



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	<input type="checkbox"/>	<input type="checkbox"/>		Erythromycin	<input type="checkbox"/>	<input type="checkbox"/>	Latex	<input type="checkbox"/>	<input type="checkbox"/>
Codeine	<input type="checkbox"/>	<input type="checkbox"/>		Tetracycline	<input type="checkbox"/>	<input type="checkbox"/>	Metals	<input type="checkbox"/>	<input type="checkbox"/>
Dental Anesthetics	<input type="checkbox"/>	<input type="checkbox"/>		Jewelry	<input type="checkbox"/>	<input type="checkbox"/>	Penicillin	<input type="checkbox"/>	<input type="checkbox"/>

Other: _____

DO YOU HAVE ANY OF THESE CONDITIONS?

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

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)
-
-



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: _____

