Middlecoff Dental Group, PLLC

How did you hear about our office? _____

Patient Name _____ _____
Last First MI Preferred Name

Address, City, State, Zip _____

Gender: Male ____ Female ____ **Family Status:** Married____ Single ____ Child____ Other ____

Birth Date:_____ Email Address _____ Social Security # _____

_____ _____ _____ Would you like Text reminders?
Home Number Cell Number Work Number Yes _____ No _____

If Patient is a Minor, person financially responsible (responsible party must sign).

_____ _____
Last First Middle Relationship to Patient

Emergency Contact and number _____

Patient's Dental History

Do you have a specific dental problem? If yes, describe.

_____

Do you have dental examinations on a routine basis?
Yes _____ No _____

Date of last dental visit. _____

Do your gums bleed? Yes _____ No _____

Do you brush and floss on a routine basis?
Yes _____ No _____

Date of last full mouth or panoramic x-ray _____

Do you use tobacco? _____

Medical History

Are you under a physician's care now? If yes, describe reason.

_____

Name of physician and phone number. _____

List **ALL** prescribed **MEDICATIONS** that you are currently taking including over the counter medications.

_____

_____

_____

_____

_____

_____

Do you take any blood thinners?(not aspirin) Yes ____ No ____
Do you take medication for osteoporosis? Yes ____ No ____
Do you have any artificial joints? Yes ____ No ____
Do you pre-medicate for anything? Yes ____ No ____

Women (check) Pregnant/trying to get pregnant ____ Nursing ____ Taking oral contraceptives ____

Are you allergic to: Aspirin ____ Penicillin ____ Codeine ____ Acrylic ____

Metal ____ Latex Rubber ____ Milk ____ Sulfa ____ None ____

Please list any **OTHER** allergies: _____

_____

Please mark all that apply:

____ Aids	____ Epilepsy or Seizures	____ Lung Disease
____ Alzheimer's Disease	____ Excessive Bleeding	____ Mitral Valve Prolapse*
____ Anemia	____ Fainting or Dizziness	____ Osteonecrosis of Jaw
____ Angina/Chest Pain	____ Glaucoma	____ Osteoporosis
____ Arthritis/Gout	____ Hay Fever	____ Psychiatric Care
____ Artificial heart Valve*	____ Heart Attack/Failure	____ Pulmonary Shunt*
____ Artificial Joint*	____ Heart Disease/Surgery*	____ Radiation Treatments
____ Asthma	____ Heart Murmur or Defect*	____ Recent Blood Transfusion
____ Bacterial Endocarditis	____ Heart Pace Maker*	____ Renal Dialysis
____ Bloody Sputum	____ Hepatitis A, B, or C	____ Rheumatic Fever*
____ Bruise Easily/Blood Disease	____ Herpes	____ Scarlet Fever
____ Cancer	____ High Blood Pressure	____ Shortness of Breath
____ Chemotherapy	____ HIV Positive	____ Sickle Cell Disease
____ Cochlear Implants	____ Hypoglycemia	____ Stomach/Intestinal Disease
____ Congenital Heart Disorder*	____ Irregular Heart Beat	____ Stroke
____ Coronary Stent*	____ Kidney Problems	____ Thyroid Disease
____ Diabetes	____ Leukemia	____ Tuberculosis
____ Drug Addiction/Alcoholism	____ Liver Disease	____ Ulcers
____ Emphysema	____ Low Blood Pressure	

Have you ever had any other serious illness not checked above or an injury or radiation to the head or neck? Discuss _____

_____

_____

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail.

I agree with the information listed above _____

Signature Date

Cancellation and Missed Appointment Policy

We always provide courtesy reminder calls, text or e-mails to remind you of your reserved appointment time. We ask that you confirm your appointment either by a return phone call, text or e mail. **If we do not get a confirmation from you regarding your appointment we reserve the right to remove your appointment from our schedule if that time is needed for another patient. If you must reschedule or cancel your appointment we require 24 hours notice to avoid a broken appointment fee. The fee for a 1st broken appointment is $25.00, 2nd $50 and 3rd broken appointment fee is $75. After 3 broken appointments we will only be able to see you on a walk in basis if our schedule allows.**

May we contact you at work?_____Work #_____Cell #_____

_____ _____

Patient or Responsible Party Date

Insurance Filing and Financial Responsibility

As a service to our patients with insurance, Middlecoff Dental Group agrees to accept an **estimated** co-payment at the time service is rendered and bill insurance for the balance.

Even with our best efforts, we can only **estimate** what insurance will pay. We are never given a **guarantee** of coverage or benefits from your insurance carrier and situations may arise when insurance will deny a claim or a portion of a claim when we submit it for payment. We will always restore teeth with tooth colored composite fillings since we feel that this type of restoration is far superior to silver amalgam fillings. Many insurance companies allow an alternate treatment of, or ***downgrade*** to silver amalgam fillings on back teeth, molars and sometimes premolars (even insurance companies recognize that this is not the best restoration). If your insurance company downgrades the difference between the cost of a composite restoration and amalgam restoration would not be paid by insurance.

Insurance is a contract between you and your carrier and if you have concerns we strongly suggest that you contact your carrier prior to your visit. In the event that insurance pays less than estimated or not at all, I agree to pay any amount not paid by my insurance to Middlecoff Dental Group.

I authorize the release of any information necessary to process my claims. The information I have given is accurate and true to the best of my knowledge.

_____ _____

Patient or Responsible Party Date

I have been provided with a copy of Middlecoff Dental Group's Privacy Policy.

_____ _____

Patient or Responsible Party Date