Main Street Dental Smiles

Dr. Elaine Schilling
306 East Main Street | Whitesboro, TX 76273
(903) 564-3451 | MainStreetDentalSmiles.com
mail@MainStreetDentalSmiles.com

| NEW PATIENT INFORMATION | | | |
|---|---|---|---|
| Patient's Name: | | | Today's Date: |
| Preferred Name: | Male / Female | | |
| Birthdate: | Age: | | SS# |
| Mailing Address: | | | |
| City: | State: | | Zip: |
| Home# | | Work# | |
| Cell# | | Other# | |
| May we contact you by email? Yes / No | E-mail: | | |
| Best time and number to reach you: | | | |
| May we contact you by text message? Yes / No | | Referred by: | |
| Employer: | | How long? | Occupation: |
| City: | State: | | Zip: |
| Status: (Please circle) Minor/Single/Married/Divorced/Separated/Widowed | | Spouse's name: | |
| Do you have any children? Yes/No How many? | | | |

| PERSON ULTIMATELY RESPONSIBLE | | | |
|---|---|---|---|
| Name: | | Drivers License #: | |
| Billing Address: | | | Phone: |
| City: | State: | | SS#: |
| Relationship: | | Payment method: Cash / Check / Credit Card | |

| ASSIGNMENT OF BENEFITS |
|---|
| _____ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company. |

| PRIMARY DENTAL INSURANCE | | | |
|---|---|---|---|
| Insurance Carrier: | | Insured's Employer: | |
| Address: | | | Insured's SS#: |
| City: | State: | | Zip: |
| ID#: | Group #: | | Phone: |
| Insured's Name: | DOB: | | Relationship: |

| SECONDARY DENTAL INSURANCE | | | |
|---|---|---|---|
| Insurance Carrier: | | Insured's Employer: | |
| Address: | | | Insured's SS#: |
| City: | State: | | Zip: |
| ID#: | Group #: | | Phone: |
| Insured's Name: | DOB: | | Relationship: |

| IN THE EVENT OF AN EMERGENCY | | |
|---|---|---|
| Contact: | Relationship: | Best Phone #: |
| 2nd Phone #: | Who is your medical doctor? | M.D.'s Phone#: |

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# Medical History

Name: _____ DOB: _____ Date: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

1. Are you under a physician's care? If yes, please explain: YES/ NO

_____

2. Have you ever been hospitalized or had a major operation? If yes, please explain: YES/ NO

_____

3. List ALL Medical Doctors and Phone numbers:

_____

_____

_____

4. Have you ever had a serious head or neck injury? If yes, please explain: YES/ NO

_____

5. Are you taking any medications, pills or drugs? If yes, please list: YES/ NO

_____

_____

_____

6. Do you have any Artificial Joints? If yes, please explain: YES/ NO

_____

7. Do you take, or have you taken, Phen-Fen or Redux? YES/ NO

_____

8. Have you ever taken Fosamax, Boniva, Actonel, Reclast or any other medications for bone density? YES/ NO

9. Are you on a special diet? YES/ NO

10. Do you use tobacco? How much per day? YES/ NO

_____

11. Do you use controlled substances? YES/ NO

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Women: Are you…

1. Pregnant/ Trying to get pregnant? YES/ NO
2. Nursing? YES/ NO
3. Taking Oral Contraceptives? YES/ NO

Are you allergic to any of the following?

| | | | |
|---|---|---|---|
| 1. Aspirin | YES/ NO | 5. Codeine | YES/ NO |
| 2. Metal | YES/ NO | 6. Sulfa Drugs | YES/ NO |
| 3. Penicillin | YES/ NO | 7. Acrylic | YES/ NO |
| 4. Latex | YES/ NO | 8. Local Anesthetics | YES/ NO |

Are you allergic to anything not listed above? Please specify. YES/ NO

_____

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## Medical History Continued

Do you have, or have you had, any of the following? Please circle.

