



# Maplewood Dental Associates, P.A.

## Welcomes You!

"Dentistry for the Entire Family"

**OFFICE USE ONLY**

Today's Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Account # \_\_\_\_\_

### Patient Information

PATIENT LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_ MI \_\_\_\_\_

STREET ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

Home: (\_\_\_\_) \_\_\_\_\_ Work: (\_\_\_\_) \_\_\_\_\_

Email: \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex:  Male  Female

SS#: \_\_\_\_\_

Employer: \_\_\_\_\_

Full-time Student?  Yes  No

If Yes, College attending: \_\_\_\_\_

Name of responsible party: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

\*\*Not referred by an individual? Select your referral source:

Insurance  Mailing  Yellow Pages  Location

Medical Assistance  Other \_\_\_\_\_

#### NOTICE OF PRIVACY POLICY & CONSENT

A copy of our Notice of Privacy Policy accompanies this consent form. We encourage you to review it carefully. By signing this form, you are consenting to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

It is your right to revoke this consent at anytime by giving us written notification.

Signature of responsible party: \_\_\_\_\_

Relationship: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

#### Emergency Contact

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

#### Dental History

Reason for today's visit: \_\_\_\_\_

Date of Last Dental Cleaning: \_\_\_\_/\_\_\_\_/\_\_\_\_ Former Dentist: \_\_\_\_\_ Name \_\_\_\_\_ City \_\_\_\_\_

How often do you brush? \_\_\_\_\_ How often do you floss? \_\_\_\_\_

Are you pleased with the appearance of your teeth?  Yes  No Explain: \_\_\_\_\_

Are any of your teeth sensitive to hot, cold, or sweet items?  Yes  No Explain: \_\_\_\_\_

Do your gums bleed when brushing?  Yes  No Explain: \_\_\_\_\_

Have you had Periodontal (Gum) treatment?  Yes  No Explain: \_\_\_\_\_

Have you noticed any problems of the jawclicking or popping?  Yes  No Explain: \_\_\_\_\_

### Dental Insurance

Name of Policy Holder: \_\_\_\_\_

Relationship: \_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

SS#: \_\_\_\_\_ Coverage:  Single  Family

Employer: \_\_\_\_\_

Insurance Co. \_\_\_\_\_ Phone #: \_\_\_\_\_

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

Group #: \_\_\_\_\_ Effective Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Are you covered by additional insurance?  Yes  No

Name of Policy Holder: \_\_\_\_\_

Relationship: \_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

SS#: \_\_\_\_\_ Coverage:  Single  Family

Employer: \_\_\_\_\_

Insurance Co. \_\_\_\_\_ Phone #: \_\_\_\_\_

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

Group #: \_\_\_\_\_ Effective Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

#### ASSIGNMENT & RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage through the above noted insurance company and assign directly to Maplewood Dental Associates, P.A. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of responsible party: \_\_\_\_\_

Relationship: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_