About You

Name:_____
Last First Mr., Mrs., Ms., Dr.

Height:_____ Weight:_____

E-mail Address:_____

In the event of an emergency, is there someone who lives near you that we should contact?

His/Her Name:_____ Relation:_____

Wk#: (___) _____ Hm#: (___) _____

Medical History

Do you have a personal physician?..... Yes No

Physician's Name:_____

Wk#: (___) _____ Date of Last Visit: _____

Your current physical health is:..... Good Fair Poor

Are you currently under the care of a physician?..... Yes No

Please explain:_____

_____

Are you taking any prescription medications/ over-the-counter drugs?..... Yes No

Please list each one:_____

_____

Do you smoke or use tobacco in any other form?..... Yes No

For women: Are you taking birth control pills?..... Yes No

Are you pregnant?..... Yes No Week# _____

Are you nursing?..... Yes No

Have you ever taken Phen-fen?..... Yes No

If so, when? _____

Are you taking or scheduled to begin taking Fosamax or Actonel?..... Yes No

If so, when? _____

Are you allergic to any of the following?

Y N Aspirin Y N Erythromycin Y N Penicillin

Y N Codeine Y N Jewelry/Metals Y N Tetracycline

Y N Dental Anesthetics Y N Latex Y N Other

Please list any other drugs / materials that you are allergic to:_____

_____

Dental History

What is the reason for your dental visit today?_____

_____

Do you require antibiotics before dental treatment?..... Yes No

Are you currently in pain?..... Yes No

Have you ever had a serious/difficult problem associated with any previous dental work?..... Yes No

Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ / TMD)?..... Yes No

Have you ever had orthodontic treatment?..... Yes No

Do you like your smile?..... Yes No

Do your gums ever bleed?..... Yes No

Do you grind or brux your teeth?..... Yes No

Date of last dental exam & x-rays:_____

Have you ever had any of the following diseases or medical problems? (Please circle option that applies)

Y N Anemia/Radiation Treatment
Y N Angina
Y N Artificial Bones/Joints/Valves
Y N Arthritis
Y N Asthma
Y N Autoimmune Disease
Y N Blood Transfusion
Y N Cancer/Chemotherapy
Y N Cardiovascular Disease
Y N Congenital Heart Defect
Y N Diabetes (Type I or II)
Y N Difficulty Breathing
Y N Drug/Alcohol Abuse
Y N Emphysema/Glaucoma
Y N Epilepsy/Seizures/Fainting Spells
Y N Fever Blisters/Herpes
Y N Glaucoma
Y N GE Reflux/Persistent Heartburn
Y N Heart Attack/Stroke
Y N Heart Murmur
Y N Heart Surgery/Pacemaker
Y N Hemophilia/Abnormal Bleeding
Y N Hepatitis
Y N High/Low Blood Pressure
Y N HIV/AIDS
Y N Hospitalized in Past 5 Years
Y N Kidney Problems
Y N Mitral Valve Propiase
Y N Osteoporosis
Y N Psychiatric Problems
Y N Rheumatic/Scarlet Fever
Y N Severe/Frequent Headaches
Y N Shingles
Y N Sickle Cell Disease/Traits
Y N Sinus Problems
Y N Tuberculosis (TB)
Y N Thyroid Problems
Y N Ulcers/Colitis
Y N Venereal Disease

Please list any serious medical condition(s) that you have ever had:_____

_____

_____

_____

Maureen M. Holley, DMD
Restorative and Cosmetic Dentistry

Welcome to our office!
Our team looks forward to bringing you into our family of patients. Please help us meet all your dental needs by completing this form. If you have any questions or need assistance, please ask us – we will be happy to help.

CONFIDENTIAL PATIENT INFORMATION

Date: _____
Patient Name: _____ SS#: _____ D/O/B: _____
Address: _____ City: _____ State: ___ Zip: _____
Home Phone: _____ Cell Phone Numbers: _____
Occupation: _____ Employed By: _____ Work Phone: _____

Whom may we thank for referring you to our office? _____

CONFIDENTIAL RESPONSIBLE PARTY INFORMATION

Name: _____ SS#: _____ D/O/B: _____
Address: _____ City: _____ State: ___ Zip: _____
Relationship to Patient: _____ Home Phone: _____ Cell Phone: _____
Occupation: _____ Employed By: _____ Work Phone: _____
Insurance Name: _____ Policy #: _____ Group#: _____

