Thank you for being a part of our practice!

MARANDA A. BLISS
DMD, PC

First Name: _____

Last Name: _____

Preferred Name: _____

Alternate Last Name: _____

Date of Birth: _____

Social Security Number: _____

Phone Number (cell): _____

Phone Number (home): _____

Phone Number (work): _____

Address:

_____

_____

Sex: _____

Marital Status: _____

Email: _____

Employer: _____

Position: _____

Emergency Contact: _____

Date of Birth: _____

Phone Number: _____

Address: _____

Preferred Pharmacy: _____

Pharmacy Address: _____

Is there anyone we can thank for referring you to our practice? _____

Or, how did you hear about our practice? _____

For your convenience, we offer the following methods of payment. Please, circle the option you prefer.

Terms of Payment:

Cash Check Credit Card: Amex Discover Mastercard Visa

_____ I am interested in the office's in-house discount plan.

_____ I plan to use insurance as a form of payment.

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Operational Policy

Patients are responsible for all charges for dental services and materials, even if they are using dental insurance as a term of payment.

This office adheres to the ADA regulations for x-rays, and patients are responsible for furnishing recent x-rays, if applicable. Furthermore, patients are responsible for any and all charges associated with x-rays taken in this office in order to meet ADA guidelines.

This is a medical office, and the staff does everything in its power to comply with HIPAA regulations.

The doctor may prescribe treatment, and patients may be dismissed from the practice for consistent refusal of treatment.

This office works to provide excellent dental care to all patients. Patients must give 24 hours' notice in the event they need to reschedule their appointment. If patients miss an appointment without contacting the office within the required time, this will be considered a missed appointment and a $50.00 fee will be charged to the account. This fee cannot be billed to any insurance company and will be the patient's direct responsibility. No future appointments can be scheduled, nor records transferred without the payment of this fee.
Additionally, if patients are more than 20 minutes late for a scheduled appointment without prior notice, this will be considered a missed appointment and the $50.00 fee will apply.

Signature of Patient or Patient's Guardian: _____

Date: _____

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Term of payment details: Dental Insurance
I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with any claims.

Signature: _____

Date: _____

Policy Holder Name: _____

Relationship to You: _____

Policy Holder Birth Date: _____

Policy Holder Social Security Number: _____

Policy Holder ID/Member #: _____

Policy Holder Employer: _____

Policy Holder Group #: _____

Insurance Company: _____

Insurance Company Phone #: _____

Insurance Company Address: _____

_____

As a courtesy to our patients, we will file your dental claims and accept assignment of benefits from participating insurance providers. There are many different types of insurance policies available. Your employer has arranged this contract between you, your employer, and the insurance company. We are not party to this contract. Ultimately, any balance remaining for services is your responsibility. Our staff will assist you to the best of our ability.

If you have two dental insurance policies, please ask for a second copy of this form.

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DMD, PC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may Refuse to Sign This Acknowledgement

I _____, have received a copy of this office's Notice of Privacy Practices.
{Print Name}

_____
{Signature}

_____
{Date}

I give permission to discuss all aspects of my dental treatment to the individuals listed below:

_____ _____
{Parents Name} {Spouse}

_____
{Parents Name}

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (please specify)

_____

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DMD, PC

Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Patient's Name: _____ Birth Date: _____

Are you under a physicians care now? **YES** **NO** If yes please explain: _____

Have you ever been hospitalized or had a major operation? **YES** **NO** If yes please explain: _____

Have you ever had a serious head or neck injury? **YES** **NO** If yes please explain: _____

Do you take, or have you taken, Pen-Fen or Redux? **YES** **NO** If yes please explain: _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing biphosphates? **YES** **NO** If yes please explain: _____

Are you on a special diet? **YES** **NO** If yes please explain: _____

Do you use tobacco? **YES** **NO** If yes please explain: _____

Do you use controlled substances? **YES** **NO** If yes please explain: _____

Medications currently taking: _____

_____

Women: Are you…

Pregnant/ Trying to get pregnant? **YES** **NO**

Taking oral contraceptives? **YES** **NO**

Nursing? **YES** **NO**

Are you allergic to any of the following (please circle the ones that apply to you)…

Aspirin Penicillin Codeine Acrylic Metal Latex

Local Anesthetics Other: _____

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Do you have or have you had any of the following?

AIDS/HIV positive **YES NO**	Cortisone Medicine **YES NO**	Hemophilia **YES NO**	Renal Dialysis **YES NO**
Alzheimer's Disease **YES NO**	Diabetes **YES NO**	Hepatitis A **YES NO**	Rheumatic Fever **YES NO**
Anaphylaxis **YES NO**	Drug Addiction **YES NO**	Hepatitis B or C **YES NO**	Rheumatism **YES NO**
Anemia **YES NO**	Easily Winded **YES NO**	Herpes **YES NO**	Scarlet Fever **YES NO**
Angina **YES NO**	Emphysema **YES NO**	High Blood Pressure **YES NO**	Shingles **YES NO**
Arthritis/Gout **YES NO**	Epilepsy or Seizures **YES NO**	Hives or Rash **YES NO**	Sickle Cell Disease **YES NO**
Artificial Heart Valve **YES NO**	Excessive Bleeding **YES NO**	Hypoglycemia **YES NO**	Sinus Trouble **YES NO**
Artificial Joint **YES NO**	Excessive thirst **YES NO**	Irregular Heartbeat **YES NO**	Spina Bifida **YES NO**
Asthma **YES NO**	Fainting Spells/Dizziness **YES NO**	Kidney Problems **YES NO**	Stomach/Intestinal Disease **YES NO**
Blood Disease **YES NO**	Frequent Cough **YES NO**	Leukemia **YES NO**	Stroke **YES NO**
Blood Transfusion **YES NO**	Frequent Diarrhea **YES NO**	Liver Disease **YES NO**	Swelling of Limbs **YES NO**
Breathing Problem **YES NO**	Frequent Headaches **YES NO**	Low Blood Pressure **YES NO**	Thyroid Disease **YES NO**
Bruise Easily **YES NO**	Genital Herpes **YES NO**	Lung Disease **YES NO**	Tonsillitis **YES NO**
Cancer **YES NO**	Glaucoma **YES NO**	Mitral Valve Prolapse **YES NO**	Tuberculosis **YES NO**
Chemotherapy **YES NO**	Hay Fever **YES NO**	Pain in Jaw Joints **YES NO**	Tumors or Growths **YES NO**
Chest Pains **YES NO**	Heart Attack/Failure **YES NO**	Parathyroid Disease **YES NO**	Ulcers **YES NO**
Cold Sores/Fever Blisters **YES NO**	Heart Murmur **YES NO**	Psychiatric Care **YES NO**	Venereal Disease **YES NO**
Congenital Heart Disorder **YES NO**	Heart Pace Maker **YES NO**	Radiation Treatments **YES NO**	Yellow Jaundice **YES NO**
Convulsions **YES NO**	Heart Trouble/Disease **YES NO**	Recent Weight Loss **YES NO**	

Comments: _____

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Doctor Comments:

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patients) health. It is my responsibility to inform the dental office of any changes in medical status. I agree that regardless of insurance coverage, I am responsible for payment of services rendered and that any party of my account balance ages past 30 days, a finance charge of 1.5% monthly will be applied.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN: _____ DATE: _____

DOCTOR SIGNATURE: : _____ DATE: _____