Welcome to Modern Dental Care, P.C.

Patient Information

Date__________ Home Phone__________ Cell Phone__________

Name__________ Soc. Sec. #__________
Last Name First Name Initial

Address__________ City__________ State_____ Zip_____

Sex ☐ M ☐ F Age_____ Birthdate__________ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient Employed by__________ Occupation__________

Email__________ Business Phone__________

In case of emergency who should be notified?__________ Phone__________

Responsible Party

Person Responsible for Account__________
Last Name First Name Initial

Relationship to Patient__________ Birthdate__________ Soc. Sec. #__________

Address (if different from patient's)__________ Phone__________

City__________ State__________ Zip__________

Business Address__________ Business Phone__________

Primary Insurance

Subscriber Name__________ Relationship to Patient__________ Birthdate__________

Address (if different from patient's)__________ Phone__________

City__________ State__________ Zip__________

Subscriber Employed by__________ Business Phone__________

Insurance Company__________ Soc. Sec. #__________

Address__________ Phone #__________ Group #__________

Additional Insurance

Subscriber Name__________ Relationship to Patient__________ Birthdate__________

Address (if different from patient's)__________ Phone__________

City__________ State__________ Zip__________

Subscriber Employed by__________ Business Phone__________

Insurance Company__________ Soc. Sec. #__________

Address__________ Phone #__________ Group #__________

Authorization

I authorize my insurance company to pay to the dentist or dental group 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__________

Name____ **Date**____________________

Dental History

Reason for Today's Visit____

Former Dentist____

Address____

Date of last dental care____________________ Date of last dental x-rays____________________

Check (✓) if you have or have had problems with any of the following:

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Clicking or popping
- ☐ Food collection between teeth
- ☐ Grinding teeth
- ☐ Loose teeth or broken fillings
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to hot
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores or growths in your mouth

How often do you floss?____________________ How often do you brush?____________________

Health History

Physician's Name______________________________ Date of last visit____________________

Have you had any serious illnesses or operations? ☐ YES ☐ NO If yes, describe____________________

Have you ever had a blood transfusion? ☐ YES ☐ NO If yes, give approximate date____________________

(Women) Are you pregnant? ☐ YES ☐ NO Nursing? ☐ YES ☐ NO Taking birth control pills? ☐ YES ☐ NO

Check (✓) if you have or have had problems with any of the following:

- ☐ AIDS / HIV
- ☐ Alzheimer's Disease
- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valve
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ COPD
- ☐ Cortisone Treatments
- ☐ Cough, Persistent
- ☐ Diabetes
- ☐ Dialysis
- ☐ Emphysema
- ☐ Epilepsy / Seizures
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches - Migraines
- ☐ Heart Murmur
- ☐ Heart Problems
  Describe________________
- ☐ Heart Pacemaker
- ☐ Herpes
- ☐ Hemophilia
- ☐ Hepatitis A,B,C
- ☐ High Blood Pressure
- ☐ Hypoglycemia
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Nervous Problems
- ☐ Pacemaker
- ☐ Psychiatric Care
- ☐ Osteoporosis
- ☐ Radiation Treatments
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Stroke
- ☐ Swelling of Feet or Ankles
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer

MEDICATIONS

List medications you are currently taking:

____

____

ALLERGIES

____

____

Verification

I verify the medical history provided above to be complete and accurate.

I understand that I am responsible for any errors or omissions as well as updating the dentist on any future changes in my medical history.

Signature____ Date____________________

Dear patient:

At Modern Dental Care our goal is to optimize your dental health by providing excellent, affordable, and timely dental care. Achieving this goal requires cooperation between the doctor, staff, and patient. When a patient fails to keep an appointment or arrives late, it puts a real hardship on everyone involved, including the doctor and the other patients. Unlike many other dental offices that choose to overbook to maximize production, we often appoint one patient at a time. **This extended time is reserved exclusively for your treatment.**

The high expense of operating a dental office continues when a patient misses their appointment. We feel the cost of broken appointments should be borne by those causing the increased cost. **As a result, patients who miss their appointments will be charged a $50.00 fee.** Please give your appointment time top priority so we can avoid this becoming an issue.

If you find that a change in your appointment time is absolutely necessary, please call us as soon as possible, with a minimum of 24 hours notice. Our voice mail is always available to take your message if you need to call after regular office hours or on the weekend.

Thank you for your cooperation.

Sincerely,

Dr. Stephen Gillespie
Dr. David Spencer

I have read and understand the Modern Dental Care policy regarding appointments.

____
Signature (patient or parent)

____
Date

FINANCIAL POLICY AND PAYMENT OPTIONS

At Modern Dental Care we believe it is important not only to provide the highest quality dental care to our patients, but also to make this care affordable. Please feel free to ask us any questions you may have regarding our financial options. We strive to provide the most pleasant dental experience possible.

Regarding insurance: The following is important and helpful information for you. As a courtesy to you, we are happy to process insurance claims. Insurance coverage is an arrangement between you and your insurance company as a form of financial support to assist you with your dental services. We ask that you bear in mind that any "estimate" that we obtain for you from your insurance is only an approximate amount that they will be paying and not a guarantee of payment. The payment for doctor's services is an agreement between you and this office. We hope you understand that any payment not made by your insurance company to the doctor within 45 days is your responsibility to take care of in the form of direct payment to this office.

The following are our payment options that we hope you will find flexible and convenient. We will be happy to meet with you and answer any questions you may have. We ask that you be prepared for payment at the time of service.

PAYMENT IN FULL:

With cash, check or credit card.
We do offer a 5% discount for cash/check only payments.

ESTIMATED PORTION:

We are happy to call your insurance company to obtain the "estimate" of what your portion will be for services rendered.

OUTSIDE FINANCING:

We can offer financing with low payments and no interest options OAC thru Care Credit.

If you do not pay the entire balance within 90 days of the monthly billing date, a service charge will be added to the account. The service charge will be a periodic rate of 1.5% per month, which is an annual rate of 18%, applied to the last months balance. In the case of default of payment, I will pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this amount or future accounts.

I have read this policy and understand my payment options.

Signature ______________________________ Date ___________________

PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

~ Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.

~ Obtain payment from third party payers.

~ Conduct normal health care operations such as quality assessments and physician certifications.

I have been informed by you or your Notice of Privacy Practices containing more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree than you are bound to abide by such restriction.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Signature: ______________________________ Date: ____________________

Patient Name: ____

Relationship to Patient: ____