1. AIDS/ HIV Positive
2. A-Fib
3. Alzheimer's/ Dementia
4. Anaphylaxis
5. Anemia
6. Angina
7. Arthritis/ Gout
8. Artificial Joint
9. Asthma
10. Blood Disease
11. Blood Transfusion
12. Breathing Problems
13. Bruise Easily
14. Bypass
15. Cancer
16. Chemotherapy
17. Chest Pains
18. Cold Sores/ Fever Blisters
19. COPD
20. Congenital Heart Disorder
21. Congestive Heart Failure
22. Convulsions
23. Cortisone Medicine
24. Depression
25. Diabetes
26. Dry Mouth
27. Drug Addiction
28. Easily Winded
29. Emphysema
30. Epilepsy or Seizures
31. Excessive Bleeding
32. Excessive Thirst
33. Faint Spells/ Dizziness
34. Frequent Cough
35. Frequent Diarrhea
36. Frequent Headaches
37. Genital Herpes
38. Glaucoma
39. Hay Fever
40. Heart Attack/ Failure
41. Heart Murmur
42. Heart Pacemaker
43. Heart Trouble/ Disease
44. Hemophilia
45. Hepatitis A
46. Hepatitis B or C
47. Herpes
48. High Blood Pressure
49. High Cholesterol
50. Hives or Rash
51. Hypoglycemia
52. Irregular Heartbeat
53. Kidney Problems
54. Leukemia
55. Liver Disease
56. Low Blood Pressure
57. Lung Disease
58. Mitral Valve Prolapse
59. Osteoporosis
60. Pain in Jaw Joints
61. Parathyroid Disease
62. Psychiatric Care
63. Radiation Treatments
64. Recent Weight Loss
65. Renal Dialysis
66. Rheumatic Fever
67. Rheumatism
68. Scarlet Fever
69. Shingles
70. Sickle Cell Disease
71. Sinus Trouble
72. Spina Bifida
73. Stomach/Intestinal Disease
74. Stroke
75. Swelling Limbs
76. Thyroid Disease
77. Tonsillitis
78. Tuberculosis
79. Tumors or Growths
80. Ulcers
81. Venereal Disease
82. Yellow Jaundice

Have you ever had any illness not listed above? If yes, please explain. YES/ NO

_____

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Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X_____ Date: _____

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# FINANCIAL POLICY

Our goal at Main Street Dental Smiles is to provide the finest quality dental care available to our patients. We offer the best in sterilization, laboratory and clinical techniques currently used in the dental field today. We do not want this quality compromised by overhead expenses. In order to keep these expenses to a minimum, we ask the following:

Payment is required at the time services are rendered. Payment can be made using the following payment types:

- Cash.
- Personal/Local Checks. Local checks will be accepted with proof of driver's license of the person writing the check. **This person must be present at the time the check is written.** A $35 service charge will be charged for all return checks.
- Credit Cards: Our office accepts most major credit cards.
- Care Credit: No interest plans are available through an outside financing company for up to 12 months. They offer low monthly payments with no annual fees or pre-payment penalties. Please ask our Financial Coordinator if you are interested.

Please understand that beginning the first day of the month following balances becoming ninety (90) days past due, a monthly finance charge will be assessed to any unpaid balance. In the case of default of payment on this account, the responsible party agrees to pay collection costs and attorney fees incurred in attempting to collect this amount or any future outstanding balances.
**REFUNDS FOR UNFINISHED TREATMENT**: Please understand that if a patient decides to discontinue treatment after it has been started, a full refund will NOT be given. Individual circumstances may be discussed with the Office Manager and/or Dentist.
**CREDIT ON AN ACCOUNT:** If an insurance company pays more than anticipated and creates a credit for the patient, we are happy to issue a refund to the patient or leave a credit on the account to be applied toward future treatment. Refund requests are handled through our CPA's office and can take up to 2-3 weeks for processing.

