

## Patient Information

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

Home Address: \_\_\_\_\_  
*Street apt#*

\_\_\_\_\_ *City state zip*

Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Gender: Male \_\_\_\_\_ Female \_\_\_\_\_ Marital Status: Married \_\_\_\_\_ Single \_\_\_\_\_ Child \_\_\_\_\_ Other \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Cell #: \_\_\_\_\_

Employer: \_\_\_\_\_ Work #: \_\_\_\_\_ ext: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_  
*(Not for spam use / will be kept confidential / requested for confirming appointments)*

Emergency contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_

## Health Information

Date of last Visit: \_\_\_\_\_ Reason for this Visit: \_\_\_\_\_

### Have you ever had any of the following? Please check those that apply:

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> Alcohol Abuse                 | <input type="checkbox"/> Congenital Heart Defect        | <input type="checkbox"/> Hemophilia               | <input type="checkbox"/> Seizures  |
| <input type="checkbox"/> Allergies ( <i>seasonal</i> ) | <input type="checkbox"/> Diabetes: <i>Type 1-Type 2</i> | <input type="checkbox"/> Hepatitis                | <input type="checkbox"/> Shingles  |
| <input type="checkbox"/> Anemia                        | <input type="checkbox"/> Difficulty Breathing           | <input type="checkbox"/> High Blood Pressure      | <input type="checkbox"/> Sickle Cell Anemia  |
| <input type="checkbox"/> Angina Pectoris               | <input type="checkbox"/> Drug Abuse                     | <input type="checkbox"/> HIV – AIDS               | <i>Last Time: _____</i>  |
| <input type="checkbox"/> Arthritis                     | <input type="checkbox"/> Emphysema                      | <input type="checkbox"/> Kidney Disease           | <input type="checkbox"/> Sinus Problems  |
| <input type="checkbox"/> Artificial Heart Valve        | <input type="checkbox"/> Epilepsy                       | <input type="checkbox"/> Liver Disease            | <input type="checkbox"/> Stomach Problems  |
| <input type="checkbox"/> Artificial Joints             | <input type="checkbox"/> Excessive Bleeding             | <input type="checkbox"/> Low Blood Pressure       | <input type="checkbox"/> Stroke  |
| <input type="checkbox"/> Asthma                        | <input type="checkbox"/> Facial Surgery                 | <input type="checkbox"/> Nervous Disorder         | <i>When: _____</i>   |
| <input type="checkbox"/> Bloody Sputum                 | <input type="checkbox"/> Fainting Spells                | <input type="checkbox"/> Night Sweats             | <input type="checkbox"/> Thyroid Problem   |
| <input type="checkbox"/> Blood Transfusion             | <input type="checkbox"/> Fever Blisters                 | <input type="checkbox"/> Pace Maker               | <input type="checkbox"/> Tuberculosis  |
| <i>When: _____</i>                                     | <input type="checkbox"/> Frequent Headaches             | <input type="checkbox"/> Psychiatric Problems     | <input type="checkbox"/> Live in a concentrated housing with or without another tuberculosis Patient |
| <input type="checkbox"/> Cancer                        | <i>How Often: _____</i>                                 | <input type="checkbox"/> Radiation Treatment      | <input type="checkbox"/> Tumor   |
| <i>When: _____</i>                                     | <input type="checkbox"/> Glaucoma                       | <i>When: _____</i>                                | <input type="checkbox"/> Ulcers  |
| <i>Type: _____</i>                                     | <input type="checkbox"/> Head Injury                    | <i>Body Area: _____</i>                           | <input type="checkbox"/> Unexplained Weight Loss   |
| <input type="checkbox"/> Chemotherapy                  | <i>When: _____</i>                                      | <input type="checkbox"/> Recent Travel Out of U.S | <input type="checkbox"/> Venereal Disease  |
| <i>When: _____</i>                                     | <input type="checkbox"/> Heart Attack                   | <input type="checkbox"/> Respiratory Problem      |  |
| <input type="checkbox"/> Chronic Cough                 | <input type="checkbox"/> Heart Disorder                 | <input type="checkbox"/> Rheumatic Fever          |  |

