TIME 9:54 AM

DATE 12/17/2008

PATIENT REGISTRATION

ID: _____ Chart ID: _____

First Name: _____ Last Name: _____ Middle Initial: ____

Patient Is: ☐ Policy Holder ☐ Responsible Party

Preferred Name: _____

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: ____

Address: _____ Address 2: _____

City, State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____ Soc Sec: _____ Drivers Lic: _____

○ Responsible Party is also a Policy Holder for Patient ○ Primary Insurance Policy Holder ○ Secondary Insurance Policy Holder

Patient Information

Address: _____ Address 2: _____

City: _____ State / Zip: _____ _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Sex: ○ Male ○ Female Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Birth Date: _____ Age: _____ Soc. Sec: _____ Drivers Lic: _____

E-mail: _____ ☐ I would like to receive correspondences via e-mail.

_____ Section 2 _____ Section 3 _____

Employment Status: ○ Full Time ○ Part Time ○ Retired

Ins Effective Date: _____

Student Status: ○ Full Time ○ Part Time

Medicaid ID: _____ Pref. Dentist: _____

Employer ID: _____ Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hyg.: _____

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

Rem. Benefits: _____.00 Rem. Deduct: _____.00

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

Rem. Benefits: _____.00 Rem. Deduct: _____.00

Medical History Updated 2015(Copy)

Patient Name: Birth Date: Date Created:

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? Name, phone number and date of last exam?	○ Yes ○ No	If yes
Height		
Weight		
Have you ever been hospitalized or had a major operation? Date? Reason?	○ Yes ○ No	If yes
Have you ever had a serious head or neck injury?	○ Yes ○ No	If yes
Are you taking any pills or medications? Please list type and dosage.	○ Yes ○ No	If yes
Do you take, or have you taken St. John's Wort?	○ Yes ○ No	If yes
Do you take, or have you taken Phen-Fen or Redux?	○ Yes ○ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	○ Yes ○ No	If yes
Are you on a special diet?	○ Yes ○ No	If yes
Do you consume alcohol? Type and frequency?	○ Yes ○ No	If yes
Do you use tobacco? Type and Frequency?	○ Yes ○ No	If yes
Do you consume grapefruit or grapefruit products? Often/daily?	○ Yes ○ No	

Women: Are you...

☐ Pregnant? ☐ Trying to get pregnant? ☐ Nursing?
☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics
☐ Valium	☐ Ibuprophen	☐ Tylenol	

Other Allergies?	☐	If yes
Do you use controlled substances?	○ Yes ○ No	If yes

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

AIDS/HIV Positive ○ Yes ○ No	Cortisone Medicine ○ Yes ○ No	Hemophilia ○ Yes ○ No	Radiation Treatments ○ Yes ○ No
Alzheimer's Disease ○ Yes ○ No	Diabetes ○ Yes ○ No	Hepatitis A ○ Yes ○ No	Recent Weight Loss ○ Yes ○ No
Anaphylaxis ○ Yes ○ No	Drug Addiction ○ Yes ○ No	Hepatitis B or C ○ Yes ○ No	Renal Dialysis ○ Yes ○ No
Anemia ○ Yes ○ No	Easily Winded ○ Yes ○ No	Rheumatic Fever ○ Yes ○ No	Angina ○ Yes ○ No
Emphysema ○ Yes ○ No	High Blood Pressure ○ Yes ○ No	Rheumatism ○ Yes ○ No	Arthritis/Gout ○ Yes ○ No
Epilepsy or Seizures ○ Yes ○ No	High Cholesterol ○ Yes ○ No	Artificial Heart Valve ○ Yes ○ No	Excessive Bleeding ○ Yes ○ No
Hives or Rash ○ Yes ○ No	Shingles ○ Yes ○ No	Artificial Joint ○ Yes ○ No	Excessive Thirst ○ Yes ○ No
Hypoglycemia ○ Yes ○ No	Sickle Cell Disease ○ Yes ○ No	Asthma ○ Yes ○ No	Irregular Heartbeat ○ Yes ○ No
Sinus Trouble ○ Yes ○ No	Blood Disease ○ Yes ○ No	Frequent Cough ○ Yes ○ No	Kidney Problems ○ Yes ○ No
Blood Transfusion ○ Yes ○ No	Frequent Diarrhea ○ Yes ○ No	Leukemia ○ Yes ○ No	Stomach/Intestinal Disease ○ Yes ○ No
Breathing Problems ○ Yes ○ No	Frequent Headaches ○ Yes ○ No	Liver Disease ○ Yes ○ No	Stroke ○ Yes ○ No
Bruise Easily ○ Yes ○ No	Low Blood Pressure ○ Yes ○ No	Swelling of Limbs ○ Yes ○ No	Cancer ○ Yes ○ No
Glaucoma ○ Yes ○ No	Lung Disease ○ Yes ○ No	Thyroid Disease ○ Yes ○ No	Date Location
Hay Fever ○ Yes ○ No	Mitral Valve Prolapse ○ Yes ○ No	Tonsillitis ○ Yes ○ No	Chemotherapy ○ Yes ○ No
Heart Attack/Failure ○ Yes ○ No	Osteoporosis ○ Yes ○ No	Tuberculosis ○ Yes ○ No	Date
Heart Murmur ○ Yes ○ No	Pain in Jaw Joints ○ Yes ○ No	Tumors or Growths ○ Yes ○ No	Chest Pains ○ Yes ○ No
Heart Pacemaker ○ Yes ○ No	Parathyroid Disease ○ Yes ○ No	Ulcers ○ Yes ○ No	Cold Sores/Fever Blisters ○ Yes ○ No
Heart Trouble/Disease ○ Yes ○ No	Psychiatric Care ○ Yes ○ No	Venereal Disease ○ Yes ○ No	Congenital Heart Disorder ○ Yes ○ No
Sleep Apnea ○ Yes ○ No	COPD ○ Yes ○ No	GERD ○ Yes ○ No	Convulsions ○ Yes ○ No
Depression ○ Yes ○ No	Bipolar ○ Yes ○ No	Schizophrenia ○ Yes ○ No	Yellow Jaundice ○ Yes ○ No
Dizziness ○ Yes ○ No	Fainting Spells ○ Yes ○ No	Fainting Spells ○ Yes ○ No	Acid Reflux ○ Yes ○ No
			Dental Fear/Anxiety ○ Yes ○ No

