



# Welcome to Matonti Dental



## Patient Information...

Date \_\_\_\_\_

Mr.  Mrs.  Ms.  Dr. First Name \_\_\_\_\_ M.I. \_\_\_\_\_ Last Name \_\_\_\_\_ Nickname \_\_\_\_\_

Sex:  Male  Female Birth Date \_\_\_\_\_ Age \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_ E-mail \_\_\_\_\_

Street \_\_\_\_\_ Apt. \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Tel.( \_\_\_\_\_ ) Cell.( \_\_\_\_\_ ) Have you ever been a patient of our practice?  Yes  No

Referred By \_\_\_\_\_ Has a family member ever been a patient of our practice?  Yes  No  
FIRST NAME LAST NAME

Employer \_\_\_\_\_ Bus. Tel.( \_\_\_\_\_ )

In case of emergency, please contact \_\_\_\_\_ Tel.( \_\_\_\_\_ ) Relation \_\_\_\_\_

## Who will be responsible for your account...

Self (If self, skip this section)  Spouse  Father  Mother  Other \_\_\_\_\_

Name \_\_\_\_\_ S.S.# \_\_\_\_\_ Birth Date \_\_\_\_\_ Age \_\_\_\_\_ Tel.( \_\_\_\_\_ )  
FIRST NAME LAST NAME

Street \_\_\_\_\_ Apt. \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Driver's Lic.# \_\_\_\_\_ Employer \_\_\_\_\_ Bus. Tel.( \_\_\_\_\_ )

## Spouse or Other Guarantor Information (if different from above)...

Name \_\_\_\_\_ Relation \_\_\_\_\_ S.S.# \_\_\_\_\_ Birth Date \_\_\_\_\_  
FIRST NAME LAST NAME

Street \_\_\_\_\_ Apt. \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Tel.( \_\_\_\_\_ ) Employer \_\_\_\_\_ Bus. Tel.( \_\_\_\_\_ )

## Insurance Information...

Student:.....  FullTime  Part Time  Not ..... School Name and Address \_\_\_\_\_  
SCHOOL NAME ADDRESS

Marital Status: ..  Married  Divorced  Widow  Single  Legally Separated \_\_\_\_\_  
CITY STATE ZIP

Employed:.....  FullTime  Part Time  Retired  Not ..... Do you belong to a PPO or HMO?  Yes  No

## Primary Dental Insurance Company

Employer \_\_\_\_\_

Bus. Address \_\_\_\_\_  
ADDRESS CITY STATE ZIP

Bus. Tel#( \_\_\_\_\_ ) Ins. Co. Name \_\_\_\_\_

ID#: \_\_\_\_\_

Ins. Address \_\_\_\_\_  
CITY

Tel.( \_\_\_\_\_ )  
STATE ZIP

Group # \_\_\_\_\_ Group Name \_\_\_\_\_

Insured Party \_\_\_\_\_ Relation \_\_\_\_\_  
FIRST NAME LAST NAME

Sex:  M  F Birth Date \_\_\_\_\_ S.S. # \_\_\_\_\_

Street \_\_\_\_\_ City \_\_\_\_\_

State, Zip \_\_\_\_\_ Tel.( \_\_\_\_\_ )

## Insurance Coverage Policy...

Our staff is happy to assist you in determining whether your insurance company will provide benefits toward the cost of your cosmetic dentistry treatment. If benefits are provided for the treatment, we will help you file your claim. Unless other arrangements have been made in advance, we do expect payment at the time of service, and we will ask your insurance company to reimburse you.

## Dental Information...

Reason for today's visit \_\_\_\_\_ Are you in pain?  Yes  No, For How Long? \_\_\_\_\_

Please indicate any of the following problems by checking off the corresponding box:

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> Discomfort, clicking, or popping in jaw   | <input type="checkbox"/> Lost / broken filling(s)   | <input type="checkbox"/> Stained teeth         | <input type="checkbox"/> Difficulty closing jaw    |
| <input type="checkbox"/> Red, swollen, or bleeding gums  | <input type="checkbox"/> Teeth grinding / clenching | <input type="checkbox"/> Locking jaw           | <input type="checkbox"/> Difficulty opening jaw    |
| <input type="checkbox"/> A removable dental appliance  | <input type="checkbox"/> Ringing in ears            | <input type="checkbox"/> Bad breath            | <input type="checkbox"/> Loose / shifting teeth    |
| <input type="checkbox"/> Blisters / sores in or around the mouth   | <input type="checkbox"/> Broken / chipped tooth     | <input type="checkbox"/> Burning tongue / lips | <input type="checkbox"/> Food caught between teeth |
| <input type="checkbox"/> Prolonged bleeding from an injury / extraction  | <input type="checkbox"/> Gum disease                | <input type="checkbox"/> Toothache             | <input type="checkbox"/> Swelling / lumps in mouth |
| <input type="checkbox"/> Recent infections or sore throat  | <input type="checkbox"/> Other _____                |  |  |
| <input type="checkbox"/> My teeth are sensitive to: <input type="checkbox"/> Hot <input type="checkbox"/> Cold |   |  |  |
| <input type="checkbox"/> Sweets <input type="checkbox"/> Biting  |   |  |  |

