New Patient Form

Meramec DENTAL CENTER

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 ☐ Widowed

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 serious 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