MONTAGUE HILLS DENTISTRY
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W E L C O M E

We are pleased to welcome you to Montague Hills Dentistry. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

PATIENT INFORMATION

Name_____ Soc. Sec. #_____
Last Name *First Name* *Initial*

Address_____

City_____ State_____ Zip_____ Home Phone_____

Cell Phone_____ E-mail Address_____

Sex □ M □ F Age_____ Birthdate_____ □ Single □ Married □ Widowed □ Separated □ Divorced

Patient Employed by_____ Occupation_____

Business E-mail Address_____ Business Phone_____

Whom may we thank for referring you?_____

Notify in case of emergency_____ Relationship_____

Home Phone_____Cell Phone_____ E-mail_____

PRIMARY INSURANCE

Person Responsible for Account_____
Last Name *First Name* *Initial*

Relation to Patient_____ Birthdate_____ Soc. Sec. # _____

Address (*if different from patient*) _____ Home Phone _____

Cell Phone_____ E-mail_____

Person Responsible Employed by _____ Occupation _____

Business Address_____ Business Phone_____

Business E-mail_____

Insurance Company_____ Phone _____

Insurance E-mail _____

Contract # _____ Group #_____ Subscriber # _____

Name of other dependents under this plan _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? □ Yes □ No

Health/ Medical Plan:_____Policy Id #_____Rx # _____Phone:_____

Subscriber Name _____ Relation to Patient_____ Birthdate_____

Address (*if different from patient*) _____ Home Phone _____

Cell Phone_____ E-mail_____

Person Responsible Employed by _____ Occupation _____

Business Address_____ Business Phone_____

Business E-mail_____

Insurance Company_____ Phone _____

Insurance E-mail _____

Contract # _____ Group #_____ Subscriber # _____

DENTAL HISTORY

What would you like us to do today?_____ Are you in dental discomfort today?_____
Former Dentist _____ Address_____
Dentist's E-mail_____ Phone _____
Date of last dental care _____ Date of last x-rays _____

Circle yes or no if you have had problems with any of the following:

Y	N	Bad breath	Y	N	Food collection between teeth	Y	N	Periodontal Treatment	Y	N	Sensitivity to sweets
Y	N	Bleeding gums	Y	N	Grinding or clenching teeth	Y	N	Sensitivity to cold	Y	N	Sensitivity when biting
Y	N	Clicking or popping jaw	Y	N	Loose teeth or broken fillings	Y	N	Sensitivity to hot	Y	N	Sores or growth in mouth

How often do you brush?_____ Floss?_____
How do you feel about the appearance of your teeth?_____
Have you ever experienced adverse reaction during or in conjunction with a medical or dental procedure?_____
Other information about your dental health or previous treatment_____

MEDICAL HISTORY

Physician's Name_____ Phone_____
Date of last visit_____ Have you had any serious illnesses or operations?_____
If yes, describe_____
Are you currently under physician care? Y N If yes, please describe_____
Have you ever had a blood transfusion? Y N If yes, give approximate date_____
Have you ever taken Fen/Phen Redux? Y N
Women: Are you pregnant? Y N Nursing? Y N Taking birth control pills? Y N

Circle yes or no whether you have had the following:

Y	N	AIDS/HIV Positive	Y	N	Cough, persistent	Y	N	Jaw pain	Y	N	Shingles
Y	N	Anaphylaxis	Y	N	Cough up blood	Y	N	Kidney disease or malfunction	Y	N	Shortness of breath
Y	N	Anemia	Y	N	Diabetes				Y	N	Skin rash
Y	N	Arthritis, Rheumatism	Y	N	Epilepsy	Y	N	Liver disease	Y	N	Spina Bifida
Y	N	Artificial heart valves	Y	N	Fainting	Y	N	Material allergies	Y	N	Stroke
Y	N	Artificial joints	Y	N	Food allergies			(**latex**, wool, metal	Y	N	Surgical implant
Y	N	Asthma	Y	N	Glaucoma			chemicals)	Y	N	Swelling of feet
Y	N	Atopic (allergy prone)	Y	N	Headaches	Y	N	Mitral valve prolapse			or ankles
Y	N	Back problems	Y	N	Heart murmur	Y	N	Nervous problems	Y	N	Thyroid disease
Y	N	Blood disease	Y	N	Heart problems	Y	N	Pacemaker/			or malfunction
Y	N	Cancer Describe_____						Heart surgery	Y	N	Tobacco habit
Y	N	Chemical dependency	Y	N	Hemophelia/	Y	N	Psychiatric care	Y	N	Tonsillitis
Y	N	Chemotherapy			Abnormal bleeding	Y	N	Rapid weight gain or loss	Y	N	Tuberculosis
Y	N	Circulatory problems	Y	N	Herpes	Y	N	Respiratory disease	Y	N	Ulcer/Colitis
Y	N	Cortisone treatments	Y	N	Hepatitis	Y	N	Rheumatic/Scarlet fever	Y	N	Venereal disease
Y	N	Osteoporosis Medication	Y	N	High blood pressure	Y	N	Radiation treatment	Y	N	Bisphosphonate Medication

Is patient currently taking any medications: If yes, list all:

_____
_____

Does patient have drug allergies? If yes, list all:

_____
_____

AUTHORIZATION

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is a change in my medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature_____ Date_____

Doctor's Signature: _____ Date_____

NOTICE OF PRIVACY PRACTICE

This notice describes how your health information may be used and disclosed, and how you can access this information. Please review it carefully.

We at Montague Hills Dentistry are required to keep your health information secure and confidential, by law. Also by law, we need to give you this notice and to follow the terms of this notice.

The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by a specialist doctor whom we may involve in your care.

We may use or disclose your health information for payment of your services. For example, we may send a report of your treatment or progress to your insurance company.

We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your treatment information into our computer system.

We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy.

We may use your information to contact you. For example, we may send newsletters or other information to you. We may also call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone.

In an emergency, we may disclose your health information to a family member or another person responsible for your care.

We will need to release some or all of your health information, when required by law.

If this practice is sold, your information will become the property of the new owner.

Except as described above, this practice will not use or disclose your health information without your prior written authorization.

You may request in writing that we not use or disclose some or all of your health information as described above. We will let you know if we can fulfill your request.

You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.

You have the right to receive communication about your health information in the manner you prefer. We will also use whatever communication method, number or system you prefer to contact you.

You have the right to transfer a copy of your health information to another practice. Notify us in writing of where you would like us to send a copy of your health information for you.

You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you want a copy of your records, we may charge you a reasonable fee for the copies. If you would like a digital copy of your records, let us know which type of file you would like and we will try to meet your needs.

You have the right to request an amendment or change to your health information, in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add new information.

You have the right to receive a report of who we disclose your information to.

If our privacy and security measures or systems are breached in any way, we will notify you.

You have the right to receive a copy of this notice.

If we change any of the details of this notice, we will notify you of the changes in writing.

Broken Appointment Policy

Please be aware that Montague Hills Dentistry reserves the right to charge patients for appointments cancelled or broken without 48-hr advance notice. Patients who need to change appointments are asked to contact our office 48-hrs prior to appointment time. **Patients who cancel appointment without providing a 48-hr notice will be charged a $50 per hour of broken or cancelled appointment time.**

Co-payment Policy: Co-payments are due on the day of appointment.

I understand the above policy, acknowledge and receive a copy of Notice of Privacy Practice and Dental Material Fact Sheets:

Print Name_____ **Signature** _____

Date_____