CONSENT FOR TREATMENT

1) I hereby authorize Dr. Holley or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by Dr. Holley to make a thorough diagnosis of my dental needs.
2) Upon such diagnosis, I authorize Dr. Holley to perform all recommended treatment mutually agreed upon by me and to employ such assistance as require to provide proper care.
3) I agree to the use of anesthetics, sedatives and other medication as necessary. I understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

Patient/Responsible Party Signature _____ Date: _____

MAUREEN M. HOLLEY, D.M.D
CONSENT FOR DISCLOSURE OF HEALTH CARE INFORMATION

Patient's Name:_____ Date of Birth:_____
SS #:_____
Doctor's Name: Maureen M. Holley DMD

My personal health information is private and confidential. I understand that my doctor and her staff work very hard to protect my privacy and preserve the confidentiality of my personal health information.

I understand that my doctor and her staff may use and disclose my personal health information to help provide healthcare to me, to handle billing and payment, and to take care of other health care operations. There will be no other uses and disclosures of this information unless I permit it.

I can ask my doctor to limit how my personal health information is used or disclosed to carry out treatment, payment or health care operations. I understand that my doctor does not have to agree to my request. If my doctor does agree to my request, I understand that my doctor and her staff would follow the agreed upon limits.

I may cancel my consent at any time by doing one of the following:

1. Signing and dating a form that my doctor or her staff can give me called "Revocation of Consent for Use and Disclosure of Health Information."
2. Writing, signing and dating a letter to my doctor directly. If I write a letter, it must say that I want to cancel my consent to authorize the use and disclosure of my personal health information for treatment payment and healthcare options.

If I cancel this consent, my doctor and her staff do not have to provide any further health care services to me.

My doctor has a detailed document called the "Notice of Privacy Practices." It contains more information about the policies and practices protection of my privacy. I understand that I have the right to read the "notice" before signing this agreement. My doctor may update this "Notice". If I ask, the doctor or her staff will provide me with the most current "Notice" and it will always be available at my doctor's office.

My signature below indicates that I have been given the chance to review a current copy of my doctor's "notice of Privacy Practices." My signature means that I agree to allow my doctor to use the disclose of my personal health information to carry out treatment, payment and healthcare operation.

_____ _____
Patient or Legal Guardian Date

_____
Relationship to Patient

Financial Information

Maureen Holley, D.M.D.

Thank you for choosing us as your health care provider!

Your dental care is our primary concern and we will give you the highest quality of care in a comfortable environment. We have asked you to complete our medical and dental history forms so that we can give you the best care possible. We now ask you to read and sign our financial policy so there is no confusion regarding fee's in our office.

Payment is expected at the time of visit. If payment arrangements are necessary, our Office Coordinator will be happy to work this out with you prior to beginning your treatment. For your convenience we do accept Master Card, Visa and American Express.

If you have insurance, please provide us with your card. If we are able to accept your insurance company's assignment, we will gladly do so, and will give you an estimate as a guideline. We will ask for your deductible and your estimated patient portion. **We can make no guarantee of the insurance company's amount of payment.** Claims are submitted promptly after treatment is rendered, and if not paid by your insurance company by the 61st day after treatment, you will be billed in full. **All accounts not paid in full within 60 days will be charged a 5% interest fee per month.**

I agree to be fully responsible for total payment of procedures performed in this office, including any portion not covered by my insurance company. I agree that should this account be referred to an attorney or agency for collection that I will be responsible for all collection costs, attorney fee and court costs. I agree to pay 5% interest per month on this account if 60 days past due. I the undersigned, have read the above and assume responsibility for my account.

Signature_____ Date_____

Dear Patient,

This letter has been prepared for you to help you better understand the complexities of dental insurance; we understand how extremely confusing it can be. To begin, we would like to highlight a MISCONCEPTION-dental insurance was not designed to pay for all dental care. Most contracts have limits and / or various degrees of co-payment.

All levels of payment by insurance companies, including allowed fees usual and customary (UCR) are **governed by Premiums paid.** They have nothing to do with the actual charge. Our fees are based upon a combination of costs, our time, and our constant dedication to supplying our patients with the highest quality dental care! The treatment recommended by our office is never based on what your insurance company will pay. Your health and treatment should not be governed by an insurance contract.

It should also be understood, that the dental insurance contract is between the patient and the insurance company. The patient bears the ultimate financial responsibility.

We hope you find this information helpful. Please take the time to view your contract thoroughly so we can better serve you. As always, feel free to ask any questions for clarification on services, billing and insurance.

Sincerely,

Dr. Maureen M. Holley

Patient Signature *Date*