Mandarin DENTAL CARE

Today's Date: _____

ABOUT YOU

Name: _____ Nickname: _____ Male___ Female ____
Last First MI Title

Address: _____
Street City State Zip Code

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Best Phone Number to contact you to confirm appointments: _____

Birthday: _____ Social Security Number: _____ Marital Status: _____

Employer: _____ Occupation:_____

Email Address: _____ Whom may we thank for referring you? _____

PERSON RESPONSIBLE FOR ACCOUNT

Name: _____ Relation: _____
Last First MI Title

Address: _____
Street City State Zip Code

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Birthday: _____ Social Security Number: _____

Employer: _____ Occupation: _____

DENTAL INSURANCE COMPANY INFORMATION

Company: _____ Group Number: _____

Address: _____
Street City State Zip Code

Phone Number: _____ Insured's Employer: _____

Insured's Name: _____ Relation: _____
Last First MI Title

Insured's ID Number: _____ Insured's Social Security Number: _____

Insured's Birthday: _____ **** If there is secondary insurance benefits, please let us know ****

PLEASE TURN OVER FOR MEDICAL HISTORY

MEDICAL HISTORY

Physician's Name: _____ Physician's Phone Number: _____

Emergency Contact/ phone number: _____Do you SMOKE or use any other form of TOBACCO? Yes ☐ No ☐

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

	YES				YES	NO		YES	NO
Aspirin				Erythromycin	☐	☐	Latex	☐	☐
Codeine				Tetracycline	☐	☐	Metals	☐	☐
Dental Anesthetics				Jewelry	☐	☐	Penicillin	☐	☐

Other: _____

DO YOU HAVE ANY OF THESE CONDITIONS?

	YES	NO			YES	NO			YES	NO
Abnormal Bleeding	☐	☐		Epilepsy	☐	☐		Memory Loss	☐	☐
Alcohol Abuse	☐	☐		Fainting Spells	☐	☐		Mitral Valve Prolapse	☐	☐
Allergies	☐	☐		Fever Blisters	☐	☐		Pace Maker	☐	☐
Anemia	☐	☐		Frequent Headaches	☐	☐		Pneumocystitis	☐	☐
Angina Pectoris	☐	☐		Glaucoma	☐	☐		Radiation Therapy	☐	☐
Arthritis	☐	☐		HIV+AIDS	☐	☐		Rheumatic Fever	☐	☐
Artificial Bones	☐	☐		Hay Fever	☐	☐		Seizures	☐	☐
Artificial Heart Valve	☐	☐		Heart Attack	☐	☐		Shingles	☐	☐
Asthma	☐	☐		Heart Surgery	☐	☐		Sickle Cell Disease	☐	☐
Blood Transfusion	☐	☐		Hemophilia	☐	☐		Sinus Problems	☐	☐
Cancer-Chemotherapy	☐	☐		Hepatitis A	☐	☐		Steroid Therapy	☐	☐
Colitis	☐	☐		Hepatitis B	☐	☐		Thyroid Problems	☐	☐
Congenital Heart Defect	☐	☐		Hepatitis C	☐	☐		Tuberculosis	☐	☐
Diabetes	☐	☐		High Blood Pressure	☐	☐		Ulcers	☐	☐
Difficulty Breathing	☐	☐		Kidney Problems	☐	☐		Venereal Disease	☐	☐
Drug Abuse	☐	☐		Liver Disease	☐	☐		Yellow Jaundice	☐	☐
Emphysema	☐	☐		Low Blood Pressure	☐	☐				

Other: _____

_____

MEDICATIONS: _____

_____

Please let our team know if you have been told to premedicate with antibiotics before dental appointments

FOR WOMEN ONLY		
	YES	NO
Are you taking birth control pills?		
Are you pregnant?		
Are you nursing?		

Patient Signature: _____ **Date:** _____

Dr. Signature: _____ **Date:** _____

SMILE EVALUATION

We would like to help you obtain the smile you've always wanted. Please take a few minutes to complete this short questionnaire.

1. Do you have any concerns about bad breath odor?

   _____

2. Are you pleased with the appearance of your teeth when you smile?

   _____

3. Are you pleased with the color of your teeth?

   _____

4. Are you pleased with the shape of your teeth?

   _____

5. Are there spaces between your teeth that you don't like?

   _____

6. Are your teeth…..

   chipped? _____ protruding? _____ hidden? _____ crowded? _____

7. Do you like the way your teeth fit together when you bite?

   _____

8. Are there old fillings or dental treatment that you aren't happy with?

   _____

9. If you could change anything about the appearance of your smile, what would that be?

   _____

10. Is there anything about the shape or alignment of your jaws that you are not happy with?

    _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received a copy of this office's Notice of Privacy Practices.

