Patient Information Form

Patient Name: _____ **Preferred/Nick Name:** _____
(Last) (First) (Middle Initial)

○ **Single** ○ **Married** ◉ **Child** ○ **Widowed** **DOB**: _____/_____/_____ **SSN:** _____-_____-_____

Address:_____ **Apt #:** _____

City: _____ **State:** _____ **Zip Code:**_____

Email: _____ **Hm Ph #:** (_____)_____
(Used to Confirm Appointments)

Wk Ph #: (_____)_____ **Cell Ph #:**(_____)_____ **Best # to Reach You:** Hm / Wk / Cell

Employer Name: _____ **Emp Ph #:** (_____)_____

Employer Address: _____

City: _____ **State:** _____ **Zip Code:**_____

Primary Care Physician: _____ **Ph #**: (_____)_____

Landlord/Apt. Complex: _____ **Ph #**: (_____)_____
(if you do not own your home)

Emergency Contact: _____ **Ph #:** (_____)_____

Whom may we thank for referring you? _____ **Ph #:** (_____)_____

Who is responsible for this Account? ☐ Same as Above _____

Address: _____ **Hm Ph #:** (_____)_____

SSN: _____-_____-_____ **DOB**: _____/_____/_____ **Wk Ph #:** (_____)_____

Primary Dental Insurance Information

Insurance Company: _____ **Ins Ph #:** _____

Claim Address: _____ **Group #:** _____

Subscriber Name: ☐ Same as Above _____
(Who's the employee)

SSN/ID#: _____ **DOB**: _____/_____/_____ **How long with this Employer?** _____

Employer/Group Name: _____ **Emp Ph #:** (_____)_____

Employer Address: _____

City: _____ **State:** _____ **Zip Code:**_____

Who is Covered Under this Policy? _____

Do You have Secondary Insurance Coverage? ☐ **Yes** ☐ **No**

_____ **Date**: _____
Signature

_____
Parent/Guardian Name (if minor)

Patient Name: _____ **DOB**: _____/_____/_____
(Please Print)

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

_____ Anemia
_____ Artificial Joints
_____ Asthma
_____ Blood Disease
_____ Cancer
_____ Diabetes
_____ Dizziness
_____ Epilepsy
_____ Excessive Bleeding
_____ Fainting
_____ Glaucoma
_____ Growths
_____ Head Injuries
_____ Heart Problems
_____ Heart Murmur
_____ Hepatitis
_____ High Blood Pressure
_____ HIV/Aids
_____ Jaundice
_____ Kidney Disease
_____ Liver Disease
_____ Mental Disorder
_____ Mitral Valve Prolapse
_____ Nervous Disorder
_____ Pacemaker
_____ Radiation Treatment
_____ Rheumatic Fever
_____ Rheumatism
_____ Seasonal Allergies
_____ Sinus Problems
_____ Stomach Problems/Ulcers
_____ Stroke
_____ Tuberculosis
_____ Tumors
_____ Venereal Disease
_____ _____

Surgeries: _____
_____
_____

Drug Allergies:_____
_____
_____
_____

Medications Currently Taking:
_____
_____
_____

Any Other Medical Info not listed above:
_____
_____
_____

_____ Have you ever been told to take Antibiotics before dental treatment? Y / N

Please Circle Yes or NO to the Following Questions:

Are you presently under the care of a Physician? Y / N
If yes, Who: _____
& Why: _____
Are you allergic to dental anesthetic? Y / N
Are you aware of a recent weight change? Y / N
Are you subject to frequent urination? Y / N
Are you often thirsty? Y / N
Are you often exhausted or fatigued? Y / N
Are you subject to frequent headaches? Y / N
Are you excessively nervous? Y / N
Are you in good health? Y / N
Do you smoke? Y / N
If yes, how much? _____
Does anyone in your family have diabetes? Y / N
Do you have prolonged bleeding after an injury? Y / N

If Female:

Are you presently in menopause? Y / N
Are you taking birth control pills? Y / N
Are you pregnant? Y / N
If Yes, Due Date: _____

Dental History (Please Circle):

How often do you brush your teeth?
Daily – 3x, 2x, 1x Other: _____
What type of toothbrush do you use?
Electric or Manual (Soft Med Hard)
Do you use Floss? Y / N
How often do you go to the Dentist?
Yearly – Once, Twice, Other: _____
When was your last Cleaning? _____
Have you had any teeth extracted? Y / N
Reasons for extractions?
Decay, Abscess, Looseness
Do you use Toothpicks? Y / N

Circle if you Have Any of the Following:

