

**MEDICAL HISTORY**

FOR

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.

- Are you under a physician's care now?  Yes  No If yes, please explain: \_\_\_\_\_
- Have you ever been hospitalized or had a major operation?  Yes  No If yes, please explain: \_\_\_\_\_
- Have you ever had a serious head or neck injury?  Yes  No If yes, please explain: \_\_\_\_\_
- Are you taking any medications, pills, or drugs?  Yes  No If yes, please explain: \_\_\_\_\_
- Do you take, or have you taken, Phen-Fen or Redux?  Yes  No \_\_\_\_\_
- Are you on a special diet?  Yes  No \_\_\_\_\_
- Do you use tobacco?  Yes  No \_\_\_\_\_
- Do you use controlled substances?  Yes  No \_\_\_\_\_

Women: Are you

- Pregnant/Trying to get pregnant?  Yes  No Taking oral contraceptives?  Yes  No Nursing?  Yes  No

Are you allergic to any of the following?

- Aspirin  Penicillin  Codeine  Acrylic  Metal  Latex  Local Anesthetics
- Other If yes, please explain: \_\_\_\_\_

Do you have, or have you had, any of the following?

- |  |  |  |   |
|--|--|--|---|
| AIDS/HIV Positive <input type="radio"/> Yes <input type="radio"/> No         | Cortisone Medicine <input type="radio"/> Yes <input type="radio"/> No        | Hemophilia <input type="radio"/> Yes <input type="radio"/> No            | Renal Dialysis <input type="radio"/> Yes <input type="radio"/> No             |
| Alzheimer's Disease <input type="radio"/> Yes <input type="radio"/> No       | Diabetes <input type="radio"/> Yes <input type="radio"/> No                  | Hepatitis A <input type="radio"/> Yes <input type="radio"/> No           | Rheumatic Fever <input type="radio"/> Yes <input type="radio"/> No            |
| Anaphylaxis <input type="radio"/> Yes <input type="radio"/> No               | Drug Addiction <input type="radio"/> Yes <input type="radio"/> No            | Hepatitis B or C <input type="radio"/> Yes <input type="radio"/> No      | Rheumatism <input type="radio"/> Yes <input type="radio"/> No                 |
| Anemia <input type="radio"/> Yes <input type="radio"/> No                    | Easily Winded <input type="radio"/> Yes <input type="radio"/> No             | Herpes <input type="radio"/> Yes <input type="radio"/> No                | Scarlet Fever <input type="radio"/> Yes <input type="radio"/> No              |
| Angina <input type="radio"/> Yes <input type="radio"/> No                    | Emphysema <input type="radio"/> Yes <input type="radio"/> No                 | High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No   | Shingles <input type="radio"/> Yes <input type="radio"/> No                   |
| Arthritis/Gout <input type="radio"/> Yes <input type="radio"/> No            | Epilepsy or Seizures <input type="radio"/> Yes <input type="radio"/> No      | Hives or Rash <input type="radio"/> Yes <input type="radio"/> No         | Sickle Cell Disease <input type="radio"/> Yes <input type="radio"/> No        |
| Artificial Heart Valve <input type="radio"/> Yes <input type="radio"/> No    | Excessive Bleeding <input type="radio"/> Yes <input type="radio"/> No        | Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No          | Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No              |
| Artificial Joint <input type="radio"/> Yes <input type="radio"/> No          | Excessive Thirst <input type="radio"/> Yes <input type="radio"/> No          | Irregular Heartbeat <input type="radio"/> Yes <input type="radio"/> No   | Spina Bifida <input type="radio"/> Yes <input type="radio"/> No               |
| Asthma <input type="radio"/> Yes <input type="radio"/> No                    | Fainting Spells/Dizziness <input type="radio"/> Yes <input type="radio"/> No | Kidney Problems <input type="radio"/> Yes <input type="radio"/> No       | Stomach/Intestinal Disease <input type="radio"/> Yes <input type="radio"/> No |
| Blood Disease <input type="radio"/> Yes <input type="radio"/> No             | Frequent Cough <input type="radio"/> Yes <input type="radio"/> No            | Leukemia <input type="radio"/> Yes <input type="radio"/> No              | Stroke <input type="radio"/> Yes <input type="radio"/> No                     |
| Blood Transfusion <input type="radio"/> Yes <input type="radio"/> No         | Frequent Diarrhea <input type="radio"/> Yes <input type="radio"/> No         | Liver Disease <input type="radio"/> Yes <input type="radio"/> No         | Swelling of Limbs <input type="radio"/> Yes <input type="radio"/> No          |
| Breathing Problem <input type="radio"/> Yes <input type="radio"/> No         | Frequent Headaches <input type="radio"/> Yes <input type="radio"/> No        | Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No    | Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No            |
| Bruise Easily <input type="radio"/> Yes <input type="radio"/> No             | Genital Herpes <input type="radio"/> Yes <input type="radio"/> No            | Lung Disease <input type="radio"/> Yes <input type="radio"/> No          | Tonsillitis <input type="radio"/> Yes <input type="radio"/> No                |
| Cancer <input type="radio"/> Yes <input type="radio"/> No                    | Glaucoma <input type="radio"/> Yes <input type="radio"/> No                  | Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No | Tuberculosis <input type="radio"/> Yes <input type="radio"/> No               |
| Chemotherapy <input type="radio"/> Yes <input type="radio"/> No              | Hay Fever <input type="radio"/> Yes <input type="radio"/> No                 | Pain in Jaw Joints <input type="radio"/> Yes <input type="radio"/> No    | Tumors or Growths <input type="radio"/> Yes <input type="radio"/> No          |
| Chest Pains <input type="radio"/> Yes <input type="radio"/> No               | Heart Attack/Failure <input type="radio"/> Yes <input type="radio"/> No      | Parathyroid Disease <input type="radio"/> Yes <input type="radio"/> No   | Ulcers <input type="radio"/> Yes <input type="radio"/> No                     |
| Cold Sores/Fever Blisters <input type="radio"/> Yes <input type="radio"/> No | Heart Murmur <input type="radio"/> Yes <input type="radio"/> No              | Psychiatric Care <input type="radio"/> Yes <input type="radio"/> No      | Venereal Disease <input type="radio"/> Yes <input type="radio"/> No           |
| Congenital Heart Disorder <input type="radio"/> Yes <input type="radio"/> No | Heart Pace Maker <input type="radio"/> Yes <input type="radio"/> No          | Radiation Treatments <input type="radio"/> Yes <input type="radio"/> No  | Yellow Jaundice <input type="radio"/> Yes <input type="radio"/> No            |
| Convulsions <input type="radio"/> Yes <input type="radio"/> No               | Heart Trouble/Disease <input type="radio"/> Yes <input type="radio"/> No     | Recent Weight Loss <input type="radio"/> Yes <input type="radio"/> No    |   |

