MDG
MATIAS DENTAL GROUP

Patient Information (Confidential)

Patient Name:
Date of Birth:
Address: *Address Line 2:*
City: *State:* *Zip Code:*
Social Security #:
Marital Status:
Gender:

Home Phone:
Work Phone:
Cell Phone:
E-mail:
Person to Contact in Case of Emergency: *Contact Info:*

Patient's *or Parent's* ***Employer****:*
Business Address:
If Patient is a Student, Name of School/ College and State:

Whom May We Thank for Referring You?

Responsible Party

Name of Person Responsible for this Account:
Relationship to Patient:
Date of Birth:
Address:
Home Phone:
Employer:
Work Phone:
Is this Person Currently a Patient in our Office?

Insurance Information

Primary Insurance
Name of Subscriber:
Relationship to Patient:
Date of Birth:
Name of Employer:
Insurance Company:
ID Nº / Social Security Nº:
Group Nº:
Ins. Phone Nº:

Secondary Insurance
Name of Subscriber:
Relationship to Patient:
Date of Birth:
Name of Employer:
Insurance Company:
ID Nº / Social Security Nº:
Group Nº:
Ins. Phone Nº:

Patient Medical History

Patient Name:

Physician Name: Office Phone: Date of Last Exam:

(Double-click box to check, or replace w/ X)	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any serious surgical operation or illness?	☐	☐
3. Are you taking any medications including non-prescription medicine? Please list:	☐	☐
4. Do you use tobacco?	☐	☐
5. Do you use alcohol, cocaine or other drugs?	☐	☐
6. Are you wearing contact lenses?	☐	☐

	Yes	No
7. Are you allergic to or have you had any reactions to the following?		
Local Anesthetics (eg. novacaine)	☐	☐
Penicillin or other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Other (please specify)		
8. Women Only:		
Are you pregnant?	☐	☐
Are you nursing?	☐	☐
Are you taking birth control pills?	☐	☐

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

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pains	☐	☐
Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Easily Winded	☐	☐
Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐
Swollen Ankles	☐	☐	Angina	☐	☐	Hay Fever / Allergies	☐	☐
Fainting/Seizures	☐	☐	Frequently Tired	☐	☐	Tuberculosis	☐	☐
Asthma	☐	☐	Anemia	☐	☐	Radiation Therapy	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Epilepsy / Convulsions	☐	☐	Cancer	☐	☐	Recent Weight Loss	☐	☐
Leukemia	☐	☐	Arthritis	☐	☐	Liver Disease	☐	☐
Diabetes	☐	☐	Joint Replacement / Implant	☐	☐	Heart Trouble	☐	☐
Kidney Diseases	☐	☐	Hepatitis / Jaundice	☐	☐	Respiratory Problems	☐	☐
AIDS of HIV	☐	☐	Sexually Transmitted Disease	☐	☐	Other (please specify)		
Thyroid Problem	☐	☐	Stomach Troubles / Ulcers	☐	☐			

Patient Dental History

	Yes	No
1. Do your gums bleed while brushing/flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour ☐liquids/foods?	☐	
4. Do you feel pain to any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have you ever experienced any of the following problems in your jaw?		
Clicking?	☐	☐
Pain?	☐	☐
Difficulty in opening or closing?	☐	☐
Difficult in chewing?	☐	☐

	Yes	No
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you ever had any difficult extractions in the past?	☐	☐
12. Have you ever had any orthodontic work?	☐	☐
13. Have you ever had any prolonged bleeding following extractions?	☐	☐
14. Have you ever had instruction on the correct method of brushing your teeth?	☐	☐
15. Have you ever has instructions on the care of your gums?	☐	☐

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release the diagnosis and the records of any examination rendered during the period of such Dental care to third party payors and/or health practitioner

Patient's/account holder Signature: **Date:**

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Financial Policy

Basic Policy: Payments for services rendered is due in full at time of service. Our office accepts checks, cash and credit cards.

