MJP Family Dental

Health History

Name_____________________________________ Date of Birth______/_____/_______
Phone 1(______)_________-_____________ Phone 2 (______)_________-________________
Address_______________________________________City_____________State_______Zip_________
Email____
Social security_____-______-________ Referred By____
Employer ____Position__________________

Dental insurance co_____________________________ Member ID___________________________
Are you the policy holder? Y / N If No: Policyholder Name________________________________
Policyholder DOB________/________/___________ Policyholder SSN________________________

Emergency Contact:
Name____________________________Relation:_____________________Phone(____)_____-_______

Medical history:
Please list any medications

____

Please list any allergies

____

Are you under a physician's care?..Yes / No
Are you allergic to: latex?................Yes / No Penicillin?.......................Yes / No
Do you have: any artificial joints?..... Yes / No An artificial heart valve?...Yes / No
Have you ever had endocarditis?...Yes / No
Were you born with a congenital heart defect...Yes / No
Have you ever taken bisphosphonates (ex. fosamax)?...Yes / No
Do you use tobacco?...........................Yes / No Are you pregnant?.....................Yes / No

Do you have any of the following:

☐Aids/HIV	☐Cancer	☐Excessive bleeding	☐Radiation	☐Stroke
☐Alzheimers	☐Chemotherapy	☐Heart Attack	☐Osteoporosis	☐Asthma
☐COPD	☐Trouble breathing	☐Tuberculosis	☐Thyroid problems	☐Anemia
☐Liver disease	☐Psychiatric problems	☐Heart surgery	☐Kidney problems	☐GERD
☐Pacemaker	☐High blood pressure	☐Diabetes	☐Blood disease	☐Epliepsy
☐Hepatitis	☐Sinus troubles	☐Herpes	☐Chest pain	☐Other

Physician name and number ____
Preferred pharmacy name and number ____

Dental history:
Date of last dental visit____
How often do you: brush? ________________________floss?________________________________
Are you experiencing oral discomfort presently?...Yes / No
Do your gums bleed?.. Yes / No
Have you ever had gum treatments?.. Yes / No
Do you: wear a nightguard?..................... Yes / No Grind your teeth?..................Yes / No
Do you experience: dry mouth?............ Yes / No Jaw pain? ....Yes / No

Signature ____ Date_______________

NAME________________________________

Welcome to MJP Family Dental. The following is an outline of our Office and Payment Policy. Please read it carefully.

- Please notify our office when you have a change of address and /or phone number

Appointment Cancellation

- It is the responsibility of the patient to keep or cancel the appointment whether or not we are able to make contact for confirmation.
- Please contact us with 24 hour notice in order to avoid a cancellation fee.
- We may be unable to reschedule an appointment that has been broken 3 or more times.

Financial policy

- We will gladly file your insurance as a courtesy and accept assignment of benefits and bill whatever remaining balance your insurance did not cover.
- You are responsible for payment of any services applied to your deductible.
- All payments, open balances, and copays are due at the time services are rendered.
- You are responsible for payment of any amount over your annual maximum.
- All payments billed by statement are due 30 days after being sent. Should legal actions be instituted, patient and guarantor agree to be responsible for all costs of collection on unpaid balances including, but not limited to, 1.5% interest (18% annually), collection fees (up to 50%), court costs and reasonable attorney fees.
- There will be a $25.00 service charge on all returned checks.

Please inquire with our staff if you are uncertain about the subjects outlined above. Your signature below will certify that you understand and will comply with this policy

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize any dentist, physician, hospital, pharmacy, insurance company, employer or insuring organization to release any information regarding my dental history, treatment or benefits payable for this claim for the purpose of validating and determining benefits payable in connection with this claim. This authorization or copy of the original shall be valid for the duration of the patient's relationship with this practice or until the information contained within changes.
AUTHORIZATION TO PAY BENEFITS TO THE DENTIST: I hereby certify to the above statements. I hereby authorize payment directly to the above named dentist of the group benefits otherwise payable to me.

AUTHORIZATION TO THE PROVIDERS OF THIS OFFICE to discuss my medical and or dental conditions with my physician, other individuals authorized by me and in the case of an emergency any healthcare provider.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
I have received a copy of this office's Notice of Privacy Practices.
PRINT
SIGNATURE
DATE