# 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
☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Single ☐ Married ☐ Divorced ☐ Separated

_____ _____
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
Any significant concerns regarding this child's medical / dental history? ☐ 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)

**Minster Dental Care will gladly submit a claim on your behalf. Please provide thorough dental insurance information below. You may be required to pay in full until adequate insurance information is received. Please be aware that copayments are due at the time of service.**

## Primary Insurance

_____
Name of Insured/Policy Holder

_____ _____
Relationship to patient Insured's birthdate

_____ _____
Employer Social Security Number

_____ _____
ID# Group #

_____
Insurance Company

_____
Insurance Company Address

_____
City State Zip Code

## Secondary Insurance

_____
Name of Insured/Policy Holder

_____ _____
Relationship to patient Insured's birthdate

_____ _____
Employer Social Security Number

_____ _____
ID # Group #

_____
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**