Last dental exam \_\_\_\_\_ Last dental x-rays \_\_\_\_\_ Times a day you brush? \_\_\_\_\_ Times a week you floss? \_\_\_\_\_

How would you rate your smile? (worst) 1 2 3 4 5 6 7 8 9 10 (best) Would you like whiter teeth?  Yes  No

**Medical History...**

Medical Doctor: \_\_\_\_\_ Tel. (\_\_\_\_) \_\_\_\_\_

- Are you in good health?  Yes  No • Are you under the care of a physician?  Yes  No
- Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?  Yes  No
- Have you had any illness, operation, or been hospitalized in the past five years?  Yes  No
- Have you, or a family member, had any unusual or serious reactions to general anesthesia?  Yes  No

**Do you have, or have you had, any of the following diseases, medical conditions, or procedures?**

- |  |   |  |   |
|--|---|--|---|
| <b>Y</b> <input type="checkbox"/> <b>N</b> <input type="checkbox"/>                      | <b>Y</b> <input type="checkbox"/> <b>N</b> <input type="checkbox"/>   | <b>Y</b> <input type="checkbox"/> <b>N</b> <input type="checkbox"/>  | <b>Y</b> <input type="checkbox"/> <b>N</b> <input type="checkbox"/>                 |
| <input type="checkbox"/> <input type="checkbox"/> Rheumatic fever                        | <input type="checkbox"/> <input type="checkbox"/> Are you immunosuppressed<br><i>(possibly from transplant surg.)</i> | <input type="checkbox"/> <input type="checkbox"/> Bleeding tendency  | <input type="checkbox"/> <input type="checkbox"/> Kidney trouble                    |
| <input type="checkbox"/> <input type="checkbox"/> Mitral valve prolapse                  | <input type="checkbox"/> <input type="checkbox"/> Hay fever / Sinus problems  | <input type="checkbox"/> <input type="checkbox"/> Problems w/ immune system<br><i>(possibly from med. / surg.)</i> | <input type="checkbox"/> <input type="checkbox"/> Are you on dialysis               |
| <input type="checkbox"/> <input type="checkbox"/> Heart murmur                           | <input type="checkbox"/> <input type="checkbox"/> Snoring / Sleep apnea   | <input type="checkbox"/> <input type="checkbox"/> Jaundice / Liver disease   | <input type="checkbox"/> <input type="checkbox"/> Arthritis / Joint disease         |
| <input type="checkbox"/> <input type="checkbox"/> High blood pressure                    | <input type="checkbox"/> <input type="checkbox"/> Respiratory problems  | <input type="checkbox"/> <input type="checkbox"/> Hepatitis  | <input type="checkbox"/> <input type="checkbox"/> Prosthetic joint / Implant        |
| <input type="checkbox"/> <input type="checkbox"/> Low blood pressure                     | <input type="checkbox"/> <input type="checkbox"/> Tuberculosis  | <input type="checkbox"/> <input type="checkbox"/> Infectious mononucleosis   | <input type="checkbox"/> <input type="checkbox"/> Osteoporosis / Osteopenia         |
| <input type="checkbox"/> <input type="checkbox"/> Chest pain/ Angina                     | <input type="checkbox"/> <input type="checkbox"/> Emphysema   | <input type="checkbox"/> <input type="checkbox"/> Gallbladder trouble  | <input type="checkbox"/> <input type="checkbox"/> Osteonecrosis                     |
| <input type="checkbox"/> <input type="checkbox"/> Heart attack(s)                        | <input type="checkbox"/> <input type="checkbox"/> Do you smoke<br><i>if so, # packs a day _____</i>                   | <input type="checkbox"/> <input type="checkbox"/> Fainting spells  | <input type="checkbox"/> <input type="checkbox"/> Stomach ulcers                    |
| <input type="checkbox"/> <input type="checkbox"/> Irregular heart beat                   | <input type="checkbox"/> <input type="checkbox"/> Do you use chewing tobacco  | <input type="checkbox"/> <input type="checkbox"/> Convulsions / Epilepsy   | <input type="checkbox"/> <input type="checkbox"/> Contagious diseases               |
| <input type="checkbox"/> <input type="checkbox"/> Cardiac pacemaker                      | <input type="checkbox"/> <input type="checkbox"/> Blood transfusion   | <input type="checkbox"/> <input type="checkbox"/> Stroke   | <input type="checkbox"/> <input type="checkbox"/> Delay in healing                  |
| <input type="checkbox"/> <input type="checkbox"/> Heart surgery                          | <input type="checkbox"/> <input type="checkbox"/> Blood disorder  | <input type="checkbox"/> <input type="checkbox"/> Thyroid trouble  | <input type="checkbox"/> <input type="checkbox"/> Anemia                            |
| <input type="checkbox"/> <input type="checkbox"/> Pneumonia / Bronchitis / Chronic cough | <input type="checkbox"/> <input type="checkbox"/> Bruise easily   | <input type="checkbox"/> <input type="checkbox"/> Diabetes   | <input type="checkbox"/> <input type="checkbox"/> Tumor or growth                   |
| <input type="checkbox"/> <input type="checkbox"/> Chronic fatigue / Night sweats         | <input type="checkbox"/> <input type="checkbox"/> A history of drug abuse   | <input type="checkbox"/> <input type="checkbox"/> A history of alcohol abuse                                       | <input type="checkbox"/> <input type="checkbox"/> Cancer / Radiation / Chemotherapy |
| <input type="checkbox"/> <input type="checkbox"/> Trouble climbing 1-2 flights of stairs | <input type="checkbox"/> <input type="checkbox"/> Eye disease / Glaucoma  | <input type="checkbox"/> <input type="checkbox"/> Sexually transmitted diseases                                    | <input type="checkbox"/> <input type="checkbox"/> Are you on a diet                 |
| <input type="checkbox"/> <input type="checkbox"/> Mental health problems                 | <input type="checkbox"/> <input type="checkbox"/> Abnormal bleeding   | <input type="checkbox"/> <input type="checkbox"/> Swollen ankles   | <input type="checkbox"/> <input type="checkbox"/> Contact lenses                    |
| <input type="checkbox"/> <input type="checkbox"/> Damaged heart valves                   |   | <input type="checkbox"/> <input type="checkbox"/> Low blood sugar  |   |
| <input type="checkbox"/> <input type="checkbox"/> Asthma                                 |   |  |   |

