PATIENT INFORMATION

NAME____
Last First Middle How do you wish to be addressed?

ADDRESS____CITY______________________STATE_______ZIP___________

TELEPHONE (H) __________________________ (W) _________________________ (C) __________________________

DATE OF BIRTH: ________________________ SEX: M F SSN: _____ - ____ - _______

EMPLOYER____ OCCUPATION_____________________________________

BUSINESS ADDRESS____ PHONE ________________________

EMERGENCY CONTACT ______________________ RELATIONSHIP_____________ PHONE ________________________

PHYSICIAN______________________________ ADDRESS____

DENTAL HISTORY

CURRENT DENTIST_____________________________________ CITY____________________ STATE________________

Date of last dental visit____________________________ Date of last dental x-rays_______________________________

Reason for Today's Visit: ____

____

Whom may we thank for referring you? ____

Have you ever had any complications following dental treatment? YES NO

If so, please explain: ____

____

Please Circle:

BAD BREATH	YES	NO	BITE CHANGES	YES	NO	SENSITIVITY TO COLD	YES	NO
BLEEDING GUMS	YES	NO	RECEDING GUMS	YES	NO	SENSITIVITY TO HEAT	YES	NO
CLICKING/POP JAW	YES	NO	GUM TREATMENT	YES	NO	LOOSE TEETH	YES	NO
DRY MOUTH	YES	NO	MOUTH PAIN, BRUSHING	YES	NO	TENDER GUMS	YES	NO
SWOLLEN GUMS	YES	NO	ORTHODONTIC TREATMENT	YES	NO	CLENCHING/GRINDING	YES	NO
LIP/CHEEK BITING	YES	NO	FOOD TRAPPING	YES	NO	SPACE CHANGES	YES	NO

How often do you brush?________________________________ How often do you floss?___________________________

Are you unhappy with the appearance of your teeth? YES NO

How do you feel about your teeth in general? ____

Do you have any specific concerns? ____

MEDICAL HISTORY

Please circle if you have been treated or are under treatment for any of the following:

AIDS/HIV	YES	NO	HEART DISEASE	YES	NO	RESPIRATORY PROBLEMS	YES	NO
ANEMIA	YES	NO	HEART VALVE	YES	NO	RHEUMATIC FEVER	YES	NO
ARTHRITIS	YES	NO	HEPATITIS	YES	NO	SEIZURE DISORDER	YES	NO
ARTIFICAL JOINTS	YES	NO	HYPERTENSION	YES	NO	SINUS PROBLEMS	YES	NO
ASTHMA	YES	NO	HYPOTENSION	YES	NO	SLEEP PROBLEMS	YES	NO
BLEEDING DISORDER	YES	NO	INFLAMMATORY DISEASE	YES	NO	STD / VENEREAL DISEASE	YES	NO
CANCER	YES	NO	JAUNDICE	YES	NO	STOMACH PROBLEMS	YES	NO
DIABETES	YES	NO	LIVER DISEASE	YES	NO	STROKE	YES	NO
FAINTING	YES	NO	LUNG DISEASE	YES	NO	SUBSTANCE ABUSE	YES	NO
GLAUCOMA	YES	NO	PSYCHOLOGICAL	YES	NO	TUBERCULOSIS	YES	NO
HEAD INJURIES	YES	NO	RADIATION THERAPY	YES	NO	ULCERS	YES	NO

OTHER:

____

____

Do you smoke or use tobacco? YES NO If yes, how much ____________ packs per day

Do you consume alcoholic beverages? YES NO If yes, how much _____________ per day

Do you need to or have you needed to in the past pre-medicate for dental procedures? YES NO

If so, what antibiotic:

____

WOMEN: Are you pregnant? YES NO Are you nursing? YES NO

MEDICATIONS: (Please list all medications, including herbal, you are currently taking and dosages or provide us with a separate list.)

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____

ALLERGIES (PENICILLIN/LATEX):

____

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maine prosthodontics

Implants • Cosmetic Dentistry • Maxillofacial Prosthetics

INSURANCE AND FINANCIAL INFORMATION

Person Responsible for Account - Please Circle   Self / Guardian / Spouse / Father / Mother

PRIMARY DENTAL INSURANCE

Last Name:	________	First Name:	________	DOB:	________
Relationship (self, spouse):	________	Address:	________	City:	________
State:	________	Zip:	________	Employer:	________
Ins Co Name	________	Subscriber/ID #:	________	Group #:	________

SECONDARY DENTAL INSURANCE

Last Name:	________	First Name:	________	DOB:	________
Relationship (self, spouse):	________	Address:	________	City:	________
State:	________	Zip:	________	Employer:	________
Ins Co Name	________	Subscriber/ID #:	________	Group #:	________

PRIMARY MEDICAL INSURANCE

Last Name:	________	First Name:	________	DOB:	________
Relationship (self, spouse):	________	Address:	________	City:	________
State:	________	Zip:	________	Employer:	________
Ins Co Name	________	Subscriber/ID #:	________	Group #:	________

SECONDARY MEDICAL INSURANCE

Last Name:	________	First Name:	________	DOB:	________
Relationship (self, spouse):	________	Address:	________	City:	________
State:	________	Zip:	________	Employer:	________
Ins Co Name	________	Subscriber/ID #:	________	Group #:	________

Payment is due in full at the time of service*. We will file an insurance claim on your behalf, we kindly request that you provide your insurance information in advance of your appointment.*

We gladly offer pre-treatment estimates. Of course it is only an estimate and charges may differ depending on the nature of your procedure. Please be aware that your insurance policy is a contract between you and the insurance company, not Maine Prosthodontics. While we will gladly file a claim on your behalf, you are ultimately responsible for charges incurred.

