welcome

PATIENT NUMBER

Age _____ Date _____

Patient's Name _____ Date of Birth _____ ❑ Male ❑ Female
Last First Initial

If Child: Parent's Name _____

How do you wish to be addressed _____
Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed ❑ Minor ❑

Residence - Street _____

City _____ State ____ Zip _____

Business Address _____

Telephone: Res. _____ Bus. _____

Fax _____ Cell Phone # _____

eMail _____

Patient/Parent Employed By _____

Present Position _____

How Long Held _____

Spouse/Parent Name _____

Spouse Employed By _____

Present Position _____

How Long Held _____

Who is Responsible for this account _____

Drivers License No. _____

Method of Payment: Insurance ❑ Cash ❑ Credit Card ❑

Purpose of Call _____

Other Family Members in this Practice _____

Whom may we thank for this referral _____

Patient/parent Social Security No. _____

Spouse/Parent Social Security No. _____

Someone to notify in case of emergency not living with you _____

DENTAL INSURANCE 1ST COVERAGE

Employee Name _____ Date of Birth _____
Relationship to patient _____
Employer Name _____ Yrs. _____
Name of Insurance Co. _____
Address _____

Telephone _____
Program or policy # _____
Social Security No. _____
Union Local or Group _____

DENTAL INSURANCE 2ND COVERAGE

Employee Name _____ Date of Birth _____
Relationship to patient _____
Employer Name _____ Yrs. _____
Name of Insurance Co. _____
Address _____

Telephone _____
Program or policy # _____
Social Security No. _____
Union Local or Group _____

CONSENT:

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

I consent to the dentist's use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment.

I consent to the disclosure of my records (or my child's records) to the following persons who are involved in my care (or my child's care) or payment for that care.

My consent to disclosure of records shall be effective until I revoke it in writing.

I authorize payment directly to the dentist or dental group of insurance benefits otherwise payable to me. I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, by my dental care payor.

I attest to the accuracy of the information on this page.

PATIENT'S OR GUARDIAN'S SIGNATURE

DATE _____

Form No. T110R

REGISTRATION

welcome

PATIENT NUMBER

Patient's Name _____
Last First Initial Nickname Date of Birth

Parent's Guardian's Name _____

DENTAL HISTORY - CIRCLE THE APPROPRIATE ANSWER

1. Is this your child's first visit to a dentist? ..... YES NO
2. If not, how long since the last visit to the dentist? _____
3. Were any x-rays or radiographs taken when your child previously visited the dentist? ... YES NO
4. Does your child eat between meals? ..... YES NO
5. Does your child eat sweets, such as candy, soda pop, chewing gum? ..... YES NO
6. When does your child brush his/her teeth?
   ❒ Upon arising ❒ After eating any food ❒ Right after meals ❒ Before going to bed
7. How does your child receive Fluoride?
   ❒ Community water level ____ ppm ❒ Well water level ____ ppm
   ❒ Fluoride drops or tablets ❒ Fluoride rinse or gel
8. Have any cavities been noted in the past? ..... YES NO
9. Does your child suck his/her thumb or fingers? ..... YES NO
10. Were any teeth (baby or permanent) removed by extraction? ..... YES NO
    Was it suggested that the space be maintained ..... YES NO
    Was an appliance placed ..... YES NO
11. Have there been any injuries to teeth, such as falls, blows, chips, etc? ..... YES NO
    If so describe _____
12. Has your child had any problem with dental treatment in the past? ..... YES NO
13. Has anyone in the family, including parents, had orthodontics? ..... YES NO
14. Has your child ever received a local anesthetic? ..... YES NO
15. Has your child ever had occlusal sealants? ..... YES NO
16. Does your child think there is anything wrong with his/her teeth? ..... YES NO