**Medication & Allergies...**

**Are you now taking, or have you ever taken:**

- |  |   |   |   |
|--|---|---|---|
| <b>Y</b> <input type="checkbox"/> <b>N</b> <input type="checkbox"/>                            | <b>Y</b> <input type="checkbox"/> <b>N</b> <input type="checkbox"/>   | <b>Y</b> <input type="checkbox"/> <b>N</b> <input type="checkbox"/> | <b>Y</b> <input type="checkbox"/> <b>N</b> <input type="checkbox"/> |
| <input type="checkbox"/> <input type="checkbox"/> Nerve pills                                  | <input type="checkbox"/> <input type="checkbox"/> Pain killers (including aspirin)                              | <input type="checkbox"/> <input type="checkbox"/> Muscle relaxers   | <input type="checkbox"/> <input type="checkbox"/> Stimulants        |
| <input type="checkbox"/> <input type="checkbox"/> Diet pills                                   | <input type="checkbox"/> <input type="checkbox"/> Tranquilizers   | <input type="checkbox"/> <input type="checkbox"/> Insulin           | <input type="checkbox"/> <input type="checkbox"/> Antidepressants   |
| <input type="checkbox"/> <input type="checkbox"/> Blood thinners<br>(Coumadin, Aspirin, Advil) | <i>Please list any other medication(s) you are taking (including natural, herbal, or homeopathic products):</i> |   |   |
|  | MEDICATION & DOSAGE FREQUENCY   |   |   |

- Any bone density medication or Bisphosphonates (Aredia, Zometa, Fosamax, Actonel)

**Are you allergic to, or had a reaction to:**

- |   |   |  |   |
|---|---|--|---|
| <b>Y</b> <input type="checkbox"/> <b>N</b> <input type="checkbox"/>                       | <b>Y</b> <input type="checkbox"/> <b>N</b> <input type="checkbox"/> | <b>Y</b> <input type="checkbox"/> <b>N</b> <input type="checkbox"/>              | <b>Y</b> <input type="checkbox"/> <b>N</b> <input type="checkbox"/>         |
| <input type="checkbox"/> <input type="checkbox"/> Penicillin                              | <input type="checkbox"/> <input type="checkbox"/> Sulfa drugs       | <input type="checkbox"/> <input type="checkbox"/> Local anesthetic (numbing med) | <input type="checkbox"/> <input type="checkbox"/> Amoxicillin               |
| <input type="checkbox"/> <input type="checkbox"/> Sodium pentothal / Valium / other tranq | <input type="checkbox"/> <input type="checkbox"/> Aspirin           | <input type="checkbox"/> <input type="checkbox"/> Codeine or other narcotics     | <input type="checkbox"/> <input type="checkbox"/> Latex                     |
| <input type="checkbox"/> <input type="checkbox"/> Soy                                     | <input type="checkbox"/> <input type="checkbox"/> Eggs / Yolk       | <input type="checkbox"/> <input type="checkbox"/> Sulfites                       | <input type="checkbox"/> <input type="checkbox"/> I have no known allergies |

*Please list any other medication or antibiotic you are allergic to:*

*Please list any allergies other than drug allergies:*

**1-4 below for women only:** (Women note: antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician / gynecologist for assistance regarding additional methods of birth control.)