### Have you ever had an ALLERGIC REACTION to any of the following? Please Check those that apply:

- |   |  |
|---|--|
| <input type="checkbox"/> Aspirin            | <input type="checkbox"/> Metals              |
| <input type="checkbox"/> Codeine            | <input type="checkbox"/> Penicillin          |
| <input type="checkbox"/> Dental Anesthetics | <input type="checkbox"/> Sulfa               |
| <input type="checkbox"/> Erythromycin       | <input type="checkbox"/> Tetracycline        |
| <input type="checkbox"/> Latex              | <input type="checkbox"/> <i>Other: _____</i> |

- Have you ever had complications following dental treatment? YES \_\_\_\_\_ NO \_\_\_\_\_  
Please Explain: \_\_\_\_\_
- Do you have any other health problems that need further clarification? YES \_\_\_\_\_ NO \_\_\_\_\_  
Please Explain: \_\_\_\_\_
- Please list any and all medications you are currently taking: \_\_\_\_\_  
\_\_\_\_\_
- Could you be pregnant? YES \_\_\_\_\_ NO \_\_\_\_\_ (If yes, please let a staff member know before exam starts)
- Why did you leave your last dentist? \_\_\_\_\_
- What are your hobbies? \_\_\_\_\_
- What are your favorite TV shows? \_\_\_\_\_
- How did you hear about us? \_\_\_\_\_

**Treatment authorization**

To the best of my knowledge all of the preceding answers and information provided are true and correct. If ever I have any change in my health or medications I understand it is my full responsibility to notify Modern Dental Care.

I authorize and give consent to Modern Dental Care to perform the dental services agreed between doctor and patient or parent or guardian to be necessary and advisable including the use of local anesthesia and other medications as indicated. I certify to the above statement regarding my medical condition.

\_\_\_\_\_ Date: \_\_\_\_\_  
*Please Print Full Name of Patient, Parent or Guardian*

\_\_\_\_\_ Date: \_\_\_\_\_  
*Signature of Patient, Parent or Guardian*

## Spouse or Parent Information

The Following is for: (please Circle one) 1. The patients spouse    2. The patients parent/guardian

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Social Security#: \_\_\_\_\_ Male \_\_\_ Female \_\_\_ Married \_\_\_ Single \_\_\_ Child \_\_\_ Other \_\_\_

Home Phone#: \_\_\_\_\_ Cell#: \_\_\_\_\_ Work#: \_\_\_\_\_ Ext: \_\_\_\_\_

Address: \_\_\_\_\_

*Street*

*Apt#*

*City*

*State*

*Zip Code*

Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

## Insurance Information

*(please give information below for the policy holder)*

**Primary Insurance Company:** \_\_\_\_\_ Phone#: \_\_\_\_\_

Policy holders name: \_\_\_\_\_ Are you the patient: YES \_\_\_ NO \_\_\_

Date of birth: \_\_\_\_\_ SS#: \_\_\_\_\_ ID#: \_\_\_\_\_ Group#: \_\_\_\_\_

Employer: \_\_\_\_\_ Work#: \_\_\_\_\_ Ext: \_\_\_\_\_

Claim Address: \_\_\_\_\_

*Street*

*City*

*State*

*Zip Code*

Patient Relationship to insured: Self: \_\_\_\_\_ Spouse: \_\_\_\_\_ Child: \_\_\_\_\_ Other: \_\_\_\_\_

**Secondary Insurance Company:** \_\_\_\_\_ Phone#: \_\_\_\_\_

Policy holders name: \_\_\_\_\_ Are you the patient: YES \_\_\_ NO \_\_\_

Date of birth: \_\_\_\_\_ SS#: \_\_\_\_\_ ID#: \_\_\_\_\_ Group#: \_\_\_\_\_

Employer: \_\_\_\_\_ Work#: \_\_\_\_\_ Ext: \_\_\_\_\_

Claim Address: \_\_\_\_\_

*Street*

*City*

*State*

*Zip Code*

Patient Relationship to insured: Self: \_\_\_\_\_ Spouse: \_\_\_\_\_ Child: \_\_\_\_\_ Other: \_\_\_\_\_



## **Patient Agreement**

*(please initial and sign)*

\_\_\_\_\_ Modern Dental Care bills your insurance company as a courtesy to you. We cannot be expected to know your insurance benefits and limitations. If you have any questions regarding your coverage, please contact your carrier.

\_\_\_\_\_ If insurance coverage is terminated or has not been updated with Modern Dental Care the patient is fully responsible for all fees incurred regardless.

