rights (HIPAA)

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such dental care to third party payors, other health practitioners and/or business affiliates. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. Any information and/or figures quoted by our office are estimates only and are not a guarantee of payment of benefits from your insurance. Claims are subject to eligibility, deductibles, limitations and exclusions within your individual policy. We are not responsible for tracking your insurance, however, we will do our very best to help answer any questions regarding your insurance. I recognize my financial obligation to pay any co-insurance, deductible and non-covered services provided, as required. I understand that under Missouri law both parental parties are legally responsible for a child's account. Children under 18 must be accompanied by a parent or guardian, or have this signed parental consent form on file for treatment to be rendered. I authorize Meramec Dental Center to provide dental services for my child. At the age of 18 patients are legally and financially responsible for their own account. If I do not pay the entire new balance within the monthly billing date, a late charge of 1.67% on the balance then unpaid and owed will be assessed each month (as allowed by law). I realize that failure to keep this account current may result in you being unable to provide additional dental services except for dental emergencies or where there is prepayment for additional services. In the case of default on payment of this account, I agree to pay a collection fee of 30% in the event Meramec Dental Center retains a collection agency. In the event Meramec Dental Center retains an attorney to collect any amount of my unpaid bills, whether or not a lawsuit is ever filed, I also agree to pay legal expenses, including without limitation court costs and reasonable attorney's fees. I have informed and will continue to inform Meramec Dental Center of any changes to my medical health and prescription drugs I may use, understanding that my medical condition or prescriptions taken for medical conditions may affect my dental condition.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES (HIPAA)

I have been informed of and offered copies of Meramec Dental Center's privacy practices and this form.

X ______________________________ **Date** ______________

Primary Dental Insurance Information

Name of Insured ______________

Address ______________

Relationship to Patient ______________

Phone ______________ Insured's Birthdate ______________

SSN ______________

Employer ______________

Address ______________

Work Phone ______________

Insurance Company ______________

Group # ______________ Employee/Cert # ______________

Insurance Company Address ______________

____

Deductible ______________

Amount Already Used ______________

Max Annual Benefit ______________

Additional Insurance

Name of Insured ______________

Address ______________

Relationship to Patient ______________

Phone ______________ Insured's Birthdate ______________

SSN ______________

Employer ______________

Address ______________

Work Phone ______________

Insurance Company ______________

Group # ______________ Employee/Cert # ______________

Insurance Company Address ______________

____

Deductible ______________

Amount Already Used ______________

Max Annual Benefit ______________

Financial Arrangements

For your convenience, we offer the following methods of payment. Please check the option which you prefer.

Payment in full at each appointment.

Cash

Personal Check

Credit Card

I wish to discuss the dental office's policy.

Late Charges

If I do not pay the entire new balance within the monthly billing date, a late charge of 1.67% on the balance then unpaid and owed will be assessed each month (If allowed by law). I realize that failure to keep this account current may result in you being unable to provide additional dental services except for dental emergencies or where there Is prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

Thank you for filling out this form completely. The information you have provided will help us serve your dental healthcare needs more effectively and efficiently. If you have any questions at anytime, please ask. We are always happy to help.

Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

	Yes	No	If yes, please explain:
Are you under a physician's care now?			
Have you ever been hospitalized or had a major operation?			
Have you ever had a serious head or neck injury?			
Are you taking any medications, pills or drugs?			
Do you take, or have you taken, Fen-Phen or Redux?			
Are you on a special diet?			
Do you use tobacco?			
Do you use controlled substances?			

Women:

Are you pregnant or trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following? Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics

Other ______

Do you have, or have you had, any of the following?

AIDS/HIV Positive	Yes	No	Excessive Bleeding	Yes	No	Lung Disease	Yes	No
Alzheimer's Disease	Yes	No	Excessive Thirst	Yes	No	Mitral Valve Prolapse	Yes	No
Anaphylaxis	Yes	No	Fainting Spells/Dizziness	Yes	No	Pain in Jaw Joints	Yes	No
Anemia	Yes	No	Frequent Cough	Yes	No	Parathyroid Disease	Yes	No
Angina	Yes	No	Frequent Diarrhea	Yes	No	Psychiatric Care	Yes	No
Arthritis/Gout	Yes	No	Frequent Headaches	Yes	No	Radiation Treatments	Yes	No
Artificial Heart Valve	Yes	No	Genital Herpes	Yes	No	Recent Weight Loss	Yes	No
Artificial Joint	Yes	No	Glaucoma	Yes	No	Renal Dialysis	Yes	No
Asthma	Yes	No	Hay Fever	Yes	No	Rheumatic Fever	Yes	No
Blood Disease	Yes	No	Heart Attack/Failure	Yes	No	Rheumatism	Yes	No
Blood Transfusion	Yes	No	Heart Murmur	Yes	No	Scarlet Fever	Yes	No
Breathing Problem	Yes	No	Heart Pace Maker	Yes	No	Shingles	Yes	No
Bruise Easily	Yes	No	Heart Trouble/Disease	Yes	No	Sickle Cell Disease	Yes	No
Cancer	Yes	No	Hemophilia	Yes	No	Sinus Trouble	Yes	No
Chemotherapy	Yes	No	Hepatitis A	Yes	No	Spina Bifida	Yes	No
Chest Pains	Yes	No	Hepatitis B or C	Yes	No	Stomach/Intestinal Disease	Yes	No
Cold Sores/Fever Blisters	Yes	No	Herpes	Yes	No	Stroke	Yes	No
Congenital Heart Disorder	Yes	No	High Blood Pressure	Yes	No	Swelling of Limbs	Yes	No
Convulsions	Yes	No	Hives or Rash	Yes	No	Thyroid Disease	Yes	No
Cortisone Medicine	Yes	No	Hypoglycemia	Yes	No	Tonsillitis	Yes	No
Diabetes	Yes	No	Irregular Heartbeat	Yes	No	Tuberculosis	Yes	No
Drug Addiction	Yes	No	Kidney Problems	Yes	No	Tumors or Growths	Yes	No
Easily Winded	Yes	No	Leukemia	Yes	No	Ulcers	Yes	No
Emphysema	Yes	No	Liver Disease	Yes	No	Venereal Disease	Yes	No
Epilepsy or Seizures	Yes	No	Low Blood Pressure	Yes	No	Yellow Jaundice	Yes	No

Have you ever had any seriously illness not listed above? 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 (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

X ______ **Date** ______

Signature of Patient of Parent or Legal Guardian