Merchant Walk Dental, P.C

How did you hear about our office? Or whom may we thank for your referral? (Circle One)
GOOGLE YELP WEBSITE ZOCDOC 1800DENTIST DRIVE BY OTHER PATIENT: _____

Patient Information:

Patient's Full Name: _____

Nickname: _____(□ Single □ Married □ Divorced □ Separated □ Widowed) (□ Male □ Female)

Address: _____ Apt____ City _____ State_____ Zip_____

Social Security Number _____Date of Birth: _____/_____/_____

Employer _____Occupation _____

Full Time Student? (□ Yes □ No) If Yes, Name/Location of School: _____

Business Address _____ Suite _____City_____ State_____ Zip_____

Employee Phone #: (_____)_____ Ext: _____Home Phone #: (_____)_____

Cell Phone #: (_____)_____ Email Address: _____

May we send appointment reminders by email? _____ Reminders by text message? _____

Emergency Contact Information:

Full Name: _____ Relationship to Patient: _____

Daytime Phone #: (_____)_____ Evening Phone #: (_____)_____

Address:_____ Apt _____ City_____ State_____ Zip_____

Primary Insurance:

Insurance Company Name _____ Insurance Company Phone #: _____

Dental Claims Mailing Address: _____

Social Security # _____Member ID #_____

Group/ Policy #_____ Employer _____

Full Name:_____ Date of Birth:_____/_____/_____

Secondary Insurance:

Insurance Company Name _____ Insurance Company Phone #: _____

Dental Claims Mailing Address: _____

Social Security # _____Member ID #_____

Group/ Policy #_____ Employer _____

Full Name:_____ Date of Birth:_____/_____/_____

I understand that it is my responsibility to immediately notify Merchant walk Dental Dental of any changes to my address, phone number, work contact information, work status, insurance changes, ect.

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Dental/Medical History

Dental History:

Are you in any dental discomfort? : _____

What is your reason for visit today? : _____

Date of last of professional cleaning: (MM/YYYY) _____/_____ Date of last x-rays: _____/_____

Previous Dentist: _____ Phone # and Location: _____

Check if you have or have had any of the following:

____ Bad Breath	____ Food collection between teeth	____ Periodontal Treatment
____Bleeding Gums	____Grinding or clinching teeth	____Clicking or popping of jaw
____Dry Mouth	____Loose teeth or broken fillings	____Sores or growths in mouth
____Sensitivity to sweets	____ Sensitivity when biting	____Sensitivity to hot or cold

How often do you brush? _____ How often do you floss? _____

How would you rate your smile on a scale of 1-10? (Circle) 1 2 3 4 5 6 7 8 9 10

What would you like to change or immediate dental concern? _____

Do you have any dental fears or anxiety? Explain: _____

Are you happy with the color of your teeth? _____ Have you considered bleaching? _____

Medical History:

Are you under a physician's care now? (Y) (N) If Yes, please explain:_____

Have you hospitalized in the last 3 years? (Y) (N) If Yes, please explain:_____

Have you ever had a head or neck injury? (Y) (N) If Yes, please explain:_____

Are you taking any medications? (Y) (N) If yes, please list all:_____

Have you taken Phen-Fen or Redux? (Y) (N) _____

Have you ever taken Fosamax, Boniva, _____

Actonel, or any other bisphosphonates? (Y) (N) _____

Are you on a special diet? (Y) (N) ***WOMEN ONLY***: Are you:

Do you use tobacco? (Y) (N) Pregnant? (Y) (N) Trying to get pregnant? (Y) (N)

Do you use controlled substances? (Y) (N) Nursing? (Y) (N) Birth-control? (Y) (N)

Are you allergic to any of the following?

□ Aspirin □ Penicillin □ Codeine □ Acrylic □ Metal □Latex □ Local Anesthetics

□ Sulfa Drugs □ Other If yes, please list: _____

Do you have, or have you had, any of the following?

☐ Autism Spectrum Disorder ☐ Not listed: _____

☐Aids/HIV Positive	☐Chest Pains	☐ Frequent Headaches	☐Hypoglycemia	☐Rheumatic Fever
☐Alzheimer's	☐Core Sores	☐Genital Herpes	☐Irregular Heartbeat	☐Rheumatism
☐Anaphylaxis	☐Congenital Heart	☐Glaucoma	☐Kidney Problems	☐Scarlet Fever
☐Anemia	☐Convulsions	☐Hay Fever	☐Leukemia	☐Shingles
☐Angina	☐Cortisone Medicine	☐Heart Attack	☐Liver Disease	☐Sickle Cell Disease
☐ Arthritis/Gout	☐Diabetes	☐Heart Murmur	☐Low Blood Pressure	☐Spinal Bifida
☐Artificial Heart Valve	☐Drug Addiction	☐Heart Pacemaker	☐Lung Disease	☐Stomach Disease
☐Artificial Joint	☐Easily Winded	☐Heart Trouble/Disease	☐Mitral Valve Prolapse	☐Stroke
☐Asthma	☐Emphysema	☐Hemophilia	☐Osteoporosis	☐Swelling of Limbs
☐Blood Disease	☐Epilepsy or Seizures	☐Hepatitis A	☐Pain in Jaw Joints	☐Thyroid Disease
☐Blood Transfusion	☐Excessive Bleeding	☐Hepatitis B or C	☐Parathyroid Disease	☐Tonsillitis
☐Breathing Problem	☐Excessive Thirst	☐Herpes	☐Psychiatric Care	☐Tumors or Growths
☐Bruise Easily	☐Fainting Spells/Dizziness	☐High Blood Pressure	☐Radiation Treatment	☐Ulcers
☐Cancer	☐Frequent Cough	☐High Cholesterol	☐Recent Weight Loss	☐Venereal Disease
☐Chemotherapy	☐Frequent Diarrhea	☐Hives or Rash	☐Renal Dialysis	☐Yellow Jaundice

I have answered all questions above honestly and to the best of my ability.