I accept full financial responsibility for this account and for all dentistry performed upon myself and my dependents in this dental office.

_____ _____
Patient Signature Date

_____ _____
MSDS Staff Signature Date

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ATTENTION ALL INSURANCE PATIENTS:
PLEASE READ THIS PAGE CARFULLY IN ITS ENTIRETY!

# AUTHORIZATION TO RELEASE AND AUTHORIZATION OF ASSIGNMENT OF BENEFITS

We strongly feel that all patients deserve the very best dental care that we can provide. Furthermore, we feel that everyone benefits when definitive financial arrangements are agreed upon. Accordingly, we have prepared this material to acquaint you with our policy.

**OUR PROFESSIONAL SERVICES ARE RENDERED TO YOU, NOT THE INSURANCE COMPANY. THEREFORE, PAYMENT FOR TREATMENT IS YOUR RESPONSIBILITY.**

Please read and sign the following:

- I authorize MSDS to release or receive any information necessary to expedite my insurance claims.
- I hereby authorize MSDS to bill my insurance company directly for their services.
- I authorize payment directly to MSDS of any insurance benefits otherwise payable to me.
- In the event I receive payment from my insurance carrier, I agree to endorse any payment I receive over to MSDS for which these fees are payable.
- I understand that there are provisions and exclusions in my dental plan that may prevent payment for my procedures. I also understand that my insurance may not inform the provider of these provisions and exclusions upon benefit verification.

I understand that it is up to me to inform MSDS of my insurance eligibility, waiting periods and benefits. I also understand that this office cannot guarantee my insurance status in any of these areas. Any insurance estimate or information given to me by the staff at MSDS is **NOT** a guarantee of actual insurance payment. I also understand that any insurance claim not paid in full after 60 days will become my responsibility to be paid at that time.

_____ _____
Patient Signature Date

_____ _____
MSDS Staff Signature Date

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# APPOINTMENT POLICY

We are glad you have chosen us to provide your dental care; however, if you miss your appointments, you compromise your care. We want to remind you of our office policies regarding missed appointments.

A missed appointment is when you fail to show for an appointment without a phone call or cancel without at least 24-hour notice.

A doctor/patient relationship is built on mutual trust and respect. As such, we strive to be on time for your scheduled appointment(s), and ask that you give us the courtesy of a call when you are unable to keep your appointment(s).

In the event an appointment is failed without a 24 hour notice, a fee of $25 will be charged to your account. We understand that circumstances arise and we will take these into consideration prior to assessment of the failed appointment fee.

**I HAVE BEEN INFORMED OF AND AGREE TO COMPLY WITH THE PAYMENT AND APPOINTMENT POLICIES OF MSDS.**

_____ _____

Patient Signature Date

_____ _____

MSDS Staff Signature Date

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# ACKNOWLEDGMENT OF PRIVACY PRACTICE

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

- Provide and coordinate my treatment among a number of health care providers who may be involved in my treatment directly or indirectly.
- Obtain payment from third-party payers for my health care services.
- Conduct normal health care operations such as quality assessment and improvement activities.

I have been informed of my dental provider's **Notice of Privacy Practices** containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such **Notice of Privacy Practices**. I understand that my dental provider has the right to change the **Notice of Privacy Practices** and that I may contact this office at the address above to obtain a current copy of the **Notice of Privacy Practices**.

I understand that I may request in writing that you restrict how my privacy information is used and disclosed to carry out any treatment, financial arrangements, or health care operations; and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____ Date: _____

Signature: _____

Relationship to Patient: _____

Dependent family members also covered by this acknowledgment:

_____

_____

_____

---

**For Office Use ONLY:**
We were unable to obtain the patient's written acknowledgment of our **Notice of Privacy Practices** due to the following reason:

- Patient refused to sign
- Emergency situation
- Communication barriers
- Other