Have you ever had any serious illness not listed above?  Yes  No If yes, please explain: \_\_\_\_\_

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 (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN \_\_\_\_\_ DATE \_\_\_\_\_



**To ensure the highest quality of care, please provide the following information:**

\_\_\_\_\_  
**Patient Name (Last) (First) (MI) (Preferred Name)**

\_\_\_\_\_  
**Date of Birth Social Security Number Email Address**

\_\_\_\_\_  
**Home Address City State Zip**

\_\_\_\_\_  
**Home Number Work Number Ext Mobile number**

\_\_\_\_\_  
**Primary Dental Insurance Group # Insurance Phone Number**

\_\_\_\_\_  
**Name of Subscriber Date of Birth Social Security Number**

\_\_\_\_\_  
**Subscriber Address City State Zip Subscriber Phone Number**

\_\_\_\_\_  
**Subscriber Employer Work Phone Number Relationship to Subscriber**

\_\_\_\_\_  
**Emergency Contact: Relationship Phone Number**

**How did you hear of Mannem Dentistry?** \_\_\_\_\_



**DENTAL HEALTH**

Reason for visit: \_\_\_\_\_

The approximate date of your last dental visit: \_\_\_\_\_

What is your primary concern about your oral health? \_\_\_\_\_

Do you feel pain in any area of your mouth? \_\_\_\_\_ Where? \_\_\_\_\_ How often? \_\_\_\_\_

Are your teeth sensitive to hot, cold, or sweet? \_\_\_\_\_ Where? \_\_\_\_\_ Duration? \_\_\_\_\_

Do you have any sensitivity or pain upon biting or chewing? \_\_\_\_\_ Where? \_\_\_\_\_

Do you notice bleeding when you floss and brush? \_\_\_\_\_ How often do you floss? \_\_\_\_\_

Do your jaws ever feel tired or sore? \_\_\_\_\_ How often do you brush? \_\_\_\_\_

Are you aware of teeth clenching, or grinding while you sleep or throughout the day? \_\_\_\_\_

Are you interested in Teeth Whitening? \_\_\_\_\_ Are you interested in Invisalign (clear braces)? \_\_\_\_\_

**DO YOU EVER EXPERIENCE THE FOLLOWING?**

**Headaches** Yes \_\_\_\_\_ No \_\_\_\_\_

**TMJ Pain** Yes \_\_\_\_\_ No \_\_\_\_\_

**Dizziness** Yes \_\_\_\_\_ No \_\_\_\_\_

**Tingling of the finger tips** Yes \_\_\_\_\_ No \_\_\_\_\_

To the extent permitted by law, I consent to Mannem Dentistry, use and disclosure of my protected health information to carry out payment activities in connection with the dental claims.