\_\_\_\_\_ At Modern Dental Care we provide the most up to date services, which include only composite which is also known as tooth colored filling material. Some insurance companies will cover only a percentage for these fillings. In this case, the patient will be responsible for the difference. *(Fees are subject to change as insurance fees change.)*

\_\_\_\_\_ Estimates that are given are "just that". We try to get as close as possible but there is no way of knowing the "exact amount". These estimates are given as a courtesy to the patient. These estimates do not include outstanding balances.

\_\_\_\_\_ Since we cannot predict the "exact" amount the insurance will pay, any remaining balance is the patient's full responsibility.

\_\_\_\_\_ Due to the individuality of each patient's mouth, treatment is subject to change therefore any "estimate" provided by our office for the patient's dental care can only be extended for a period of 90 days from the date of the patient's examination.

\_\_\_\_\_ In the event of a "No Show" for a scheduled appointment without **24 hours notice, a charge of \$55.00** will be billed to the patient.

\_\_\_\_\_ The patient's portion of the bill is due on the day of treatment. We accept MasterCard, Visa, American Express, debit, and Cash. We do not accept checks. One of our staff members will be happy to go over the payment options we have available.

\_\_\_\_\_ As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon payment from the patients for the cost incurred in their care, and financial responsibility on the part of each patient must be determined before treatment.

\_\_\_\_\_ In the event of an emergency after business hours, a **\$135.00 emergency fee** will be charged to the patients and will be due on that visit in addition to any treatment fees incurred at the time of the emergency visit.

***\*\*Fees are subject to change with out notice.***

\_\_\_\_\_ Date: \_\_\_\_\_

*Please Print Full Name of Patient, Parent or Guardian*

\_\_\_\_\_ Date: \_\_\_\_\_

*Signature of Patient, Parent or Guardian*



## Appointment Policy

Here at Modern Dental Care we value our patient's time. This is why we do not double book for treatment. Unfortunately, when a patient has booked more than 60 minutes, does not show up, and does not give our office 24 hour notice we are left with an opening that would have accommodated another patient. When no notice is given we are then unable to fill that time, forcing other patients who could have benefited from that time, to take another/later appointment.

We ask that you not only be considerate of our time, but of all our patients as well, when an appointment is made we consider that appointment confirmed at that time. **Please remember, your appointment was considered confirmed that day you made it.**

Appointments that require more than **90 minutes** for treatment will require a deposit of the treatment portion on the day the appointment is made. If you need to re-schedule and you give 24 hour notice, the deposit you made will remain in your chart as a "**deposit on treatment**" if you fail to show up for your appointment and a **24 hour notice is not given**, per your patient agreement, **\$55.00** will be then taken from the deposit for that appointment.

On occasion there are emergency situations that will arise and may run us a bit behind. We will **never** try to "**make up time**" by shorting you on your appointment. We give great care and time for all of our patients. We pride ourselves on the quality of care given to each and every patient. Some patients have extensive treatment plans that require more time than expected to explain treatment. This consideration will be given to all of our patients, as each one of you has different needs.

On behalf of Dr. Edington and his team we would like to welcome you to our office. Our goal is to meet all your individual dental needs and to make your appointments as comfortable and informative as possible.

Please remember if you love us, tell your friends, family, and co-workers. If you don't love us please bring your concerns to our office manager. We will be happy to try and resolve any issue and make your return to our office a more pleasant experience. Thank you for choosing Modern Dental Care.

### **Extraordinary Care for Today's Smiles.**

\_\_\_\_\_ Date: \_\_\_\_\_  
*Please Print Full Name of Patient, Parent or Guardian*

\_\_\_\_\_ Date: \_\_\_\_\_  
*Signature of Patient, Parent or Guardian*





**ACKNOWLEDGEMENT OF RECEIPT OF  
NOTICE OF PRIVACY PRACTICES**

I, \_\_\_\_\_, have the opportunity to receive a copy of this  
*(please print patients name)*  
office's Notice of Privacy Practices.

\_\_\_\_\_  
*Signature of Patient, Parent or Guardian* Date: \_\_\_\_\_

**For Office Use Only**

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

- Individual refuse to sign.
- Communication barriers prohibited obtaining the acknowledgement.
- An emergency situation prevented us from obtaining the acknowledgement.
- Other (please specify)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_