Signature____ Date____________________________

I ATTEST TO ACCURACY OF INFORMATION ON THIS FORM.

* You May Refuse to Sign This Acknowledgment*

I have received a copy of this office's Notice of Privacy Practices.

Print Name: ____

Signature: ____

Date: ____

For Office Use Only

____

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

ð Individual refused to sign

ð Communications barriers prohibited obtaining the acknowledgement

ð An emergency situation prevented us from obtaining acknowledgement

ð Other (Please Specify)

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Managed Care Waiver Form

HMO's

Welcome to our practice. **IF YOU ARE BEING REFERRED TO OUR PRACTICE DUE TO A MEDICAL CONDITION** (i.e. cancer, radiation, chemotherapy, congenital birth defect, or a recent trauma to the head or neck) **please review and complete the information below.**

You will need to obtain a referral from your Primary Care Physician for an "Out Of Network – Non-Participating Provider as we are NOT enrolled as a Network Provider. However, we are the only practice in Maine, New Hampshire, and Vermont that is qualified and trained to perform Maxillofacial Prosthetics. We want to be sure that your medically necessary visit(s) go smoothly and meet your expectations. **Please bring your medical insurance card to your appointment.**

To date, we have not received confirmation of a referral. Please take a moment to review the statements below, and place a check mark by the description that best explains your understanding of the status of your referral to our practice.

_____ I did not obtain a referral from my Primary Care Physician and I am **knowingly** self-referring for this visit. I understand that I will be responsible for any charges.

_____ I did not obtain a referral from my Primary Care Physician because I do not believe it is required. I understand that if the services are a covered service the benefits may be decreased or not covered at all without the proper "Out of Network, Non-Par referral".

______ My Primary Care Physician has agreed to refer me for this visit and it appears your Office has not received the appropriate referral. I understand that it is my responsibility to contact my Primary Care Physician immediately to confirm this referral and to obtain the authorization number for this visit. If a referral authorization is not confirmed prior to my visit, I will be responsible for any charges.

____ ________________________

Patient Signature (Guardian) Date

If you have any questions regarding your insurance, please contact our office and speak with our Insurance Coordinator. Referrals to our specialty practice are for **medical reasons only**, not routine dental care.

Patient Financial Policy

Patient Name: ____

Patient Date of Birth: ____

Patient agrees to pay for all portions of services, due in full, at the time services are provided by our office. We work for you, and are committed to providing the best dental and medical care possible. Our Financial Coordinator will do everything possible to maximize benefits for your specific needs, which aren't always what your insurance company agrees to cover and/or determines that they will reimburse you.

Patient Financial Class Policies:

You are required to present a valid insurance card at every visit and as needed throughout your care.

Medical Commercial Insurance Carriers: We do not participate with or accept payment from any insurance company. *We ask that you pay us in full at the time of service.* We will assist you by filing a claim and any necessary documentation with your carrier and they will determine the reimbursement allowed for services based on your insurance policy's language**. *It is your responsibility to ensure all authorizations/referrals are in place prior to the start of treatment.***

Medicare Part B: Our office is a non-participating Medicare provider. We will file all of the necessary paperwork on your behalf; however, we ask that you pay us in full at the time of services. Medicare will reimburse you directly.

MaineCare (Medicaid): Our office is a MaineCare participating provider. We will bill MaineCare for you. ***All services that are NOT covered by MaineCare are the patient's responsibility and payment in full at the time of service is expected.***

Martin's Point: We do not participate with Martin's Point. We ask that you pay us in full at the time of service. We will assist you by filing a claim and any necessary documentation with Martin's Point and they will determine the reimbursement allowed for services. ***It is your responsibility to ensure all authorizations/referrals are in place prior to the start of treatment.***

Worker's Compensation: If you visit to our office is work related please provide your case number and the carrier's name prior to your visit in order for us to bill the worker's compensation company. ***We require written approval of procedures and the amount to be paid prior to the start of treatment.***

Dental Insurance: We do not participate with or accept payment directly from Dental Insurance Providers. We ask that you pay us in full at the time of service. We will assist you by filing a claim with your carrier and they will determine the reimbursement allowed for services based on your insurance policy provisions.

Cancellation Policy: You will be charged for failed or cancelled appointments without prior notification of 48 hours. This fee covers only a portion of the overhead such as salaries, electric, heat, etc., which still has to be paid whether you are present or not. Once an appointment has been made, please remember this time has been reserved for you.

Accepted Methods of Payment for Services:

For your convenience we accept: Cash, Personal Checks*, Credit cards (MasterCard, Visa, and Discover) as well as Debit cards.

If not paid according to the terms as outlined above; the patient (or person with financial responsibility) understands that outstanding balances will be sent to Collections after 90 days delinquent unless *prior to treatment* other arrangements have been made with our Financial Coordinator. In the event your account is turned over for collections, you agree to pay all additional fees accessed in the collection of the debt. These fees include collection agency and/or attorney fees incurred by our office.

*Returned checks are assessed a $25.00 NSF charge.

The patient is ultimately responsible for all fees for services. I have read, understood and agree to the above financial policy for payment of professional fees.

Signature: ____
(Patient/Guardian)

Date: ____