

Date: _____

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Middleton Family Dentistry

Family. It's the people you rely on. At Middleton Family Dentistry, we build relationships with our patients based on trust and comfort. Our friendly team will exceed your expectations and make you feel right at home.



Thank you for choosing us for your dental needs. What brought you to Middleton Family Dentistry?

Website Google/Internet Reviews Facebook Insurance Referral _____ Other _____

Patient Information

Check appropriate box: Single Married Divorced Widowed

First Name: _____ Middle Initial: _____ Last Name: _____

Birthdate (mm/dd/yyyy): _____ Email: _____ Phone#: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Gender: _____ Employer: _____ Employer's Phone#: _____

SS#/SIN (Required by dental insurance companies): _____ Insurance Plan: _____

Subscriber ID#: _____ Group#: _____ Ins. Phone#: _____

Ins. Claims Mailing Address: _____

Responsible Party Check here if same as above

Parent/Guardian's Full Name: _____ Birthdate: _____ Phone#: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Emergency Contact: _____ Relation: _____ Phone#: _____

Dental History (New patients ONLY) Previous Dentist: _____ Last Exam Date: _____

Medical History

- | | Yes | No |
|---|--------------------------|--------------------------|
| 1. Are you pregnant or currently nursing?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you been hospitalized for a surgical operation or serious illness within the last 5 years?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, please explain _____ | | |
| 2. Are you taking any medications, including non-Prescription medicine?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, please explain _____ | | |
| 3. Have you taken Viagra, Revatio, Cialis, or Levitra in the last 24 hours?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you use tobacco products and/or vaping devices?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you use controlled substances?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Are you allergic to or have you had any reactions to any of the following? | | |
| Local anesthetics (e.g., Novocaine)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Penicillin..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Sulfa Drugs..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Barbiturates..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Sedatives..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Hydrocodone/Codeine..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Aspirin..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Metals (e.g., nickel, mercury, etc.)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Latex Rubber..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Other (please list)..... | <input type="checkbox"/> | <input type="checkbox"/> |

- | | Yes | No |
|--|--------------------------|--------------------------|
| 7. Do you have or have you had any of the following? | | |
| Joint Replacement or Implant..... | <input type="checkbox"/> | <input type="checkbox"/> |
| High/Low Blood Pressure..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Disease/Attack..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Cardiac Pacemaker..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Mitral Valve Prolapse..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Cancer/Leukemia/Radiation Therapy..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Stroke..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Arthritis..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Hepatitis/Jaundice..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Sexually Transmitted Infection..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Aids or HIV Infection..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Stomach Troubles/Ulcers..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Tuberculosis..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Glaucoma..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Asthma/COPD/Emphysema..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Sleep Apnea..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Fainting/Seizures/Epilepsy..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Kidney Disease..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Thyroid Problem (hypo/hyper)..... | <input type="checkbox"/> | <input type="checkbox"/> |

9. Are you currently taking or have you taken any of the following medications for osteoporosis?
- | | |
|--|---|
| <input type="checkbox"/> Actonel (Risedronate) | <input type="checkbox"/> Aredia (Pamidronate) |
| <input type="checkbox"/> Zometa (Zoledronic) | <input type="checkbox"/> Fosamax Plus D |
| <input type="checkbox"/> Bonifos (Clodronate) | <input type="checkbox"/> Skelid (Tiludronate) |
| <input type="checkbox"/> Didronel (Etidronate) | <input type="checkbox"/> Boniva (Ibandronate) |
| <input type="checkbox"/> None | <input type="checkbox"/> Other _____ |

ACKNOWLEDGEMENT OF HIPAA

Please check one. I have read a copy of Middleton Family Dentistry's HIPAA Privacy Notice.

I **allow** the following person(s) to obtain my information protected by the HIPAA Privacy Notice.

_____ and _____
The person(s) above may have access to my treatment, billing, and appointment information.

I **do not allow** anyone outside of Middleton Family Dentistry to have access to this information.

FINANCIAL POLICIES

Thank you for choosing Middleton Family Dentistry. An important part of our mission is making the cost of optimal care manageable by providing several payment options. Please read through the policies and let us know if you have any questions.

- Middleton Family Dentistry requires payment at the beginning of treatment.
- For patients without dental insurance, we offer a 5% courtesy discount for treatment that is paid in full with cash or check at the time of the appointment.
- Care Credit is subject to credit approval. No discounts are offered for payment with Care Credit.
- For patients with dental insurance, we are happy to work with your carrier to maximize your benefits. However, all co-pays or estimated patient portions are due at the time of service. If we receive more than is estimated from insurance, we will issue a refund to you. In the the event that your insurance pays less than what was estimated, the new balance due will be your responsibility.
- Any overdue balance not paid within 30 days will be subject to a finance charge of 1.5% monthly (18% annually). Any account with a patient balance over 90 days may be turned over to a collection agency for collection, and any fees charged by the agency and/or attorney will be the patient's responsibility.
- Middleton Family Dentistry will charge a \$40.00 return check fee.

APPOINTMENT POLICIES

Please initial each policy to demonstrate your understanding.

_____ In our office, we value the time appointed for all of our patients. If you are unable to make it to your appointment on time, please call, and we may be able to find a later appointment for you on the same day if the schedule permits.

_____ As a courtesy to the practice and other patients, please give at least 48 hours notice if you need to cancel or reschedule, so that we may offer that appointment time to another patient. We reserve the right to charge a \$35.00 administrative fee for not showing up to an appointment, or for appointments cancelled without a 48 hour notice.

By initialing above and signing below, I have read and understand the information presented, and all my questions have been answered.

Signature: _____ Date: _____