We are pleased to welcome you and/or your child to Mangat Dental Center! Please take a few minutes to fill out this form as completely as you can. If you have any questions, we're more than happy to assist you. We look forward to providing premium dental services and maintaining your dental health.

PATIENT INFORMATION

Date _____
SS/HIC/Patient ID # _____
Patient Name _____
Address _____
City _____
State _____ Zip _____
E-mail _____
Sex ☐ M ☐ F Age _____ Birthdate _____
☐ Married ☐ Widowed ☐ Single ☐ Minor
☐ Separated ☐ Divorced ☐ Partnered for _____ years

Occupation _____
Patient Employer/School _____
Employer/School Address _____
_____
Employer/School Phone (_____) _____
Spouse's Name _____
Brithdate _____ SS# _____
Spouse's Employer _____
Whom may we thank for referring you? _____

DENTAL INSURANCE

Subscriber's Name _____
Relationship to Patient _____
Brithdate _____ SS# _____
Insurance Co. _____
Group # _____ Phone (____) _____

Subscriber's Name _____
Relationship to Patient _____
Brithdate _____ SS# _____
Insurance Co. _____
Group # _____ Phone (____) _____

Is patient covered by secondary insurance? ☐ Yes ☐ No

PHONE NUMBERS

Home (_____) _____ Work (_____) _____ Ext _____ Cell (_____) _____
Spouse's Work _____ Best time and place to reach you _____

EMERGENCY CONTACT (In case of an emergency, specify someone who does not live in your household.)

Name _____ Relationship _____
Home (_____) _____ Work (_____) _____ Ext _____ Cell (_____) _____

DENTAL HISTORY

Reason for today's visit _____
_____
Former Dentist _____
City/State _____
Date of last dental visit _____
Date of last dental X-rays _____
How often do you floss? _____
How often do you brush? _____
Do you wear contact lenses? ☐ Yes ☐ No

Please check (☒) "yes" or "no" to indicate if you have had any of the following:

Bad breath	☐ Yes	☐ No	Jaw pain or tiredness	☐ Yes	☐ No
Bleeding gums	☐ Yes	☐ No	Lip or cheek biting	☐ Yes	☐ No
Blisters on lips or mouth	☐ Yes	☐ No	Loose teeth or broken fillings	☐ Yes	☐ No
Burning sensation on tongue	☐ Yes	☐ No	Mouth breathing	☐ Yes	☐ No
Chew on one side of mouth	☐ Yes	☐ No	Mouth pain	☐ Yes	☐ No
Cigarette, pipe, or cigar smoking	☐ Yes	☐ No	Orthodontic treatment	☐ Yes	☐ No
Clicking or popping jaw	☐ Yes	☐ No	Pain around ear	☐ Yes	☐ No
Dry mouth	☐ Yes	☐ No	Periodontal treatment	☐ Yes	☐ No
Fingernail biting	☐ Yes	☐ No	Sensitivity to cold	☐ Yes	☐ No
Food collection in teeth	☐ Yes	☐ No	Sensitivity to heat	☐ Yes	☐ No
Foreign objects in mouth	☐ Yes	☐ No	Sensitivity to sweets	☐ Yes	☐ No
Grinding teeth	☐ Yes	☐ No	Sensitivity when biting	☐ Yes	☐ No
Gums swollen or tender	☐ Yes	☐ No	Sores or growths in mouth	☐ Yes	☐ No

MEDICAL HISTORY

Physician's Name _____ Date of last Visit _____

Phone (_____)_____ Pharmacy _____ Phone (_____)_____

Please check (☒) "yes" or "no" to indicate if you have had any of the following:

AIDS	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Tonsilitis	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	HIV Positive	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Arthritis, Rheumatism	☐ Yes	☐ No	Jaundice	☐ Yes	☐ No	Tumors or growths	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Jaw Pain	☐ Yes	☐ No	Ulcer	☐ Yes	☐ No
Back Problems	☐ Yes	☐ No	Kidney disease	☐ Yes	☐ No	Venereal disease	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Liver disease	☐ Yes	☐ No			
Chemical Dependency	☐ Yes	☐ No	Low blood pressure	☐ Yes	☐ No	**Have you ever had or been diagnosed with:**		
Chemotherapy	☐ Yes	☐ No	Nervous problems	☐ Yes	☐ No	Artificial heart valves	☐ Yes	☐ No
Circulatory Problems	☐ Yes	☐ No	Psychiatric care	☐ Yes	☐ No	Artificial joints, screws, Pins, etc	☐ Yes	☐ No
Cortisone Treatments	☐ Yes	☐ No	Radiation treatment	☐ Yes	☐ No	Bleeding abnormally, with extractions or surgery	☐ Yes	☐ No
Cough, persistent or bloody	☐ Yes	☐ No	Respiratory disease	☐ Yes	☐ No	Blood disease	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Scarlet fever	☐ Yes	☐ No	Congenital heart lesions	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	Shortness of breath	☐ Yes	☐ No	Heart murmur	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No	Sinus trouble	☐ Yes	☐ No	Hernia repair	☐ Yes	☐ No
Fainting or dizziness	☐ Yes	☐ No	Skin rash	☐ Yes	☐ No	Mitral valve prolapse	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No	Special diet/Weight loss	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No
Headaches	☐ Yes	☐ No	Stroke	☐ Yes	☐ No	Rheumatic fever	☐ Yes	☐ No
Heart Problems	☐ Yes	☐ No	Swollen feet or ankles	☐ Yes	☐ No			
Hepatitis Type _____	☐ Yes	☐ No	Swollen neck glands	☐ Yes	☐ No	**Are you allergic to:**		
Herpes	☐ Yes	☐ No	Thyroid problems	☐ Yes	☐ No	Aspirin	☐ Yes	☐ No
						Barbiturates	☐ Yes	☐ No
Have you ever had any complications following dental treatment? ☐ Yes ☐ No			**Have you ever taken any of these medications?**			Codeine	☐ Yes	☐ No
			Blood Thinners	☐ Yes	☐ No	Ibuprofen	☐ Yes	☐ No
If yes, please describe _____			Coumadin	☐ Yes	☐ No	Latex	☐ Yes	☐ No
_____			Warfarin	☐ Yes	☐ No	Local Anesthesia	☐ Yes	☐ No
Have you ever been hospitalized or do you have other health concerns? ☐ Yes ☐ No			Diet Medications	☐ Yes	☐ No	Metals (i.e. gold)	☐ Yes	☐ No
			Dexfenfluramine	☐ Yes	☐ No	Penicillin	☐ Yes	☐ No
If yes, please describe _____			Fen-phen	☐ Yes	☐ No			
_____			Pondimin	☐ Yes	☐ No	Other _____		
Women: Are you pregnant? ☐ Yes ☐ No			Redux	☐ Yes	☐ No			
Due date _____			Levoxyl	☐ Yes	☐ No			
Are you nursing? ☐ Yes ☐ No			Synthroid	☐ Yes	☐ No			
Taking birth control pills? ☐ Yes ☐ No								

Please PRINT all medications now taking: _____

_____

SIGNATURES

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

Insurance Agreement: I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr. _____ all
Name of Insurance Company(ies)
insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Authorization to Release Protected Health Information: I understand that there may be a need to consult with other health care providers. I voluntarily authorize Dr. _____ to use and/or
Name of Doctor Disclosing PHI
disclose my Protected Health Information (PHI) related to _____. The information will be used and/or disclosed for the
Describe in detail the Protected Health Information you are authorizing to be used and/or disclosed
purposes of _____. I authorize Dr. _____ to receive and use the information.
Describe each purpose for which you are authorizing your Protected Health Information to be used and/or disclosed *Name of Doctor Receiving PHI*
This authorization will end when my current treatment plan is completed or one year from the date signed below. I understand that once the information is released it may be re-disclosed by the recipient and may no longer be protected by federal privacy regulations. I understand that I may revoke this authorization at any time by notifying, in writing, the above-named doctor disclosing the PHI. However, if I do revoke this authorization, it will not have any effect on any actions taken by the above-named doctor disclosing the PHI prior to their receipt of the revocation. I understand that my treatment cannot be conditioned on whether I sign this authorization. I understand I may refuse to sign this authorization.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative *Date*

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative *Relationship to Patient*

DOCTOR'S COMMENTS & UPDATE

(to be completed by your dentist)

Medical Clearance Letter Sent to _____ Date _____

Results_____

Signature _____ Date _____

FINANCIAL POLICY

We feel everyone benefits when there is a definite and clear understanding of our financial policy prior to dental treatment. Please review the following:

1. An estimate of your total fee will be outlined in detail with you at the time of your initial visit. Payment is due at the time of service.

2. With any treatment involving laboratory fees, such as crowns, bridges, dentures, and partials, you may choose to pay 50% of the total fee on the preparation date and the balance upon delivery.

3. PATIENTS WITH INSURANCE:
   As a courtesy, our office will file your insurance claims as long as you provide us with current and proper information. You are expected to pay your co-pay and deductibles at the time services are rendered. If your insurance company does not make a payment within 60 days, you will be notified. If payment is not received within 90 days, you are responsible for the full remaining balance.

4. MISSED APPOINTMENT FEE:
   We appreciate your consideration in giving our office at least 24 hour advanced notice if you need to reschedule your appointment. If you do not show up to your appointment *without prior notice*, a $25.00 fee will be charged to your account. If you do not show up for a bridge or root canal treatment appointment *without prior notice*, a $75.00 fee will be charged to your account.

5. RETURNED CHECKS:
   A $35.00 fee applies to all returned checks from the bank. You will be responsible for the balance on your account.

For your convenience, we accept **CASH, PERSONAL CHECKS, VISA, MASTERCARD**, and **AMERICAN EXPRESS.** We can also assist you in obtaining a **3 MONTH, 6 MONTH, or 12 MONTH NO INTEREST FINANCING PLAN** through Care Credit Finance.

I HAVE READ AND AGREE TO ALL OF THE ABOVE FINANCIAL POLICIES:

Name of Patient	Signature of Patient	Date

Notice of Privacy Practices Acknowledgement

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plant, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from a third-party payer.
- Conduct normal health care operations such as quality assessments and physical certifications.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time, and that I may contact this organization to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patients Name _____

Signature _____

Date _____/_____/_____

Office Use Only

I attempted to obtain the patient's signature in acknowledgement of this Notice of Privacy Practices, but was unable to do so as documented below:

Reason: _____ Date: _____/_____/_____

Initials: _____