FOR OFFICE USE ONLY
Chart #
Patient Name:
DOB:
Reviewed By:

MAHEC DENTAL HEALTH CENTER AND CENTER FOR ADVANCED TRAINING

PATIENT INFORMATION

Patient Name: _____ Date: _____

Family Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other Gender: ☐ Female ☐ Male

Social Security #: _____ Birth Date: _____

E-Mail address: _____

Phone : _____ ☐ Home

_____ ☐ Cell

_____ ☐ Work

Best # to Call: ☐ Home ☐ Cell ☐ Work Best time to call:

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

Address: _____

_____

Emergency Contact Information

Name:_____ Relationship:_____

Phone Number:_____

Join Our Patient Portal

Are you interested in signing up for our online patient portal? The patient portal allows you to communicate with your provider and the business office team, as well as view your dental records.

☐ Yes ☐ No

Referral Information

Whom may we thank for referring you to our practice?

☐ Friend- Patient ☐ Family - Patient Name of person who referred you:

☐ Dental Office ☐ Physician Office ☐ Internet Search ☐ Work/Employer ☐ School

☐ Yellow Pages ☐ Advertisement/News Paper ☐ Other:

Spouse or Responsible Party Information

The following information is for: ☐ Patient's Spouse ☐ Other Responsible Party (Parent/Guardian) ☐ Self/Patient **(skip this section)**

Name: _____ Gender: ☐ Female ☐ Male

Last, First MI

Social Security #: _____ Birth Date: _____

Phone : _____ ☐ Home ☐ Cell ☐ Work

_____ ☐ Home ☐ Cell ☐ Work

_____ ☐ Home ☐ Cell ☐ Work

Best # to Call: ☐ Home ☐ Cell ☐ Work Best time to call: _____

Address: _____

Street Apt #

_____

City State Zip Code

Employment Information

☐ Self/Patient ☐ Other Responsible Party (Parent/Guardian/Other)

Name of Employer: _____ Occupation: _____

Address: _____

Street City State Zip Code

Phone: _____

Insurance Information

☐ **Self-Pay (No Insurance)**

PRIMARY:

Name of Insurance Company: _____

ID Number: _____ Group Number: _____

Address: _____

Street City State Zip Code

Phone: _____

SECONDARY:

Name of Insurance Company: _____

ID Number: _____ Group Number: _____

Address: _____

Street City State Zip Code

Phone: _____

We are a General Dentistry Practice that also supports a one-year Advanced General Practice Residency. All of our doctors are dental school graduates. We provide a complete range of dental care with only the most complicated cases referred out. Our fees for services are very competitive with other practices in this area.

Please sign at the bottom of this page to acknowledge that you received this form and understand each policy, and date the form beside your signature.

Appointment Times:
We ask that all patients arrive 15 minutes before their appointed time in order to update records and verify dental insurance.

Emergency Appointments (Regular Business Hours):
If you are experiencing a dental emergency, please call the office after 8:15am. We will contact your doctor and make every effort to address your emergency situation as quickly as possible.

Pediatric Appointments:
Children 6 years and older are able to receive treatment at our facility, however children seen are required to be able to be seen by the doctor in the back on their own. Parents will be consulted after the exam is completed.

Minors/Guardians:
If you are filling out paperwork or making treatment decisions for another individual, please indicate your relationship to the patient and provide legal documentation.

Unattended Children:
Please do not bring children to the dental center unless they have an appointment or a caretaker. For safety reasons, children are not permitted to accompany patients in the treatment areas and cannot be left unattended in the waiting room. The Dental Health Center and staff will not be able to monitor children.

Radiographs:
If you have had dental x-rays taken recently at another office, please request that copies be sent to our office before your appointment. Dental radiographs are needed to aid the dentist in assessing your oral health. Our office is equipped with the most modern and safest digital x-ray technology.

Medications:
Please bring a list of current medications that you are taking with you to your first appointment and every appointment thereafter if there are new prescriptions or changes in dosages.

Estimated fees:
Any fees quoted over the phone are estimates and not a guaranteed price for treatment. Written treatment plans and insurance estimates will be given before treatment is rendered.

After Hours Service:
Our Dental Office hours are generally from 8:00AM to 5:00PM, Monday through Friday. If you have a true dental emergency after hours; swelling, bleeding or facial trauma, please go to your nearest Emergency Department. You may also reach our on call doctor after hours at (828) 257-0038.

Patient 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

Signature of patient, parent or guardian: _____ Date: _____

Signature of Spouse or Responsible Party: _____ Date: _____

Relationship to Patient: _____

Notice of Privacy Acknowledgement

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.

Signature of patient, parent or guardian: _____ Date: _____

Signature of Spouse or Responsible Party: _____ Date: _____

Relationship to Patient: _____

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: _____ _____

_____ _____

Signature of patient, parent or guardian: _____ Date: _____

Signature of Spouse or Responsible Party: _____ Date: _____
Relationship to Patient: _____

Consent for Services

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 anesthesia, local anesthesia and/or nitrous oxide inhalation 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.

Signature of patient, parent or guardian: _____ Date: _____

Signature of Spouse or Responsible Party: _____ Date: _____

Relationship to Patient: _____