PETRA I. MAYER D.D.S., P.C.

ABOUT YOU

□ Mr. □ Mrs. □ Miss □ Ms. □ Dr. □ Minor

Patient Name_____

Name you like to be called_____

Street Address_____

City_____ State_____ Zip_____

Home Phone_____

Work Phone_____

Cell Phone_____

Best number to reach you?_____

Employer_____

Occupation_____

Birthdate_____ □ Male □ Female

Social Security Number_____

Email Address_____

Today's date_____

Referred by_____

Name of general dentist_____

In case of emergency, please contact:

Name_____

Relationship_____

Work phone_____Home phone _____

Person responsible for your bill_____

Relationship to patient_____

PREFERRED PHARMACY

PHARMACY NAME_____

CROSS STREETS_____

How did you find our office?

___General Dentist ___Friend ___Internet ___Phone book

DENTAL INSURANCE

Do you have dental insurance? □Yes □ No

Dental Insurance company_____

Group number _____

Insurance company phone # _____

Person with primary coverage _____

Their birthdate _____

Their employer_____

Their Social Security or ID#_____

MEDICAL HISTORY

Are you currently under the care of a physician? □ Yes □ No

If yes, please explain_____

_____

Physician's name and phone number_____

Are you currently taking any medications or herbal supplements? □ Yes □ No

If yes, please list medications and/or supplements and doses per day_____

_____

_____

Are you pregnant or breast feeding? □ Yes □ No Due date_____

If applicable, are you taking birth control? □ Yes □ No

Do you require antibiotics for joint replacements or heart conditions prior to dental treatment? □ Yes □ No

Have you ever taken any bone density related treatment medications? (ie. bisphosphonates) □Yes □ No

Have you ever had an abnormal response to dental treatment or dental anesthetic? □ Yes □ No

Are you allergic to any of the following?

Penicillin/ Amoxicillin	□ Yes □ No	Doxycycline/ Tetracycline	□ Yes □ No
Sulfa drugs	□ Yes □ No	Erythromycin	□ Yes □ No
Latex	□ Yes □ No	Codeine	□ Yes □ No
Aspirin	□ Yes □ No		

Are you allergic to any other drugs or substances? □ Yes □ No

If yes, please list_____

Do you have or have you ever had any of the following diseases or medical conditions? (If yes, please describe details)

Heart disease	□ Yes □ No	Pacemaker/Defibrillator	□ Yes □ No
Heart surgery	□ Yes □ No	Low blood pressure	□ Yes □ No
Heart defect	□ Yes □ No	High blood pressure	□ Yes □ No
Rheumatic fever	□ Yes □ No	Arrhythmia	□ Yes □ No
Heart murmur	□ Yes □ No	Arthritis	□ Yes □ No
Artificial heart valve	□ Yes □ No	Drug dependency	□ Yes □ No
Glaucoma	□ Yes □ No	Alcohol dependency	□ Yes □ No
Anemia	□ Yes □ No	Emphysema/ COPD	□ Yes □ No
Sinus/ Ear problems	□ Yes □ No	Seizures	□ Yes □ No

Do you have or have you ever had any of the following diseases or medical conditions? (If yes, please describe details)

Liver disease	□ Yes □ No		Kidney disease	□ Yes □ No	
Osteoporosis	□ Yes □ No		Cancer/ Leukemia	□ Yes □ No	If yes, when? _____
Lupus	□ Yes □ No		Bleeding disorder	□ Yes □ No	
Asthma	□ Yes □ No		HIV/AIDS	□ Yes □ No	
Tuberculosis	□ Yes □ No		Bronchitis	□ Yes □ No	
Depression/ Anxiety	□ Yes □ No		Headaches/ Migraines	□ Yes □ No	
Hypo/Hyperthyroidism	□ Yes □ No		Diabetes	□ Yes □ No	Type_____
Ulcers/ colitis	□ Yes □ No		Jaw pain or disorder	□ Yes □ No	

Heart attack □ Yes □ No If yes, when?_____

Stroke □ Yes □ No If yes, when?_____

Hepatitis □ Yes □ No If yes, what type?_____ and what year was it diagnosed?_____

Any other medical condition not listed? □ Yes □ No If yes, please list. (space provided also to describe conditions from list above) _____

SIGNATURE_____ DATE_____

SIGNATURE_____ DATE_____

SIGNATURE_____ DATE_____

AKNOWLEDGEMENT OF PRIVACY RIGHTS

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, unde the Health Insurance & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

1. Provide and coordinate my treatment among a number of health care providers who may be involved in that treatmen directly or indirectly.
2. Obtain payment from third-party payers for my health care sérvices
3. Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review such *Notice of Privacy Practices.* understand that my dental provider has the right to change the *Notice of Privacy Practices,* and that I may contact this office to obtain a current copy of the practices.

I understand that I may request in writing that this office restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I understand that the office is not required to agree to my requested restrictions, but if the office does agree then it is bound to abide by such restrictions.

