MAPLE LEAF DENTAL

NEW PATIENT FORM

PATIENT INFORMATION

Patient's last name:	First:	Middle:	Today's date:		
Marital status: ☐ Single ☐ Married ☐ Other	Social Security#:	Driver's License #:	Birth date:	Age:	Sex: ☐ M ☐ F
Street address:				Home Phone:	
Apt #:	City:	State:	ZIP Code:	Cell Phone:	
Occupation:	Employer:			Work Phone:	
E-mail Address:					

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Name of Insured: Last Name:	First:	Middle:	Birth date of insured:	SSN of Insured:
Insurance Plan Name:				
Insurance Plan Address:				
P.O. Box	City:	State:	ZIP Code:	Insurance Plan Phone:
Employer Name:				

You are responsible for knowing your insurance plan benefits and what portion of charges it may pay, if any.

HOW DID YOU HEAR ABOUT US?

☐ Referred by a friend	☐ Relative	☐ Insurance Plan	☐ Radio Ad
☐ Direct Mail	☐ Outdoor Sign / Drove by	☐ Walk in	☐ Website
☐ Online	☐ Search engine	☐ Other	

What was the primary reason you chose to come to us?

IN CASE OF EMERGENCY

Name of Primary Medical Doctor:		Phone:	
Name of local friend or relative (not living at same address):	Relationship to patient:	Home Phone:	Work Phone:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the dentist. I understand that I am financially responsible for any balance. I also authorize Maple Leaf Dental or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

14754 Memorial Dr, Suite 100 Houston, TX 77079 ☎ 281.497.5558 281.497.7181 office@mymapleleafdental.com

MAPLE LEAF DENTAL

MEDICAL HISTORY FORM

Today's date:	Patient Name:

DENTAL HEALTH INFORMATION		
☐ Yes	☐ No	Are you currently under a physician's care?
		If yes, what for? _____
		Treating physician's name: _____ Phone Number: _____
☐ Yes	☐ No	Have you had any serious illness, operations, or hospitalization?
		If so, describe and give approximate dates: _____
☐ Yes	☐ No	Has there been any change in your general health in the past year?
☐ Yes	☐ No	Have you ever had intravenous sedation or general anesthesia?
☐ Yes	☐ No	Do you have dental anxiety and would like to discuss options? Eg: Nitrous oxide or sedation

OTHER HEALTH INFORMATION		
Do you have or have you ever had:		
☐ Yes	☐ No	Rheumatic fever or Rheumatic heart disease?
☐ Yes	☐ No	Cardiovascular disease (chest pain, heart attack, high blood pressure, stroke, heart surgery, angioplasty, pacemaker)?
☐ Yes	☐ No	Lung disease (asthma, emphysema, chronic cough, bronchitis, pneumonia, TB, shortness of breath)?
☐ Yes	☐ No	Neurologic disorders (seizures, epilepsy, fainting, dizziness, nervous disorder)?
☐ Yes	☐ No	Blood disease (bleeding disorder, anemia, blood transfusion, do you bruise easily)?
☐ Yes	☐ No	Liver disease (jaundice, hepatitis)?
☐ Yes	☐ No	Kidney disease?
☐ Yes	☐ No	Arthritis? (which joints)?
☐ Yes	☐ No	Stomach ulcers or intestinal problems?
☐ Yes	☐ No	Glaucoma?
☐ Yes	☐ No	Frequent or recurring mouth sores?
☐ Yes	☐ No	Implants / artificial joints anywhere in the body? (heart valve, hip, knee)?
☐ Yes	☐ No	Radiation therapy (X-ray treatment for cancer) in head or neck region?
☐ Yes	☐ No	Noises in jaw joint, pain near ear when chewing, or do you grind or clench your teeth?
☐ Yes	☐ No	Sinus or nasal problems?
☐ Yes	☐ No	Any disease, drug, or transplant operation that has depressed your immune system?
☐ Yes	☐ No	Recurrent infections of any kind?
☐ Yes	☐ No	HIV or AIDS Virus?
☐ Yes	☐ No	Tuberculosis?

MAPLE LEAF DENTAL

MEDICAL HISTORY FORM

Today's date:	Patient Name:

PRESCRIPTIONS & ALLERGIES

List current medications / drugs / supplements below:

Are you allergic to or have had a bad reaction from:

☐ Yes	☐ No	Local anesthetic (Novocaine-like drug)?
☐ Yes	☐ No	Penicillin, Amoxicillin, Cephalosporins? Other:
☐ Yes	☐ No	Other antibiotics?
☐ Yes	☐ No	Barbiturates, sedatives?
☐ Yes	☐ No	Aspirin, ibuprofen, NSAIDS, or other pain medicines?
☐ Yes	☐ No	Codeine or other narcotics or opioids?
☐ Yes	☐ No	Latex?

Other allergies or reactions (provide a brief explanation):

☐ Yes	☐ No	Do you have hay fever, frequent skin rashes, etc.? Do you use alcohol? If so, how much per day? ____
☐ Yes	☐ No	Do you smoke? If so, what product and how many per day?_____For how long? _____
☐ Yes	☐ No	Do you use spit tobacco? If so, for how long? _____
☐ Yes	☐ No	Are you, or have you ever been, in a drug or alcohol recovery program?
☐ Yes	☐ No	Do you have any other medical condition not listed above that you think the doctor should know about?
☐ Yes	☐ No	Do you wish to talk to the doctor privately about anything?

WOMEN ONLY

☐ Yes	☐ No	Are you taking birth control medication?
☐ Yes	☐ No	Are you pregnant, trying to become pregnant, or <u>any chance</u> you might be pregnant?
☐ Yes	☐ No	Are you breast feeding?
☐ Yes	☐ No	Are you taking hormonal replacement?

