MAHEC

Chart #:
FOR OFFICE USE ONLY

**MAHEC DENTAL HEALTH CENTER AND CENTER FOR ADVANCED TRAINING**

**Patient Information: Please verify and update if necessary**

Patient Name: _____ Date: _____
Last, First MI *(Preferred Name)*

Family Status: _____ Gender: _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Preferred appointment times: ❑ Morning ❑ Afternoon ❑ Any Time ❑ M ❑ T ❑ W ❑ T ❑ F

Address: _____
Street Apt #

_____
City State Zip Code

## HEALTH INFORMATION UPDATE

**As part of your health history update, please indicate if you have had any changes to the following:**

| | | | |
|---|---|---|---|
| **Medications?** | **YES** | **NO** | **Details:** _____ |
| **Health?** | **YES** | **NO** | **Details:** _____ |
| **Allergies?** | **YES** | **NO** | **Details:** _____ |
| **Hospitalizations?** | **YES** | **NO** | **Details:** _____ |

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

Reviewed by: _____ Date: _____

**Any changes in Spouse or Responsible Party Information? If yes, please complete below:**

The following is for: ❑ the patient's spouse ❑ the person responsible for payment

Name: _____

❑ Male ❑ Female ❑ Married ❑ Single ❑ Child ❑ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____

Street City State Zip Code

**Any updates in Employment Information? If yes, please complete below:**

The following is for: ❑ the patient ❑ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____

Street City State Zip Code

Phone: _____

**Any updates in Insurance Information? If yes, please complete below:**

**Primary**

Name of insured: _____ Is insured a patient? ❑ Yes ❑ No

First MI Last

Insured's Birth Date: _____ ID Number: _____ Group #: _____

Insured's Address: _____

Street City State Zip Code

Insured's Employer Name: _____

Address: _____

Street City State Zip Code

Patient's relationship to insured: ❑ Self ❑ Spouse ❑ Child ❑ Other

Insurance Plan Name and Address: _____

**Secondary**

Name of insured: _____ Is insured a patient? ❑ Yes ❑ No

First MI Last

Insured's Birth Date: _____ ID Number: _____ Group #: _____

Insured's Address: _____

Street City State Zip Code

Insured's Employer Name: _____

Address: _____

Street City State Zip Code

Patient's relationship to insured: ❑ Self ❑ Spouse ❑ Child ❑ Other

Insurance Plan Name and Address: _____

## Consent for Treatment:

I consent to have examinations and treatment. I understand that my examination and treatment may be completed by resident dentist. I am aware that the practice of dentistry is not an exact science and no one has made guarantees about the results of my treatment. I understand that I have the right to ask questions concerning my treatment plan. I agree to notify my provider should I have any concerns about treatment.

Patient, Parent or /Legal Guardian Signature _____ Date: _____

## Verbal Communication Consent:

MAHEC is authorized to discuss my treatment of care and financial information concerning the care and services provided to me with the following individuals:

_____

_____

Patient, Parent or /Legal Guardian Signature _____ Date: _____

## Notice of Privacy Acknowledgment:

I have been given the opportunity to read MAHEC's Notice of Privacy Practices and my questions concerning the Notice have been answered. I understand if I choose not to sign the acknowledgment that MAHEC will continue to provide services to me and will use and disclose my Protected Health Information (PHI) for treatment and payment when necessary.

Patient, Parent or /Legal Guardian Signature _____ Date: _____

## Financial Policy:

*As a condition of my treatment at MAHEC Dental Health Center, I understand that:*

- *The practice expects payment on the date of service*
- *The practice accepts cash, checks, debit cards or major credit cards*
- *The practice will help prepare and file insurance claims on my behalf, if I have dental insurance. However, I understand that all dental services furnished, including emergency services, will be charged directly to the patient and the patient (or parent/legal guardian) is personally responsible for payment of all dental services*
- *I authorize payment of all insurance benefits directly to MAHEC Dental Health Center and I authorize them to file insurance on my behalf, if applicable. I also authorize them to release dental care and/or account information to my insurance as required to satisfy claims.*
- *A service charge of 1-1/2% per month (18% per annum) will be applied to any unpaid balance for all accounts exceeding 60 days, unless previous written financial arrangements have been made with MAHEC Dental Health Center.*
- *The estimate provided for dental care can only be extended for a period of six months from the date of the patient examination.*
- *It is my responsibility to keep appointments and to call at least 24 hours prior, if I need to cancel. I understand that failure to do this may result in being dismissed from the practice.*
- *I grant my permission to the practice to telephone me at home or at my work to discuss matters related to this form.*

I have read and understand the above: _____ Date: _____

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*I voluntarily consent to routine dental services which may include diagnostic aids (such as x-rays) to make a proper diagnosis of my dental needs. Upon such diagnosis, I authorize the dentist or designated dental staff to perform all recommended treatments, procedures and medication administrations as prescribed by the dentist and agreed upon by me, or my legal guardian. I understand that topical and/or local anesthesia may be used during the dental treatment and I consent to their use in my care, if needed. I understand I have the right to ask questions about my treatment and/or procedure and the right to refuse any treatment or procedure. I agree to notify my dental provider of my concerns.*

I have read and understand the above: _____