\_\_\_\_\_  
**Print Name** **Signature** **Date**

\_\_\_\_\_  
**Print Name** **Relationship (if minor)** **Date**



## CONSENT FOR USE & DISCLOSURE OF HEALTH INFORMATION

**Purpose of Consent:** By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

**Notice of Privacy Practices:** You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our Notice provides a description of our treatment payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice is available. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. These changes may apply to any of your protected health information that we maintain.

**Contact Person:** Kim Preece

**Telephone:** 512.402.9090

**Fax:** 512.402.9091

**Right to Revoke:** You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the contact person listed above. Please understand that revocation of this consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

**I have fully read and considered the contents of this consent form. I understand that by signing this Consent form, I am giving my consent to use and disclose my protected health information to carry out treatment, payment activities, and health care operations.**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

(Patient Name or Guardian Name)

**Address** \_\_\_\_\_

**Telephone** \_\_\_\_\_ **Social Security** \_\_\_\_\_ **Email Address:** \_\_\_\_\_

Please add me to Mannem Dentistry address book  YES  NO

Email address is for correspondence between Mannem Dentistry and yourself ONLY. You will receive quarterly Mannem Dentistry News OR we may use as alternative contact if other forms of correspondence have failed.



## Office Policy

### **Payment will be collected at the time of service for all non-contracted fees and co- insurance.**

**Resin Consent:** I understand this office is an amalgam (Mercury) free practice and I consent to the use of resin (tooth colored) filling material. I am aware that my insurance company may only pay up to the amalgam allowance for posterior resin restorations. **I will pay the estimated fee (50%) and be responsible for any differences after my insurance payment has been received.**

**Insurance Contracts:** If we have a "participating contract" with your insurance company, we will accept assignment on all covered services and bill your insurance carrier as a courtesy to you. You are responsible for the co-pay, co-insurance, and deductible and for all non covered services. Insurance plans represent a contract between yourself and your insurance company. These contracts are not between Mannem Dentistry and the insurance company. We will do our best to help you obtain benefits, but we cannot be responsible if your carrier does not pay. Further, if a member of our staff advises you that you are fully covered or implies that you owe nothing it is your responsibility to contact your insurance company for verification. Therefore, it is your responsibility to make certain your carrier makes prompt payment, and to handle any disputes that may arise.

**Financial Consent:** I agree to pay all co-insurance fees, in full at the time I receive treatment. Furthermore, I accept full financial responsibility for all balances on my account. I understand **Mannem Dentistry** is billing my insurance as a courtesy, and it is my responsibility to know and understand the exclusions and limitations of my dental plan. I understand **Mannem Dentistry** is only able to estimate my out of pocket expense and I agree to pay any balances (after 30 days) and I will contact my insurance plan to be reimbursed.

Third party financing may be available for patients requiring treatment (\$500 or more) through Care Credit. This type of finance must be approved in advance. The terms of this contract consists of no more than twelve equal installments, free of interest or finance charges.

**Missed Appointments:** Our policy is to charge for missed appointments unless a cancelation is received (minimum) 1business day in advance. This charge is \$80 per hour of scheduled time.

**Children in the office:** ALL children 17 years of age and under scheduled for treatment must have a parent or legal guardian present in the office during their appointment. **A waiver for this policy may be obtained from the office and must be signed by parent or responsible party.**

We reserve the right to dismiss any patient from our practice for inappropriate behavior in our office or on the phone.

I acknowledge that I am responsible to pay all charges for treatment administered by this dental practice as outlined above. Should my account be placed with a collection agency for nonpayment, I will be responsible for all collection costs, including court costs and associated attorney fees.

**I have read the policies and will abide with the terms outlined above.**

Responsible Party Signature \_\_\_\_\_ Social Security # \_\_\_\_\_

Printed Name \_\_\_\_\_

Date \_\_\_\_\_