I authorize Krantz Dental Care to discuss my dental or financial information with:

_____

_____
Please Print Name

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

Mandarin DENTAL CARE

Payment Options and Policies

Mandarin Dental Care, P.A. strives to offer convenient payment options while at the same time maintaining the high standard of comprehensive dental care that our patients deserve. At the onset of your treatment, we will provide you with an estimate of your total treatment costs. Our goal is to help you afford your dental choices.

Please understand that this will only be an estimate. Should the need for additional treatment arise during the course of the original treatment plan, the fees could change. Be assured that we will notify you of fee changes and obtain your approval prior to proceeding with treatment. Please take a moment to review the financial options offered and indicate your choice of payment.

- **Plan A:** Payment in full on the day of each visit. You may pay by cash, check, credit or debit card. We gladly accept Mastercard, American Express, Discover and Visa.

- **Plan B**: We are pleased to offer our patients an extended monthly payment plan option through the dental financing company, Care Credit.

- **Plan C:** Our goal is to help you maximize your dental insurance benefits. As a courtesy, we are happy to bill your dental plan for services. Please remember that the contract itemizing your dental benefits is between you, your employer, and your insurance carrier. Regardless of coverage, your estimated co-payment is due in full the day of treatment. If your dental plan does not pay within 60 days of treatment, you must pay any outstanding balance and seek reimbursement from your dental plan. If your dental plan pays more than expected, you will receive a refund. Also remember that dental benefit plans are not designed to cover all of your dental needs. Rather, the amount your dental plan contributes towards your dental care is based on the plan selected and purchased by your employer.

Again, feel free to contact any member of our team if you have questions regarding the payment options described above. We thank you for trusting us with your dental care.

I have chosen Plan_____(above) and accept full financial responsibility for this account and for all dentistry performed upon myself and/or my dependents in this dental office.

I certify that I am covered by_____insurance company and that I assign all insurance benefits, otherwise payable to me. I understand that it is my responsibility to confirm my insurance eligibility, waiting periods, and benefits. I also understand that this office cannot guarantee my insurance status in any of these areas. Any insurance estimate or information given to me by this office is not a guarantee of actual insurance payment. I also understand that any insurance claim not paid in full after 60 days in addition to any co-payment and deductible will become my responsibility to pay at that time.

I hereby authorize Mandarin Dental Care, P.A. to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

I understand that it is my responsibility to notify the office within 48 hours of an appointment if I am unable to keep that appointment. I also understand that my account will be charged a fee of $50.00 for each missed appointment.

Patient/Guardian Signature:_____Date: _____

Mandarin DENTAL CARE

Informed Consent Form for General Dental Procedures

You the patient have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment.

Do not consent to treatment unless and until you discuss potential benefits, risks, and complications with your dentist and all of your questions are answered. By consenting to treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

It is very important that you provide your dentist with accurate information before, during and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialists, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.

Certain heart conditions may create a risk of serious or fatal complications. If you (or a minor patient) have a heart condition or heart murmur, advise your dentist immediately so s/he can consult with your physician if necessary.

The patient is an important part of the treatment team. In addition to complying with the instructions given to you by this office, it is important to report any problems or complications you experience so they can be addressed by your dentist.

If you are a woman on oral birth control medication you must consider the fact that antibiotics might make oral birth control less effective. Please consult with your physician before relying on oral birth control medication if your dentist prescribes, or if you are taking antibiotics.

As with all surgery, there are commonly known risks and potential complications associated with dental treatment. No one can guarantee the success of the recommended treatment, or that you will not experience a complication or less than optimal result. Even though many of these complications are rare, they can and do occur occasionally.

Some of the more commonly known risks and complications of treatment include, but are not limited to the following:

1. Pain, swelling, and discomfort after treatment.
2. Infection in need of medication, follow-up procedure or other treatment.
3. Temporary, or on rare occasion, permanent numbness, pain, tingling or altered sensation of the lip, face, chin, gums, and tongue along with possible loss of taste.
4. Damage to adjacent teeth, restorations or gums.
5. Possible deterioration of your condition which may result in tooth loss.
6. The need for replacement of restorations, implants or other appliances in the future.
7. An altered bite in need of adjustment.
8. Possible injury to the jaw joint and related structures requiring follow-up care and treatment, or consultation by a dental specialist.
9. Root tip, bone fragment or a piece of dental instrument may be left in your body, and may have to be removed at a later time if symptoms develop.
10. Jaw fracture.
11. If upper teeth are treated, there is a chance of a sinus infection or opening between the mouth and sinus cavity resulting in infection or the need for further treatment.
12. Allergic reaction to anesthetic or medication
13. Need for follow-up treatment, including surgery.

This form is intended to provide you with an overview of potential risks and complications. Do not sign this form or agree to treatment until you have read, understood, and accepted each paragraph stated above. Please discuss the potential benefits, risks, and complications of recommended treatment with your dentist. Be certain all of your concerns have been addressed to your satisfaction by your dentist before commencing treatment.

_____	_____
Patient Signature Date	Witness Date
_____	_____
Print Patient Name	Parent/Legal Guardian Date