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DENTAL INSURANCE AND FINANCIAL INFORMATION

Payment :

Please be aware that the payment of accounts is the responsibility of the patient or parent/guardian, if the patient is a minor. We accept the following methods of payment : checks, cash, VISA, MasterCard, Discover, or CareCredit (please ask for details).

Dental Insurance :

A dental insurance policy is a contract between you, your employer and the insurance carrier. If you have any questions regarding your plan, we ask that you contact your carrier prior to your appointment regarding the specific details of your plan. We will also assist you in any way possible to resolve insurance issues.

We are happy to submit claims for you. Our office accepts assignment of benefits from many plans, with the understanding that you, the patient, assume responsibility for any unpaid balance.

Dental Insurance Facts :

- Dental Insurance IS NOT meant to be a pay-all. It can only be of assistance in paying for necessary dental care.
- You may receive notice from your insurance carrier thating that the dental fees are higher than they consider reasonable and customary. How does an insurance company determine this ? They may survey a geographic area, find the average fee for each procedure, take 90% of that fee, and consider it customary. MOST doctors' fees are considered higher than average by the insurance carriers.
- Please be advised that many insurance carriers tell their subscribers that procedures will be covered up to 80%, or covered at 100%. They do not, however, clearly specify plan allowances, annual maximums, or limitations. This can be misleading.
- Some routine dental services are not covered by all insurance plans.

Patient Information

Patient Name: _____ Date: _____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Teen/College Student

Social Security #: _____ Date of Birth: _____

Phone (Home): _____ (Work): _____ Cell: _____

Contact me by: ☐ Phone ☐ E-mail E-mail address: _____

Address: _____
Street

_____
City State Zip

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

Have your ever had any of the following? Please check those that apply:

☐ AIDS	☐ Excessive Bleeding	☐ Liver Disease	☐ Stomach Problems
☐ Allergies _____ _____	☐ Fainting	☐ Mental Disorders	☐ Stroke
	☐ Glaucoma	☐ Mitral Valve Prolapse	☐ Tuberculosis
☐ Anemia	☐ Growths	☐ Nervous Disorders	☐ Tumors
☐ Arthritis	☐ Hay Fever	☐ Pacemaker	☐ Ulcers
☐ Artificial Joints	☐ Head Injuries	☐ **Pregnancy**	☐ Sexually Trans.Disease
☐ Asthma	☐ Heart Disease	Due date:_____	☐ Codeine Allergy
☐ Blood Disease	☐ Heart Murmur	☐ Radiation Treatment	☐ Penicillin Allergy
☐ Cancer	☐ Hepatitis	☐ Respiratory Problems	OTHER:
☐ Diabetes	☐ High Blood Pressure	☐ Rheumatic Fever	☐ _____
☐ Dizziness	☐ Jaundice	☐ Rheumatism	
☐ Epilepsy	☐ Kidney Disease	☐ Sinus Problems	☐ _____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Are you taking any Medications, Prescription Drugs, or anything else we should be aware of? ☐ Yes ☐ No
  If yes, please explain: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctor at the next appointment.

_____ Date: _____
Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other_____

Name of person or office referring you to our practice: _____

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext:_____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City State Zip Code

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Insurance Plan Name and Address: _____

_____

_____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Insurance Plan Name and Address: _____

_____

_____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and agree to their content.

_____ Date: _____ Relationship to Patient: _____

Signature of patient, parent or guardian

DENTAL CONCERNS

WHAT CAN WE DO TO MAKE YOU FEEL MORE AT HOME?

□ Would you like to be reminded of your appointments?
□ By Phone □ By e-mail □ By both

□ Would you like fresh coffee when you arrive?

□ Would you like a personal walkman or CD player to listen to?

□ Will you need blankets to help with the temperature?

□ Will you need a pillow to support your neck?

□ Would you like sunglasses to wear during your appointment?

□ Can you suggest any other amenities which would make your dental appointment more comfortable? _____

WHAT DID YOU *NOT* LIKE ABOUT PREVIOUS DENTAL APPOINTMENTS?

□ Was the treatment itself uncomfortable? Please explain: _____
_____

□ Was the staff unfriendly? Please explain: _____
_____

□ Were there financial issues that were not properly explained?

WHAT ARE YOUR FEELINGS ABOUT THE FOLLOWING:

Front Teeth

Are you happy with the color? □ Yes □ No
Are you happy with the length? □ Yes □ No
Are they crowded or crooked? □ Yes □ No Are braces an option for you? □ Yes □ No
Are you happy with their overall appearance? □ Yes □ No
Can you tell us what, if anything, you would like to change about them? _____

Back Teeth

Are they sensitive to hot or cold foods/drinks? □ Yes □ No
Does food get trapped between them when you eat? □ Yes □ No
Is there anything about them you would like to change? _____

Gums

Do they ever bleed? □ Yes □ No Are they sensitive? □ Yes □ No
Are you seeing a Periodontist? □ Yes □ No If yes, who? _____
Do you think you have bad breath? □ Yes □ No
Is there anything about them you would like to change? _____

Missing Teeth

Do you have any missing teeth? □ Yes □ No
Are you wearing a replacement? (denture/partial/crown/bridge) □ Yes □ No
Is your denture or partial comfortable? □ Yes □ No
Have you ever been told about implants and how they can work for you? □ Yes □ No

WHAT IS THE VERY FIRST THING YOU WOULD LIKE US TO DO TO HELP YOU?

_____
_____

RECORDS RELEASE FORM

To Dr. _____
_____
_____

I hereby authorize release of Dental records for _____
to be sent to: [please print name]

John F. Midlige, D.M.D.
60 Midvale Road
Mountain Lakes, N.J. 07046

Signature:_____
Date:_____