MEDICAL HISTORY

1. Does your child have a health problem? ..... YES NO
2. Is your child under care of physician? ..... YES NO
   If yes, since when and why? _____
   Phone
3. Name of physician _____
4. Is your child receiving any medication? ..... YES NO
   What? _____
5. Is your child allergic to penicillin, antibiotics or other drugs? ..... YES NO
6. Is your child allergic to or sensitive to any metals or latex? ..... YES NO
7. Does your child have other allergies? ..... YES NO
8. Has your child had any serious illness? ..... YES NO
   When _____ What _____
9. Has your child ever had surgery? ..... YES NO
10. Does your child have a heart murmur? ..... YES NO
11. Is surgery contemplated? ..... YES NO
12. Does your child experience severe or prolongated bleeding? ..... YES NO
13. Does your child have AIDS or has he/she tested HIV positive? ..... YES NO
14. Has your child tested positive for hepatitis? ..... YES NO
15. Is your child subject to nervous disorders? ..... YES NO
    ❒ Fainting? ❒ Seizures? ❒ Dizziness? ❒ Behavioral/Learning problems?
16. Does your child have frequent headaches? ..... YES NO
17. Has your child had history of: (Circle appropriate responses) diabetes, heart trouble, asthma, kidney infection, rheumatic fever, epilepsy, cerebral palsy, liver problems, congenital birth defects, mental retardation, eyesight problems, cancer, infections, speech impairments, hearing loss.

COMMENTS

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

PATIENT'S / GUARDIAN'S SIGNATURE _____ DATE _____

DENTIST'S SIGNATURE _____ DATE _____

ANEST.

MED. ALERT

CHILD DENTAL MEDICAL HISTORY

Form No. T131CDM

Dr. Brophy and her team would like to welcome you to the practice. We are committed to providing the best dental care for your particular needs. We will only be able to accomplish this by spending adequate time necessary to diagnose and treat your dental needs. This treatment is very important to your health and should not be postponed by financial concerns.

Patients under the age of 18 must be accompanied by a parent. It is necessary for the parent to give permission for the treatment and to sign off on the medical history of the patient. The parent who accompanies the child to the office is responsible for payment of the fee.

To enable you to proceed without delay our office offers several financial options. We encourage you to select a financial arrangement that works best in your budget. For your convenience we offer the following financial arrangements when the total cost of your treatment exceeds $500. (Fees less than $500 are to be paid at the time of service.) Our philosophy is to make dentistry affordable to everyone and we hope this helps you to make us your dental home.

1. *Our patients with insurance coverage are expected to pay the patient portion of the fees directly to our office. As a courtesy, we will file your insurance claims.*
2. *The patient portion of the fee for a crown may be paid in two installments: 50% of the fee is payable at the first visit and the remaining 50% is due when the crown is seated.*
3. *The patient portion of the fee for fixed or removable prosthetics may be paid in three equal installments. The first 33% is due at the initial visit, the second 33% is due at the try in visit, and the remaining 34% is due at the delivery visit.*
4. *The fee for treatment may be financed through Care Credit, upon credit approval.*
5. *We accept most major credit cards: Visa, MasterCard, Discover & CareCredit.*

DENTAL INSURANCE

I understand my dental insurance is a contract between the insurance carrier and myself, not between Mahoning Valley Family Dental or Dr. Brophy and the insurance carrier. As such, I understand that I am responsible for the full amount of all fees incurred for dental treatment. Any payments received by Dr. Brophy from my insurance carrier will be credited to my account or refunded to me if I have paid the fees in full.

FINANCIAL RESPONSIBILITY

I/We agree and personally guarantee, in consideration of services and materials provided by Dr. Brophy to be responsible for payment in full of all dental fees. In the event that this matter is turned over to an attorney for collections, I/We agree that I/We shall pay all costs incurred in the collection of this debt.

Print Patient's Name: _____

Patient/ Parent Signature _____ Date _____

Mahoning Valley Family Dental Care

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May refuse to Sign This Acknowledgement

I, (PATIENT NAME) _____, have been offered a copy of this office's Notice of Privacy Practices.

_____

{PATIENT /GUARDIAN SIGNATURE}

_____

{DATE}

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communication barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (Please Specify)