_____ _____

Signature **Date**

Merchants Walk DENTAL'S FINANCIAL POLICY

Payment/Financing Policy

All payments/co-pays for services is expected on the day of your appointment. We accept cash, money orders, debit cards, and all major credit cards including: MasterCard, Visa, Discover, and American Express. We will ***ONLY*** accept personal checks from established patients that have a good payment history with our office. If you are eligible, you can finance your treatment plan. Our office offers treatment financing through non-affiliated, third-party lenders (such as CareCredit & Citi Health). This is based on credit approval and offers no-interest promotional plans. This will allow patients to continue their treatment while making low monthly payments. All applications can be filled out right here in our office and all decisions are instant.

Treatment Plan Estimates

Our office prepares a Treatment Plan Estimate so that patients can understand the estimated costs of their recommended treatment prior to its start. The Treatment Plan Estimate is a good-faith attempt to predict the cost of your treatment based on the facts known to us when the estimate is made. As your treatment progresses, your dentist may determine in consultation with you that different or additional treatment is necessary and your financial responsibility may change.

Insurance Policy

This office accepts insurance, however, I understand that it is solely my responsibility to confirm which treatments or procedures are covered and/ or paid by my insurance (including, but not limited to, any applicable deductibles, exclusions, and annual or lifetime maximums.) As a courtesy, Merchant Walk Dental will attempt to verify my insurance coverage from the information that I provide and will file a claim for each visit. I am required to pay the estimated portion of any procedures or treatment that will not be covered by my insurance in full the day of service is rendered. I understand that insurance claims will only be filed if I provide Merchants Walk Dental with my correct social security number and/or insurance identification number. Merchants Walk Dental will estimated what my balance will be, and I understand that although I pay my estimated patient balance on the date of service, the insurance estimate may differ from what my insurance carrier ultimately pays. There is no guarantee of payment until a claim has been processed. I will be responsible for any amounts not paid by my insurance for any reason, and I may receive a bill/statement for any balance due which will mailed immediately payable upon receipt.

Account Balances/ Collections

All account balances over 30 days will incur an interest charge at the maximum rate allowed. I understand that I will be charged the maximum service charge allowed by law for any returned check, electronic transaction or any debit sent or provided at Merchants Walk Dental. I must inform Merchants Walk Dental, in writing, of any concerns, questions, or disputes that I may have concerning the treatment or charges in a timely manner but not more than 30 days from either the completion of a procedure or awareness of dispute. I understand that if I fail to pay my account upon it becoming due, Merchants Walk Dental may report my account to credit rating bureaus or to a collection agency and/or take legal action against me for full payment, including but not limited to all related reasonable attorney fess, collection and/or court costs.

Discontinuing Treatment/ Refund Policy

Our office will refund any amount paid for treatment that you did not receive. However, I understand if I discontinue treatment for a requested procedure, including but not limited to partials, dentures, crowns, bridgework, or whitening trays, I remain responsible for paying all lab related costs for materials and services that were incurred before I discontinued treatment. All related costs will be deducted from any refund in which I may be entitled for discontinuing treatment and I may receive a bill/statement for a balance due. Patients requiring crown or bridge services may cancel treatment with no charge prior to natural teeth being prepared or altered for the prosthetic. All Refunds will be processed back to the original form of payment, except cash payments will be refunded by check.

No Show/Cancellation Policy

I understand that I will be charged $30 for any no call/no show appointments. If you are unable to keep your appointment, kindly give a 24 hour notice, or our office has the right to charge.

I have read and agree to the above terms and conditions. I may request a copy of this policy.

Signature: _____ Date:_____

Print Name: _____ Relation: _____

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Merchants Walk Dental Dental's Privacy Policy:

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

1) Conduct, plan and direct my treatment and follow- up among the multiple healthcare providers who may be involved in that treatment directly and/or indirectly.
2) Obtain payment from third-party payers, such as an insurance company.
3) Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you or your Notice of Privacy Practice containing a more complete description of the uses and discloses of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree than you are bound to abide by such restrictions.

By signing below, I acknowledge that I have been given the right to review Merchants Walk Dental Dental's Notice of Privacy Practices, as mandated by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") prior to signing this consent.

Signature_____ Relationship: _____Date_____

Authorization to Discuss Patient Medical Care

How is the information on the form used?
Anytime your designated person(s) calls or makes a request on your behalf, we will verify the individual has your permission to receive the information and then we will share the information.

What are some examples of when this might be useful?
- If an elderly parent wants an adult child to help understand medical treatment instructions
- If an adult child is helping with billing questions
- If a friend is helping an elderly patient with health issues
- If a college student wants information shared with a parent
- If an adult child calls to find out his/her parent's appointment time

Can the person I designate also get copies of my medical records?
No, they can only receive verbal information. To get copies of medical records, you must complete a separate Authorization form

What if I change my mind?
You can change or revoke (stop) this process at any time by writing to us at the address shown below.

What happens if I don't complete this form?
We will continue to protect your private health information as required by law.

After a child graduates from high school or turns 18, by law, they must give authorization for their parents/guardians to receive ANY medical information regardless if they are paying for their treatment.

I, _____give permission for the following people to obtain medical information or to speak with Merchants Walk Dental's staff regarding any of my medical needs.
Name: _____ Relationship _____
Name: _____ Relationship _____
Name: _____ Relationship _____

Patient Signature: _____ Date: _____