Mouth Ulcers
Receding Gums
Bleeding Gums
Halitosis (bad breath)
Sensitive Teeth
Loose Teeth
Grinding Teeth
Past Periodontal Tx
Clenching
Past Orthodontic Tx
Shifting Teeth
Trench mouth, (Pyorrhea
Who Treated your Perio / Ortho?
Dr. _____

Is there anything about your smile that you would like to change or improve? _____
_____

Signature: _____ **Date:** _____/_____/_____

MY Dentists
Drs, Michalski, Yeager and Pinnavaia
Consent for Use and Disclosure of Health Information

Print Name _____ DOB: _____

PLEAE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment payment activities and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities, and healthcare, operations of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our notice is available on our website. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices; we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Office Manager of Drs. Yeager, Michalski and Pinnavaia
Telephone: 704-375-8577 Fax: 704-331-9987
Address: 411 Billingsley Road, Suite 102 Charlotte, NC 28211

Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the contact person listed above. Please understand that revocation of this consent will not affect any action we took in reliance of this consent before we received your revocation and that we may decline to treat you or to continue treating you if you revoke this consent.

Signature: I have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that by signing this consent form I am giving my consent to your use and disclosure of my protected health information to carry out treatment payment activities and health care operations.

Please list any persons you wish to have access to your account: (All areas of account will be accessible, unless documented below.)

_____

_____

_____

_____

SIGNATURE _____ DATE _____

If not Patient, Print Name and Relation: _____

MY Dentists Financial Policies and Release of Information

Thank you for choosing MY Dentists for your dental health care. Our main concern is that you receive the proper and optimal treatment needed to restore your health.

It's important to remember that your insurance coverage is a contract between your employer and your insurance company. Benefits and coverage vary significantly from plan to plan depending upon what your employer has agreed to with the insurer. Please keep in mind that insurance is not designed to provide 100% benefit, but rather is meant to ***assist*** in the cost of dental care.

As a courtesy to our patients, we are happy to file claims on your behalf. To do this, you must provide us accurate and up-to-date insurance information.

- Your estimated out-of-pocket expense is required at the time of service unless prior arrangements have been made.
- We accept Cash, Check, Debit Cards, Visa, MasterCard, Discover, AMEX, and Care Credit.
- Once applicable insurance has paid, any remaining balance will be the responsibility of the patient due upon receipt of statement.
- Our office is committed to helping you maximize your insurance benefits. Because insurance policies vary, we can only estimate your coverage in good faith, but cannot guarantee coverage due to the complexities of insurance contracts.
- We recommend that all patients contact their insurance company to better understand their benefits and how claims will be processed.
- We will attempt to help you receive full insurance benefits; however, you are personally responsible for your account, and we encourage you to contact your insurance company if they have not paid within 30 days.
- Your treatment plan will include a breakdown of all applicable fees, and we will inform you of all costs before treatment is administered. If special arrangements are needed, please talk to our financial manager prior to receiving service.
- Any account 60 days or older will assess finance charges at a rate of 1-1.5% per month, 18% per year.
- If the patient is a minor (18 years and younger), the parent or guardian is responsible for payment of the account, in accordance with the policies outlined herein.

Missed Appointments: Your scheduled appointment time has been reserved specifically for you. If you are unable to keep an appointment please notify us (even after hours) at least 24 hours in advance. Failure to notify us less than 24 hours before your appointment may result in a minimum broken appointment charge of $42.00.

R**eturned Checks**: For checks returned to us, as unpaid by your bank, we will charge you a $35.00 fee.

Past Due Accounts: Over due accounts will be referred to a collection agency if more than 90 days past due. If your account goes to collection, you agree to be responsible for all fees involved in the collection process.

I certify that I have read and understand the "Financial Policies" and agree to all terms and conditions as stated above. I certify that the information that I have provided is correct to the best of my knowledge. I understand that it is my sole responsibility to verify insurance coverage and I also understand that it is my responsibility to inform MY Dentists of any changes associated with my insurance status. I agree to make an in-full, prompt payment to MY Dentists when billed for any and all charges not covered or paid by insurance. I hereby assign and direct to pay any and all benefits for dental services under this claim to MY Dentists.

I authorize the release of any dental information to my primary care or referring physician, to consultants if needed and as necessary to process my insurance claims and prescriptions. I authorize the use of this signature on all my insurance claims.

MY Dentists has my authorization to charge my credit card for any current or past due personal balance upon receiving my verbal or written permission.

Patient/Guardian Signature: _____ Date: _____

Submit