Patient Name (PRINT)_____ Date_____

Signature_____

Relationship to Patient_____

INTRODUCTION QUESTIONNAIRE

PLEASE CIRCLE YES OR NO

Has anyone every encouraged you to seek periodontal therapy before? ..... YES NO

Has periodontal disease and therapy been explained to you? ..... YES NO

If yes, when and by whom? _____

Do you know the meaning and importance of dental plaque and dental calculus (i.e. tartar)? ..... YES NO

Have you ever had periodontal therapy? ..... YES NO

If yes, when and why? _____

When was your last dental examination? _____

What was done as a result of that examination? _____

How often did you go to the dentist before then? _____

What has been your most common reason for going to the dentist? _____

_____

Are you satisfied with your previous dental care? ..... YES NO

Have you had any serious trouble associated with dental treatment? ..... YES NO

If yes, explain _____

Have you had any teeth extracted (pulled)? ..... YES NO

If yes, explain _____

Have you ever had endodontic therapy? (i.e. a root canal to remove the nerve from a tooth) ..... YES NO

Have you ever had orthodontic treatment? (had your teeth straightened) ..... YES NO

Has a dentist ever equilibrated your bite? (reshaped your teeth to make them fit together better) . YES NO

Has a dentist made you an appliance to protect your teeth from grinding or clenching forces? ..... YES NO

If yes, do you wear it every night? ..... YES NO

Would you consider yourself to be a good patient? ..... YES NO

If not, why? _____

Has a dentist ever used anything to help you relax during a dental appointment? ..... YES NO

If yes, what was used and how did you feel about it? _____

Are you satisfied with the appearance of your teeth? ..... YES NO

Do you want to try to maintain your own teeth? ..... YES NO

How do you feel about dentures? _____

Would it disturb you if you lost your teeth some day? ..... YES NO

Are you aware that your diet can affect your teeth and your gums? ..... YES NO

Do you eat refined carbohydrates (ie. Sugar, white bread, pastries, candy, cookies, Coke, etc.)? YES NO

Do you regularly eat foods from each of these categories: ..... YES NO
Milk and dairy products, grain and cereals, meats, fruits and vegetables?

How would you assess your normal diet as far as nutrient content? .....GOOD FAIR POOR

Do you supplement your diet with vitamins, minerals, wheat germ, etc.? ..... YES NO

Do you frequently or habitually smoke? ..... YES NO

If yes, would you be willing to quit smoking in order to preserve your teeth? ..... YES NO

Do you frequently or habitually drink alcoholic beverages? ..... YES NO

Are you aware of a habit of grinding or clenching your teeth? ..... YES NO

If yes, which habit _____ When do you clench or grind? _____

How long have you been aware of this habit? _____

Do you have any other oral habits (such as biting your fingernails, pencils, paper clips, thread, or pipe stems)?

_____

DR. PETRA I. MAYER DDS, PC

INSURANCE AND FINANCIAL POLICY:

Please Initial

_____ We will gladly file an insurance claim to your primary insurance carrier for you. Please understand that insurance companies rarely reimburse the full amount, usually only paying between 30 to 50% after all deductibles have been met. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some insurance companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any balance not paid by your insurance company within 60 days after treatment.

_____ We will be happy to submit a pretreatment estimate to your insurance company. This usually takes four to six weeks to receive a reply. The portion you will pay will be the difference between our submitted fees and the amount the insurance company will pay, not the difference between their allowed fees and the amount they will pay.

_____ If we do not have a pretreatment estimate from your insurance carrier or you decide against having a pretreatment estimate submitted to your insurance carrier prior to your treatment or surgical procedure, we will require a 50% down payment at the time of service.

_____ Insurance companies do not routinely pay for more than two exams and cleanings per year. Therefore, we must collect for all exams and cleanings at the time of service.

_____ If you do not supply us with complete and accurate insurance information, you will be required to make payment in full for all services.

_____ Please understand that payment in full will be expected within 60 days of treatment even if your insurance has not paid. A finance charge of 1.5% (18%APR) will be assessed after that time on all remaining balances. Outstanding balances over 90 days will be turned over to a professional collection agency.

_____ Financial arrangements are individualized for every patient. Please speak to the office manager if you need to make other financial arrangements.

_____ There is a $30.00 fee for any returned checks.

_____ I can read and understand English. My questions have been answered to my satisfaction.

CANCELLATIONS:

_____ We require a 48 hour (2 business days) cancellation notice for any appointment other than surgery or there will be a $75.00 fee assessed. We require a one week notice for surgery cancellations or there will be a $200.00 fee assessed. Please remember our office is only open Monday through Thursday.

The responsible party understands and agrees to the financial policy outlined above and will be responsible for all fees for treatment. The signature below is my authorization for release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

_____ _____ _____

Date Signature of patient (or Guardian if minor) Witness