MONTCHANIN IMPLANT CENTER
G. WILLIAM KELLER, D.D.S.
MARIA TIBBS, D.D.S., M.S.
periodontics and implantology

Patient Information

Patient Name: ____ Date:__________
Last First MI (Preferred Name)

Gender: ____________ Family Status: ____________

Social Security #: ______________________________ Birth Date: ___________________________

Phone (Home): ____________ (Work): ______________ Ext: _______ (Mobile):________________

E-Mail address_________________________ Preferred Contact Method____________

Address: ____
Street Apartment #

____
City State Zip Code

Health Information

Date of Last Dental Visit: ________________ REASON FOR REFERRAL ______________________________

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

- ☐ AIDS
- ☐ Allergies
- ☐ Cholesterol
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ DIABETES
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ OSTEOPOROSIS
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Anxiety/Depression
- ☐ Pacemaker
- ☐ Pregnancy
  Due date: __________
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy

OTHER:
- ☐ _______________

- ☐ CURRENT SMOKER
  Date quit: _________

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: ____
- Do you take a vitamin D supplement? ☐ Yes ☐ No
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: ____
- Do you require antibiotic pre-medication prior to dental visits? ☐ Yes ☐ No What medication? ____________
  If yes, please explain: ____
- Name of Physician: ________________________________ Phone: ____________
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: ____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

____ Date: ________________
Signature of patient, parent, or guardian

Referral Information

Who may we thank for referring you to our practice? ☐ Another patient, friend ☐ Another patient, relative

☐ Dental Office ☐ Other - Online Search ☐ Other - Print Advertising ☐ Other - Social Media ☐ Other: _________

Name of General Dentist, friend or relative referring you to our practice: ______________________

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: ____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other ______________

Social Security #: ____________________________ Birth Date: ____________________________

Phone (Home): ______________ (Work): ______________ Ext: _____ Best time to call: ____________

Address: ____

Street Apartment #

____

City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: ______________________________ Occupation: ______________________________

Address: ____

Street City, State Zip Code Phone

Dental Insurance (Not Medical) Information

Primary

Name of Insured: ____ Is insured a patient? ☐ Yes ☐ No

Last First MI

Insured's Birth Date: ______________ ID **#:** __________________ Group #: ____________________

Insured's Address: ____

Street City State Zip Code

Insured's Employer Name: ____

Address: ____

Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other __________________

Insurance Plan Name and Address: ____

____

Secondary

Name of Insured: ____ Is insured a patient? ☐ Yes ☐ No

Last First MI

Insured's Birth Date: ______________ ID#__________________ Group #: ____________________

Insured's Address: ____

Street City State Zip Code

Insured's Employer Name: ____

Address: ____

Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other __________________

Insurance Plan Name and Address: ____

Consent for Services

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

Please be advised that consultations may be recorded for employee training purposes.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients' insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge on the unpaid balance may be charged on all accounts exceeding 90 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof.

I grant my permission to you or your assignee to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

____________________________________ Date: ___________ Relationship to Patient: ________________

Signature of patient, parent, or guardian

____________________________________ Date: ___________ Relationship to Patient: ________________

Signature of guarantor of payment/responsible party

MEDICAL INFORMATION

Patient Name:____ Date:____________________

Emergency Contact Name and Number: ____

DO YOU SMOKE? ____________ HOW MUCH? ____

Please attach a list of daily medications with dosage and conditions to this form or list medications and conditions below. Bringing this list with you to your scheduled appointment will save you considerable time.

____

____

____

DO YOU HAVE ANY JOINT REPLACEMENTS? _____________________

If yes, what was the date of your surgery? _______________________

DO YOU PREMEDICATE FOR DENTAL APPOINTMENTS? ______________________________________

If yes, with what medication? ____

DO YOU CLENCH OR GRIND YOUR TEETH OR HAVE YOU BEEN TOLD YOU DO? _________________

If yes, do you wear a night guard appliance? _______________________________

ARE YOU DIABETIC? Y____ N____ If Yes - Prediabetes Type 1 or Type 2? ____________

Medication: ____

Last A1C Level: _____________________ Date of Blood work: ________________

Provider who manages your Diabetes Name and Number: _________________________________

ARE YOU BEING TREATED FOR OSTEOPOROSIS/OSTEOPENIA? ___________

Medication: ____

Date of last injection (if applicable) ______________ Date of next injection ___________

Do you have an allergy to IODINE or SHELL FISH? ___________________________

Please list any Allergies or Uncomfortable reactions to medications, food or products:

____

PATIENT INTAKE FORM

Name: ___________________________ Date: ____________________

1. What are your main dental concerns and what brings you in today?

____

____

2. How are these concerns impacting your life on a day-to-day basis?

____

____

3. What are the most important factors/questions that you want to clarify prior to deciding to move forward with treatment?

____

____

4. Are you the primary decision maker for dental or healthcare decisions?

____

5. Have you seen another specialist for your current oral health condition? If "yes", what was your treatment plan?

____

____

HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

Date: ________________

The undersigned acknowledges review of a copy of the currently effective Notice of Privacy Practices for this healthcare facility (10-page document is available for review in our office. It will be copied upon request) A copy of this signed, dated document shall be as effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

______________________________ ______________________________

Please ***print*** name of Patient — Please ***sign*** for Patient / Guardian of Patient

______________________________ ______________________________

Legal Representative / Guardian — Relationship of Legal Representative / Guardian

Your comments regarding Acknowledgements or Consents: ______________________________

____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:

☐ First Name Only ☐ Proper Sir Name ☐ Other ________________________

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes stepparents, grandparents and any care takers who can have access to this patient's records):

Name: ________________________ Relationship: ___________________________

Name: ________________________ Relationship: ___________________________

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

☐ Cell Phone Confirmation ☐ Home Phone Confirmation ☐ Work Phone Confirmation
☐ Email Confirmation ☐ Text Message to my Cell Phone ☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

☐ Cell Phone Confirmation ☐ Home Phone Confirmation ☐ Work Phone Confirmation
☐ Email Confirmation ☐ Text Message to my Cell Phone ☐ **Any of the Above**

I AUTHORIZE **The Montchanin Center for Periodontics and Implantology, LLC** (DBA Montchanin Implant Center) to release to my insurance company or its intermediaries or carriers any information needed to process insurance claims. I permit a copy of this authorization to be used in place of the original and request payment of dental or medical insurance benefits either to myself or to the party who accepts assignment when indicated.

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

☐ It was emergency treatment ☐ The patient was unable to sign because ______________________________

☐ The patient refused to sign ☐ I could not communicate with the patient ☐ Other:______________________

____
Signature of Privacy Officer