New Patient Enrollment Form

We will need to gather some information in order to begin a new patient record. The information gathered below is strictly confidential and will be used for internal officeuse and insurance purposes only.

Patient Information

Today's Date Name: *First* *Middle* *Last*

Date of birth: MM DD YYYY Social Security Number:

Age: Sex: M F Address:

Home Phone: Cell Phone: Work Phone:

☐ Please check this box if you would allow us to send appointment reminders via text message in the future.

☐ Please check this box if you would allow us to send appointment reminders and messages about your dental care via email. We assure your confidentiality, and your address will remain secure within our practice and not be shared with any third party

Email: Patient's employer:

Spouse Name: First Last: Spouse Date of birth: MM DD YYYY

Spouse Social Security Number: Spouse's employer:

If you are completing this form for another person, what is your relationship to that person?

Your Name: Relationship: Cell Phone:

Emergency Contact

Emergency Contact Name: Phone Number:

Insurance Information

Do you have dental insurance? Y N Subscriber Name:

Relationship to patient: Subscriber Birth Date: MM DD YYYY

Address: Phone Number:

Insurance Company: Address:

Subscriber employed by:

Are you happy with your current dental insurance or would you like more information on other options? Y N

If you answered, "NO" to this question, would you like more information regarding membership?:

____

If you have dental insurance, please provide all pertinent information to our front office personnel for verification. Miner Dental accepts most dental plans, and we are preferred providers for many companies.

Remember, your dental insurance is a contract between your employer and the dental insurance company. It is ultimately your responsibility to know the details of your plan. We will always help you with any questions you may have.

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Assignment and release of benefits

I, the undersigned, certify that I (or my dependent) have insurance coverage through and assign benefits directly to Miner Dental for services rendered. I understand that I am financially responsible for all charges, whether or not paid by my insurance. I hereby authorize Miner Dental to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party: Relationship: Date: MM DD YYYY

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Miner Dental Practice Standards

Treatment

We pride ourselves on offering the highest quality of care possible. Our doctors do not allow insurance companies to dictate the course of a patient's treatment. We are a full-service mercury-free practice. We do not place any silver amalgam fillings but rather only place composite "white" fillings or porcelain restorations.

Appointments

We realize that our patient's time is valuable; therefore, we make every effort possible to minimize or eliminate the wait. We reserve time specifically for each patient and we will do everything in our power to get our patients in and out on time. We request the same courtesy from our patients.

If you find it impossible to keep an appointment, please call our office at least 48 hours in advance.

Appointments not canceled within 24 hours and multiple canceled or no show appointments will be, at our discretion, charged a $50.00 fee. Also, multiple canceled appointments will not be rescheduled and patients will be placed on a strict last-minute availability for any appointment.

Financial Responsibility

- Patient portion is always due on the day of service unless alternative financial arrangements have been made.
- We offer many payment options to allow your treatment to be comfortable and affordable. Please ask us about our payment plans when scheduling treatment.
- Payments extending beyond 30 days from the first billing will accrue interest at the rate of 1.5% per month on the unpaid balance (18% annual rate).
- There is a $25.00 charge for all returned checks (NSF).
- In the event of default, I promise to pay legal interest on the indebtedness, collection costs and related legal fees.
- We take pride in our knowledge and make every attempt to gain access to all dental plan information. The final balance owed is always dependent upon the benefit processed by your insurance. You are responsible for any amount not covered by your insurance.

Please sign below indicating your acceptance of the practice standards

- I have read and I understand the Miner Dental Practice Standards.
- I acknowledge that, upon request, I will be provided with a copy of the HIPPA privacy practices.
- I give permission for my dentist and clinical team to take any necessary radiographs, study models, and photographs to make a complete diagnosis of my dental needs. I also give permission for my dentist and dental team to anonymously use my photographs for in-office patient education.
- I will be given the opportunity to discuss my treatment plan with the doctor and financial arrangements will be agreed upon before commencing treatment.