- 1) Is there a possibility of pregnancy?  Yes  No
- 2) Expected delivery date: \_\_\_\_\_
- 3) Are you nursing?  Yes  No
- 4) Are you taking birth control pills:  Yes  No

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of his / her staff, responsible for any errors or omissions that I have made in the completion of this form.

**X** \_\_\_\_\_ **X** \_\_\_\_\_ **X** \_\_\_\_\_

Signature of patient (Parent or Guardian if Minor) Reviewed by Date

**FEES & PAYMENTS**

We make every effort to keep down the cost of your care. You can help by paying upon completion of each visit. Other arrangements can be made with our office manager depending upon special circumstances. An estimate of the charge for any procedure or surgery you may require will be given to you upon request. If you have any dental and/or medical insurance we will be glad to fill out the proper forms, but please complete the identifying information on this form.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company.** You will be responsible for all collection costs, attorneys' fees, and court costs.

**X** \_\_\_\_\_ **X** \_\_\_\_\_

Signature of patient (Parent or Guardian if Minor) Date

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

**X** \_\_\_\_\_ **X** \_\_\_\_\_

Signature of patient: (Parent or Guardian if Minor) Date

---

THIS NOTICE DESCRIBES TO WHOM MEDICAL INFORMATION ABOUT YOU MAY  
BE DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.  
PLEASE REVIEW CAREFULLY

---

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides privacy protections to your medical records. Our benefits office (or other third party designated by our office) may sometimes need to disclose medical information or payment information protected by HIPAA in relation to our group health plans to your family members or close friends involved in your health care. For example, your spouse may need to contact us if you are in the hospital to determine a particular procedure is covered under our group health plan or may need assistance filing a claim for medical services. Under HIPAA, unless you specifically object we are allowed to use our professional judgment in deciding whether to discuss your medical and payment information with your family members or close friends. However, we would like to provide you with the opportunity to tell us with whom we may discuss your medical or payment information under our group health plans.

You may communicate with the following individuals relating to my medical or payment information: \_\_\_\_\_

---

---

**COMPLAINTS:**

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services and/or the Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to Matonti Dental. If you prefer, you can discuss your complaint in person or by phone.

**FOR MORE INFORMATION:**

If you want more information about our privacy practices, call or visit Matonti Dental.

**ACKNOWLEDGEMENT OF RECEIPT:**

I acknowledge that I have received a copy of the HIPAA Consent form.

Signature of patient/parent/or guardian: \_\_\_\_\_

Date: \_\_\_\_\_

---

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

---

I authorize Matonti Dental to release health information identifying me (including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services) under the following terms and conditions:

1. Detailed description of the information to be released:
2. To whom may the information be released [name(s), or class(es) of recipients]:
3. The purpose(s) for the release (if the authorization is initiated by the individual, it is permissible to state "at the request of the individual" as the purpose, if desired by the individual):
4. Expiration date or event relating to the individual or purpose for the release:

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to the office listed at the top of this form.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

[For marketing authorizations, include, as applicable: We will receive direct or indirect remuneration from a third party for disclosing your identifiable health information in accordance with this authorization.]

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Signature of Patient/Parent/Guardian: \_\_\_\_\_

Date: \_\_\_\_\_



# MATONTI DENTAL

## OFFICE AND FINANCIAL POLICY

- Payment is due at the time of treatment unless other arrangements were made prior to starting the procedure.
- All treatment plans will be honored for 90 days in the event that fees change.
- Insurance companies will not guarantee benefits over the phone or the internet. The insurance portion of all treatment plans is only an estimate. Any unpaid insurance balance is ultimately the patient's responsibility.
- All minor children, under the age of 18, must be accompanied by a parent or legal guardian the entire time they are receiving dental treatment.
- There will be a charge of \$55.00 per hour/per scheduled appointment if an appointment is canceled without a minimum of 24 hours' notice.
- We reserve the right to reschedule a patient if you are 15 minutes late or more for your scheduled appointment time.

We know that your time is valuable, as is ours. We will do our best to see each patient promptly at their scheduled appointment at their scheduled appointment time but we want our patients to understand that from time to time an emergency may arise that will cause us to run late for the next scheduled appointment. We will inform you of the delay and if it is necessary for you to reschedule, we will schedule your appointment back at the soonest available time. We truly appreciate your understanding.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_