Have you ever had or do you have a serious illness not listed above?	○ Yes ○ No	If yes

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:

X Date:_____

Mount Mansfield Dentistry

Gary Morris, DDS
Michael Morris, DDS

Sedation and General Dentistry

77 South Main St Waterbury VT 05676
802.244.6366

Financial Policies

Thank you for choosing us as your dental health care provider. We understand that dental treatment may involve a significant financial investment to achieve the goal of good dental health. To avoid any misunderstanding, we request that you read our financial policy prior to beginning any treatment. Please speak with Susan O'Brien, our Office Manager, if you have concerns. We will do everything we can to help you receive the care that you need and want. Communication with us is essential and appreciated.

Payment is due at the time of service ***We accept: Cash, Checks & Credit Cards (Master Card, Visa, Discover). We also offer an extended payment plan option via Care Credit for approved patients. (When opting to enroll with Care Credit understand that significant finance charges may incur if you do not comply with the terms of the agreement).***

Insurance

Understand that your dental insurance is an agreement between the insurance company and you, not between your insurance company and Mount Mansfield Dentistry. Also understand that you are responsible for your dental account balance regardless of your insurance coverage. As a courtesy, Mount Mansfield Dentistry will gladly submit insurance claims for covered expenses. Taking into consideration your co-payment, annual maximum, any deductibles and our past experience with your insurance we will do our best to ***estimate*** your out-of-pocket responsibility and insurance coverage. Mount Mansfield Dentistry does not guarantee that our estimate is correct. If the insurance company does not respond to your dental insurance claim within 30 days of the date of service, the remaining balance will be expected in full at that time. We do not accept assignment of secondary insurance; however, we will, when possible, continue to assist you in obtaining reimbursement from your insurance company.

Usual and Customary Fees

Our practice is committed to providing the best possible care for all of our patients and we are confident that our fees are both fair and appropriate for this area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Collection Agency

In the unfortunate event that we have to refer your outstanding balance to an outside collection source, you agree to reimburse us the fees of the Collection Agency, which may be based on a percentage maximum of 30% of the debt, all costs and expenses including attorneys' fees we incur in such collection efforts.

Missed Appointments

Please understand that your appointment time is reserved exclusively for you and failure to comply with the cancellation/rescheduling terms listed below will result in a fee charged in accordance with the scheduled appointment.

Cleaning Appointments	**Appointments with Dentist**
24 hours notice for Tue – Fri appointments	**36 hours notice for Tue-Fri appointments**
Notice by noon on Fri for Mon appointments	**Notice by 4:00 on Thu for Mon appointments**
$55 Missed Appointment Fee	**$75 and up Missed Appointment Fee**

We thank you for considering our other patients who are also in need of prompt dental treatment.

Signature _____ **Date**_____