# MINSTER DENTAL CARE

**PATIENT INFORMATION** (PLEASE PRINT) ***CONFIDENTIAL***

________________________________ Male / Female ______________
First Middle Initial Last Birthdate

________________________________ ________________________________
Mailing Address City, State and Zip Code

_____/__________ _____/__________ ______________________________
Home Phone Cell Phone E-mail address (for office communication)

**Patient is**: Minor Single Married Divorced Widowed Separated

______________________ _____/______________
Patient's Employer Work Phone- if can be contacted there
Is there dental coverage through this employer? YES NO **If YES - Please complete insurance information on back**

______________________ ______________________ _____/______________ Current patient YES NO
Spouse's Name Employer Work Phone- if can be contacted there
Is there dental coverage through this employer? YES NO **If YES - Please complete insurance information on back**

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**PARENT INFORMATION (for minor children)**

______________________________ ______________________________
Mother's Name Father's Name

______________________________ ______________________________
Mailing Address (if different than patient) Mailing Address (if different than patient)

______________________________ ______________________________
City, State and Zip Code City, State and Zip Code

_____/__________ _____/__________ _____/__________ _____/__________
Contact Phone Number Work Phone Contact Phone Number Work Phone

______________ ______________ ______________ ______________
Social Security Number Date of Birth Social Security Number Date of Birth

______________ YES NO ______________ YES NO
Employer **Dental** Insurance Employer **Dental** Insurance

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I understand that I am financially responsible for all charges incurred and have seen the office policy form. I understand a minimum of $2.00 per month or 2% of my total balance finance charge will be assessed on all unpaid balances over 30 days. I authorize ***MINSTER DENTAL CARE*** permission to use and disclose health/personal information about me (or said minor) for treatment, payment and healthcare operations (as stated in 2013 HIPAA). If patient is a minor, authorization is hereby granted for ***MINSTER DENTAL CARE*** to provide dental care for said minor.

**Signature of Patient** (over 18) OR **Parent/Guardian** (If Minor) X______________________________

Relationship to Patient ______________________ Date ______________________

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## NEW PATIENTS

Reason for today's visit ______________________________________
Former Dentist ______________________ City/State ______________________
Reason for Leaving ______________________________________
Last dental visit ______________ Last dental cleaning ______________ Last dental x-rays ______________

If minor, has child ever been in the hospital? Yes No If yes, why? ______________________
If minor, has child ever been to the Emergency room? Yes No If yes, Why? ______________________
If minor, has child had any unfavorable experiences in a dental / medical office? Yes No

## IF NEW PATIENT --- PLEASE COMPLETE:

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Bad breath | Yes | No | Food collect between teeth | Yes | No | Piercings – tongue&/or lip | Yes | No |
| Bleeding gums | Yes | No | Grinding teeth | Yes | No | Sensitivity to cold | Yes | No |
| Blisters on lips or mouth | Yes | No | Gums swollen or tender | Yes | No | Sensitivity to heat | Yes | No |
| Burning sensation on tongue | Yes | No | Jaw Pain or tiredness | Yes | No | Sensitivity to sweets | Yes | No |
| Chew on one side of mouth | Yes | No | Lip or cheek biting | Yes | No | Sensitivity when biting | Yes | No |
| Chew tobacco | Yes | No | Loose teeth or broken fillings | Yes | No | Smoking-cigarette/pipe/cigar | Yes | No |
| Clicking or popping jaw | Yes | No | Mouth breathing | Yes | No | Sores/growths in mouth | Yes | No |
| Dry mouth | Yes | No | Mouth pain, brushing | Yes | No | Thumb/finger sucking | Yes | No |
| Fingernail / lip biting | Yes | No | Orthodontic treatment | Yes | No | | | |
| Fluoride supplements | Yes | No | Pacifier | Yes | No | How often do you floss? ________________ | | |
| Fluoride rinse | Yes | No | Pain around ear | Yes | No | How often do you brush? _______________ | | |
| Fluoridated water | Yes | No | Periodontal treatment | Yes | No | | | |

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# DENTAL INSURANCE INFORMATION – (PLEASE PROVIDE CARD FOR COPYING)

## Primary Insurance

_______________________________________
Name of Insured

_______________ _______________
Relationship to patient Insured's birthdate

_______________ _______________
Employer Social Security Number

_______________________________________
Insurance Company

_______________________________________
Insurance Company Address

_______________________________________
City State Zip Code

## Secondary Insurance

_______________________________________
Name of Insured

_______________ _______________
Relationship to patient Insured's birthdate

_______________ _______________
Employer Social Security Number

_______________________________________
Insurance Company

_______________________________________
Insurance Company Address

_______________________________________
City State Zip Code

### Federal Truth in Lending Statement

In the event that your insurance applies services to a deductible, determines a service is not payable due to frequency, is not covered, or is disallowed for any reason the balance will become the responsibility of the patient or responsible party. In the event this occurs you will be billed for the services not covered for any reason, rejected, or applied to the deductible. I understand that if an insurance plan has an adjustment from the provider for services and the amount required by the insurance is either more or less than what was estimated at the time of service by the provider, I may be billed an additional amount after insurance benefits and any adjustments are determined.

I have read and understand that the services provided may be covered in part or in full by my insurance carrier. In the event the insurance does not pay the dentist for covered, non-covered, or services applied to a deductible I am fully responsible for the balance.

### Authorization and Release

I authorize and request my insurance company to pay directly to Minster Dental Care otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_______________________________________ _______________________

**Signature of patient (or parent/guardian if minor)** **Date**