# mintdental

Welcome to our dental practice! We are so glad you are a part of our dental team.
Please complete the following forms.

**Patient Information**

Legal Name: _____

Home Address: _____

City: _____State: _____ Zip: _____

Home#: _____ Cell#: _____ Alt#: _____ E-Mail: _____

DOB: _____ Gender: _____ Preferred Name: _____

Previous Dentist: _____ Date of last dental visit: _____ Were X-rays taken? _____

Name of your physician: _____Phone #: _____

***It is required that we have physician information on file***

Do you have any **medical conditions**? If so, please list: _____

Are you taking any **medications** daily**?** If so, please list: _____

Have you ever been **hospitalized**? If so, please explain: _____

Are you **allergic** to anything? If so, please explain: _____

Do you need to **pre-medicate?** If so, please explain: _____

Do you have a **latex allergy?** _____

Do you use **tobacco products**? If so, please write type and frequency: _____

Are you taking **oral or IV bisphosphonates?** Any history of use? _____

Are you **pregnant or trying to get pregnant?** _____

Do you experience **excessive bleeding?** Please explain: _____

Do you use **controlled substances?** If so, please explain: _____

**Please Circle Y/N for the following:**

| | | | | | |
|---|---|---|---|---|---|
| AIDS/HIV | Y/N | Emphysema | Y/N | Irregular Heartbeat | Y/N |
| Anemia | Y/N | Epilepsy/Seizures | Y/N | Low Blood Pressure | Y/N |
| Angina | Y/N | Excessive Bleeding | Y/N | Mitral Valve Prolapse | Y/N |
| Arthritis/Gout | Y/N | Fainting/Dizziness | Y/N | Osteoporosis | Y/N |
| Artificial Heart Valve | Y/N | Heart Attack/Failure | Y/N | Pain in Jaw Joints | Y/N |
| Artificial Joint | Y/N | Heart Murmur | Y/N | Psychiatric Care | Y/N |
| Asthma | Y/N | Heart Pacemaker | Y/N | Recent Weight Loss | Y/N |
| Cancer | Y/N | Heart Trouble/Disease | Y/N | Renal/Kidney Problems | Y/N |
| Chemo/Radiation | Y/N | Hemophilia | Y/N | Sickle Cell Disease | Y/N |
| Cold Sores/Fever Blisters | Y/N | Hepatitis A, B, C | Y/N | Stroke | Y/N |
| Cortisone Medicine | Y/N | Herpes | Y/N | Swelling of Limbs | Y/N |
| Diabetes | Y/N | High Blood Pressure | Y/N | Thyroid Disease | Y/N |
| Drug Addiction | Y/N | High Cholesterol | Y/N | Tuberculosis | Y/N |

****Highlighted items may require a medical consult with physician prior to dental treatment****

**Other**: _____

***Emergency Contact:*** Name: _____ Relationship: _____ Telephone Number: _____

## How May We Contact You?

Patient Name: _____

*Please circle **YES or NO** for the following questions:*

- May we leave voicemails regarding appointments? YES / NO

  Preferred telephone number to receive correspondences: _____

- May we send emails regarding appointments? YES / NO

  Preferred Email address to receive correspondences: _____

- May we send text messages regarding appointments? YES / NO

  Preferred telephone number to receive correspondences: _____

- May we release information to anyone other than yourself? YES / NO

  If yes, who & relationship to you**?** _____

- May we leave the above messages regarding sensitive financial or medical information? YES / NO

The office of Linker & Raynor Family Dentistry is authorized to release protected health information about the above named patient to the entities named above. I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected.

**Patient Information**

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward. I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

**Signature: _____ Date: _____**

*If this form is being completed on behalf of a minor, a parent or legal guardian must complete and sign this form*

**Primary Insurance Info**

Patient's Name: _____

Policy Holder's Social Security #: _____ Policy Holder's DOB: _____

Responsible Party's Address: _____

City: _____ State: _____ Zip Code: _____

Relationship to Policy Holder: Self / Spouse / Child / Other

Policy Holder's Employer: _____Insurance Company: _____

Member ID: _____Group Number: _____

**Secondary Insurance Info**

Policy Holder's Social Security #: _____ Policy Holder's DOB: _____

Relationship to Policy Holder: Self / Spouse / Child / Other

Employer: _____Insurance Company: _____

Member ID: _____Group Number: _____

**Employment Info:** Full time / Part time / Retired

Student Info: Full time / Part time

Employer Name: _____ Employer Phone #: _____

*By signing this document I agree for Drs. Linker and Raynor to submit insurance claims on my behalf. I also agree that I am financially responsible for the account balance.*

**Signature: _____Date: _____**

**HIPAA**

*See Notice of Privacy Practices*

I agree that I have received a copy of the Notice of Privacy Practices for the office of Dr. Linker & Dr. Raynor

**Signature**: _____**Date**: _____

## Late/Broken Appointment Policy

We set aside specific time for each one of our patients to ensure we are able to provide quality dental treatment. We understand that situations arise in which you can't make your scheduled appointment. We ask that you provide at least **24-hour notice** to **change or cancel** your appointment. By doing so, we can offer your time to another patient who is waiting to receive treatment. The lack of adequate notice is considered a no show.

**TWO or more no shows and cancellations with less than 24-hour notice may be subject to a $50 cancellation fee.** Patients who do not show up or give adequate notice three (3) or more times may be dismissed from the practice and may be denied future appointments. Cancellation fees are the sole responsibility of the patient and must be paid in full before the next appointment.

We understand that special circumstances may cause you to miss your appointment or give adequate notice. Cancellation fees in this instance may be waived at the discretion of the doctors.

## Financial Policy/Agreement

Please understand that all fees are given as an **estimate** based on your own insurance policy. We try our hardest to give you the most accurate patient portion, and even with a pre-determination from insurance it is still only an estimate. We request ***all payment of patient portions be taken care of at the time of the appointment*** unless there are other financial arrangements made. Either Dr. Linker or Dr. Raynor approves all financial agreements.

*By signing this document I have read and understand the late/broken appointment policy and the financial policy/agreement.*

**Signature**: _____**Date:** _____

If this form is being completed on behalf of a minor, a parent or legal guardian must complete and sign this form.