Signature of Responsible Party: ___________________ Name:____________________________ Date: __________________

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Adult Health History

Height: **Weight:**

Do you have any of the following disease or problems:

	Y	N		Y	N
Active Tuberculosis			**Persistent cough greater than a 3 weeks duration**		
Cough that produces blood			**Been exposed to anyone with tuberculosis**		

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

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Dental Information

	Y	N		Y	N
Do your gums bleed when you brush or floss?			**Are your teeth sensitive to cold, hot, sweets, or pressure?**		
Does food or floss catch between your teeth?			**Is your mouth dry?**		
Have you had any periodontal (gum) treatments?			**Have you ever had orthodontic (braces) treatment?**		
Have you had any problems associated with previous dental treatment?			**Are you currently experiencing dental pain or discomfort?**		
			Do you have earaches or neck pains?		
Do you have any clicking, popping or discomfort in the jaw?			**Do you clench your teeth?**		
			Do you have sores or ulcers in your mouth		
Do you wear dentures or partials?			**Have you ever had a serious injury to your head or mouth?**		
What is the reason for your dental visit today?			**Date of your last dental exam?**		

Medical Information

Joint Replacement

Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? Y N Date:

Allergies:

Latex	Penicillin	Erythromycin	Clindamycin
Dental anesthetics	Codeine	Sulfa drugs	Other

Medical / Dental / Surgical History

	Y N		Y N
Do you have a primary care physician?		Do you use any form of tobacco?	
Do you dip, use snuff, or vape?		Are you pregnant, or trying to become pregnant?	
Are you nursing?		Do you experience abnormal or excessive bleeding?	
Adverse reaction to dental treatment or Anesthetic		If "yes", please explain:	
Do you still have your wisdom teeth?			
		Have you ever been told by a physician or surgeon that you need to premedicate prior to dental treatment?	

	Y N		Y N	
Alcohol abuse		Anemia		Acid reflux or GERD (if so; which?)
Arthritis		Artificial bones or joints		(if so; please list)
Asthma		Autoimmune disorder		Bleeding disorder
Blood transfusion		Blood disorder		History of chemotherapy or radiation
History of cancer		If yes, please explain		Cold sores
Chickenpox		Colitis		
Congenital heart defect		Chronic pneumonia		Difficulty breathing
Diabetes		Type (I) (II)		Epilepsy
Drug abuse		Emphysema		Hemophilia
Fainting spells		Frequent headaches		Hepatitis A, B, or C
History of heart attack		If so when?		Herpes
History of heart surgery		If so when?		Heart murmur
Heart condition		If so, please list		HIV/AIDS
High blood pressure		High cholesterol		Jaundice
Hospitalizations within the last 10 years		Jaw pain		Low blood pressure
Kidney problems		Liver disease		
Mitral Valve prolapse		Osteoporosis		If so, when was it placed?
Have you ever taken Fosomax or any other bisphsphonates to treat osteoporosis?		Pacemaker		
		Psychiatric care or treatment		Rheumatic fever
Periodontitis or periodontal disease		Sexually transmitted infection		Shingles
History of frequent seizures		Sinus problems		Sleep apnea
Sickle Cell		Steroid therapy		Thyroid problems
Snoring		If yes, when		Tonsilitis
History of stroke		Ulcers		
Tuberculosis (TB)				

Please list any surgical procedures you have had with corresponding dates

Please list ALL medications; prescription, over-the-counter, and supplements:

Cosmetic

Are you happy with your smile? Y N

Do you whiten your teeth? Y N

If there was something you could change about your smile, what would it be? ____________________________________

Periodontal

When was the last time you had a prophylaxis (teeth cleaning)? ________________

Have you ever, or have you ever been told that you need a "deep cleaning" or a scaling and root planing in order to treat periodontal disease/infection? Y N

Y N

Have you ever been seen by a periodontist (gum specialist)? Y N

If so, what for?

How often were you getting your teeth cleaned at your previous dentist? Every 3 months: 4 months: 6 months:

Orthodontic

Have you ever had braces or clear aligner therapy? Y N

Do you notice your teeth shifting? Y N

Is orthodontic treatment something that you are interested in?

Implant Dentistry

Do you have missing teeth due to infection or decay? Y N

Do you have bridge work? Y N

Is replacing your missing teeth something you would be interested in?

Sleep

Have you been diagnosed with sleep apnea? Y N

Do you grind or clench your teeth at night? Y N

Do you snore?

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?

Name of physician or dentist making recommendation: ____

Do you have any disease, condition, or problem not listed above that you think we should know about? Y N

Please explain:

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian **Name** **Date**