MEDICAL HISTORY SIGNATURE

I understand the importance of a truthful health history and realize that incomplete information may have an adverse effect on my treatment. To the best of my knowledge, the information above is complete and accurate.

Name of person completing this section (of different than patient) and relationship to patient:

Signature of person completing health history *Date*

Doctor's initials: _____

14754 Memorial Dr, Suite 100 Houston, TX 77079 ☎ 281.497.5558 281.497.7181 office@mymapleleafdental.com

To My Appreciated Patient,

This year marks the beginning of many exciting changes. Our vision is to create a warm, welcoming and family oriented environment that offers quality dental health care. We hope to exceed your expectations as your team of caring, honest professionals, and to earn the loyalty and trust of our patients, who in turn will appreciate our value and time. We intend to be committed to your overall well-being by focusing on patient awareness and offering you choices of available care, which will impact your health in a positive way.

Therefore, the following policies must be agreed upon:

1. Emergencies: It is our goal to eliminate all of the potential dental emergencies you may have by providing care for you before it becomes a problem. In the rare instance that you do have an emergency we will provide you with the next available emergency appointment.
2. We request that you be on time for your visits. If you are more than 10 minutes late, you may have to reschedule your appointment.
3. If you miss an appointment, we ask that you call to reschedule. It is critical to your health to do so to avoid setbacks in your oral health.
4. No-shows are not acceptable. Failure to make an appointment not only compromises your health but inconvenience other patients who may have requested an office visit during your scheduled appointment. If you cannot make an appointment (except in the case of an emergency) you are expected to call within 48 hours of your appointment to reschedule. **There is a $100.00 fee for all no-show appointments and this fee is not covered by insurance.** A portion of this fee will be donated to a charity of our choice.
5. Insurance: Treatment recommendations are based on your health not on your insurance or lack thereof. If you have insurance, it is your responsibility to be aware of what your benefits are. Remember insurance companies are not concerned about your health or well-being, we are. As a courtesy we will provide you with an estimate of benefits; however, you are fully responsible for any treatment performed. Your benefits are a contract between you and your insurance company. As a reminder, we cannot be responsible for what your insurance will or will not cover.
6. We run a Zero Balance office. In order to achieve this, we require 50% of your total patient out of pocket expense to reserve an appointment with Dr. Giovanetti. Please contact our office if you have any questions regarding financial options.

In closing, our goal is to create an exceptional experience every time you visit out office. Please feel free to discuss any issues that arise. No problem is too big or too small.

Yours in Health,

Dr. Giovanetti

_____	_____
(Patient's Printed Name)	(Patient's Signature)
_____	_____
(Date)	(Staff Signature)

RELEASE

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

I AUTHORIZE THE DENTIST TO PERFORM DIAGNOSTIC PROCEDURES AND TREATMENT AS MAY BE NECESSARY FOR PROPER DENTAL CARE, INCLUDING X-RAYS.

I AUTHORIZE RELEASE OF ANY INFORMATION CONCERNING MY (OR MY CHILD'S) HEALTH CARE, ADVICE, AND TREATMENT PROVIDED FOR THE PURPOSE OF EVALUATING AND ADMINISTERING CLAIMS FOR INSURANCE BENEFITS.

I AUTHORIZE RELEASE OF ANY INFORMATION CONCERNING MY (OR MY CHILD'S) HEALTH CARE, ADVICE, AND TREATMENT TO ANOTHER DENTIST.

I AUTHORIZE PHOTOGRAPHS TO BE TAKEN, INTRAORALLY AND EXTRAORALLY. I AUTHORIZE USE OF THESE PHOTOGRAPHS BY THE DENTIST WITHIN THE PRACTICE, AS WELL AS EXTERNALLY, FOR EDUCATIONAL PURPOSES AND/OR CASE PRESENTATIONS. I AUTHORIZE THE DENTAL STAFF TO VERIFY MY CREDIT WORTHINESS IN ANTICIPATION OF POSSIBLE EXTENSION OF CREDIT.

I HEREBY AUTHORIZE PAYMENT OF INSURANCE BENEFITS OTHERWISE PAYABLE TO ME DIRECTLY TO MAPLE LEAF DENTAL. IF THE INSURANCE COMPANY MISTAKENLY REIMBURSES ME, I AM RESPONSIBLE FOR SIGNING ANY REIMBURSEMENT OVER TO LISA GIOVANETTI, DDS.

I UNDERSTAND THAT MY DENTAL CARE INSURANCE CARRIER OR PAYOR OF MY DENTAL BENEFITS MAY PAY LESS THAN THE ACTUAL BILL FOR SERVICES. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR PAYMENTS IN FULL OF ALL ACCOUNTS. BY SIGNING THIS STATEMENT, I REVOKE ALL PREVIOUS AGREEMENTS TO THE CONTRARY AND AGREE TO BE RESPONSIBLE FOR PAYMENT OF SERVICES NOT PAID, IN WHOLE OR PART, BY MY DENTAL CARE PAYOR OR GUARANTOR.

PATIENT/PARENT (GUARDIAN)_____**DATE:** _____

ACCOUNT GUARANTOR (IF DIFFERENT)_____ **DATE:** _____

CONSENT FOR USE AND DISCLOSURE
OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name:_____

Address:_____

Telephone:_____ Email:_____

Social Security #: _____

SECTION B: TO THE PATIENT – PLEASE 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 accompanies this Consent. 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. If we change our 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 Dave Swift, Privacy Officer, at our office by phone, fax, mail, or email.

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

Signature:_____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:
Personal Representative Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT