MailloxDentistry
WHERE SMILES BEGIN

HIPAA PRIVACY PRACTICES

I acknowledge that Mailloux Dentistry's "Notice of Privacy Practices" has been made available to me. I understand I have the right to review Mailloux Dentistry's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of healthcare operations at Mailloux Dentistry.

The Notice of Privacy Practices is also provided upon request at the main administration desk of this practice. This Notice of Privacy Practices also describes my rights and Mailloux Dentistry's duties with respect to my protected health information.

Mailloux Dentistry reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting that a revised copy be sent in the mail or by asking for one at the time of my next appointment.

_____

Signature of Patient or Personal Representative *Date*

_____

Description of Personal Representative's Authority (Parent/Legal Guardian) *Date*

Please list below the names of person(s) authorized to gain access to patient account information:

_____

_____

_____

For office use only:

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:

- The patient refused to sign
- Communication barrier
- Emergency situation

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PATIENT INFORMATION

Dr. Mr. Mrs. Ms. _____
(CIRCLE ONE) LAST FIRST INITIAL SHORT NAME

Date of Birth: ____ / ____ / ____ Sex: M F

Patient SS #: _____ Driver's License #: _____

Home Address: _____
STREET CITY STATE ZIP

Email Address: _____

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

Patient's Employer: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

How did you hear about our office? _____

I would like appointment reminders by: Text ☐ Phone call ☐

DENTAL INSURANCE INFORMATION

Subscriber's Name: _____ SS#: _____

Relationship to Patient: _____ Subscriber's Date of Birth: ____ / ____ / ____

Insurance Company Name: _____ Group Number: _____

Employer Name and Full Address: _____ Member ID: _____

Work Phone: _____

DO YOU HAVE OTHER DENTAL COVERAGE?

No Yes, please complete the following:

Subscriber's Name: _____ SS#: _____

Relationship to Patient: _____ Subscriber's Date of Birth: ____ / ____ / ____

Insurance Company Name: _____ Group Number: _____

Employer Name and Full Address: _____ Member ID: _____

Work Phone: _____

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DENTAL & MEDICAL INFORMATION

Name: _____

What is the reason for your dental visit today? _____

Date of last exam: ___ / ___ / ___ What was done at that time? _____

Name of previous dentist: _____

Have you had any problems associated with previous dental treatment? No If yes, please list:

_____

Do you or have you had any of the following?

Bleeding, sore gums	Y	N	Brux or grind teeth	Y	N
Teeth sensitive to cold/hot, sweets, pressure	Y	N	Have you had any past periodontal (gum) treatments?	Y	N
Unpleasant taste/bad breath	Y	N	Ever had orthodontic (braces) treatment?	Y	N
Frequent sores, ulcers in mouth/lips	Y	N	Ever had a serious injury to your head or mouth?	Y	N
Swelling/lumps in mouth	Y	N	Are you happy with your smile?	Y	N
Loose Teeth	Y	N	Are you interested in improving your smile?	Y	N
Currently experiencing pain or discomfort	Y	N	Are you interested in whitening?	Y	N
Earaches or neck pains	Y	N	Have you ever taken any medications for bone density?	Y	N
Clicking, popping, or discomfort in the jaw	Y	N	*(Fosamax, Boniva, Reclast, Zometa, Prolia, Humana, Xgeva)*		
Dry mouth	Y	N	Please list and date: _____		
Difficulty opening or closing jaw	Y	N	_____		
			_____		

Are you now under the care of a physician? Y N Date of last physical exam: ___ / ___ / ___

Physician Name: _____ Location: _____

What is your general state of health? Excellent Good Fair Poor

If female: Are you pregnant or nursing? Y N

Has there been any change in your general health within the last year? Y N

If yes, what condition is being treated? _____

Have you had any major surgeries or illnesses in the past 5 years? Y N

If yes, what was the illness or problem? _____

Do you or have you had any of the following?

Epilepsy or Seizures	Y	N	High Blood Pressure	Y	N	Cancer	Y	N
Fainting or Dizziness	Y	N	Irregular Heart Beat	Y	N	Type: _____		
Emphysema / Bronchitis	Y	N	Rheumatic Fever	Y	N	Chemotherapy	Y	N
Tuberculosis / PPD+	Y	N	Heart Murmur	Y	N	Radiation Therapy	Y	N
Asthma	Y	N	Mitral Valve Prolapse	Y	N	Thyroid Disease	Y	N
Sinus Problems	Y	N	Congenital Heart Lesions	Y	N	AIDS / HIV+	Y	N
Bleeding / Blood Disorder	Y	N	Heart Surgery	Y	N	Arthritis	Y	N
Bruise / Bleed Easily	Y	N	Artificial Heart Valves	Y	N	Artificial Joints	Y	N
Hepatitis A, B, C	Y	N	Pacemaker	Y	N	Diabetes	Y	N
Liver Disease	Y	N	Stroke	Y	N	Organ Transplants	Y	N
Pneumonia	Y	N	**Allergies:**			Osteoporosis / Penia	Y	N
Nervousness / Anxious	Y	N	Penicillin	Y	N	Snoring	Y	N
Kidney Problems	Y	N	Clindamycin	Y	N	Sleep Apnea	Y	N
Heart Problem	Y	N	Other: _____			Tobacco Use	Y	N
Chest Pain / Angina	Y	N				Vaping	Y	N
						Interested in quitting?	Y	N

Do you have any condition, disease, or problem not previously listed? _____

List all prescription or over the counter medicines, vitamins, natural or herbal preparations, and/or dietary supplements:

_____

Patient Signature, Date: _____ Dentist Signature, Date: _____

Patient Signature, Date: _____ Dentist Signature, Date: _____

Patient Signature, Date: _____ Dentist Signature, Date: _____

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WRITTEN FINANCIAL POLICY

Thank you for choosing Mailloux Dentistry. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

- Cash, Check, Visa, Mastercard, American Express, or Discover Card

  We offer a 5% courtesy accounting adjustment to patients who pay for their treatment with cash or check prior to completion of care for treatment plans of $500 or more. (Discount cannot be used in combination with insurance).

- Convenient Monthly Payment Options[1] from CareCredit Healthcare Credit Card
  - Allow you to pay over time.
  - No annual fees or pre-payment penalties.

Please Note:

Mailloux Dentistry requires payment prior to the completion of your treatment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment. However, if we do not receive payment from your insurance carrier within 30 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier. All co-pays are due at time of treatment.

Cancellation Policy:

A fee of $50 is charged for patients who cancel 2 times or more in a calendar year without 48-hour notice.

A fee of $50 is charged for any MISSED appointment.

Mailloux Dentistry charges $25 per returned check.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

_____ _____

Patient, Parent, or Guardian Signature *Date*

_____

Patient Name (Please Print)

[1] Subject to credit approval

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PERMISSION TO USE PHOTOGRAPHS

I, _____ , on behalf of myself or a minor or incapacitated child of mine, grant permission to Mailloux Dentistry, its representatives, employees, and related businesses to photograph my case.

I authorize Mailloux Dentistry, it assigns and transferees to copyright, use and publish the photographs in print and/or electronically, in perpetuity.

I agree that Mailloux Dentistry may use such photographs of me with or without my name for any lawful purpose, including for such purposes as publicity, education, illustration, advertising, and web content, in perpetuity.

Check box that applies:

- ☐ I consent to use of my pictures.
- ☐ I authorize the use of my intra-oral, retracted, and oral photos for the above mentioned uses and purposes with the exception of no identifying pictures such as headshots and/or names.

I HAVE READ AND UNDERSTAND THE ABOVE

Signature: _____ Date: _____

I, _____ as parent or guardian of the child(ren) named below, authorize as described above for my minor child(ren) whose name(s) is/are:

_____ _____

Printed name of child Printed name of child

Signature: _____ Date: _____