PATIENTS WITH INSURNANCE: As a service to our patient, we will bill your insurance carrier, provided proper insurance information is given to us. We will also assist you in billing your secondary insurance carrier, if applicable. And in researching unpaid claims. Every effort will be made to closely estimate your copayments and deductibles which are due at time of service, but the ultimate responsibility for any unpaid balance rests on you. Please understand that insurance is a contract between you and your insurance company. If an insurance carrier has not paid within 60 days of billing, any unpaid professional fees are due and payable in full from you. **Non-covered charges**: Any charges not paid by your insurance carrier will require payment in full at the time services are provided or upon notice of insurance claim denial.

CANCELLATION OF APPOINTMENTS: Our goal is to provide high quality of care at low cost to our patients and in fairness to other patients and the doctor, we require at least 48 hours' notice when canceling an appointment. There is a **$50/half hour** fee for missed appointments without 48 hour notification, which will be due payable from you. Payment plans are available and arrangements must be made in *advance* of treatments. **Account Balances are Due Upon a Receipt of Statement from our Office**. Any charges incurred by this office related to collection of overdue accounts will be added to the patients account. A fee of **$35** will be charged for any returned checks.

I hereby assign all dental and/or surgical benefits, private insurance, and other health plans, to **Thiago Matias D.D.S.** This assignment will remain in effect until revoke by me in writing. A photocopy of this assignment is considered to be valid as the original. I understand that I am financially responsible for all charges whether or not paid by my insurance carrier. I hereby authorize said assignee to release all information necessary to secure the payment.

I have read and understood and agree to the above financial policy for payment of professional fees. I understand that **I AM ULTIMATELY RESPONSIBLE FOR ALL FEES FOR SERVICE PROVIDED TO ME.**

Patient/account holder Signature:

Date:

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I have received a copy of this office's Notice of Privacy Practices.

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

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Section III (Optional):
PERSONAL REPRESENTATIVE, FAMILY OR OTHER ENTITIES AUTHORIZED ACCESS TO PROTECTED HEALTH INFORMATION TO BE USED AND/OR DISCLOSED

Name or specifically identify these persons and/or other entities you are authorizing to make use of and/or to disclose your protected health information regarding treatment, payment and other healthcare operations.

x _____
Name of Authorized Person or Entity Relationship Phone #

x _____
Name of Authorized Person or Entity Relationship Phone #

Section IV: AUTHORIZATION FOR USE OF ANSWERING MACHINE AND/OR VOICE MAIL

Matias Dental Group staff routinely are unable to contact patients directly during normal business hours. On these occasions our offices leave messages on communication devices provided by our patients. Due to the new federally mandated HIPAA Privacy Rule we must obtain your authorization to continue this mode of communication. Protected Healthcare information that we may possibly disclose on your home, work or cell phone would include, but is not limited to: test/lab results, prescription/pharmacy information, appointment instructions for visits and procedures, and surgical posting/scheduling information.

_____(Initial) I agree to allow Matias Dental Group staff to leave messages that include Protected Healthcare Information on all three communication devices: home, work and cell phone.

_____(Initial) I agree to allow Matias Dental Group staff to leave messages that include Protected Healthcare Information on the following: Please initial next to the applicable communication devices:
_____ Home number, _____ work number or _____ cell number.
_____(Initial) No, I do not agree to allow Matias Dental Group staff to leave messages that include Protected Healthcare Information on all three communication devices: home, work and cell phone.

x _____
Signature Date

FOR MATIAS DENTAL GROUP USE ONLY

Section V: UNABLE TO OBTAIN NOTICE RECEIPT ACKNOWLEDGMENT

Option 1: I could not obtain a signed Notice Receipt Acknowledgment from the patient for the following reason:

_____

_____

Option 2: I attempted to obtain a signed Notice Receipt Acknowledgement from the patient on __/___/___, but was unable for the following reason: _____

_____

x _____

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Matias Dental Group Employee Signature Date