Welcome

to Tyngtown Dental

Please take a few minutes to answer the following questions so we can better assist you with your dental needs.

PATIENT INFORMATION

Date ________________________ Soc. Sec # ________________________ Birthdate __________________________

Name ____
Last Name First Name Middle

Address ____ Phone _____________________________________

City ____ State ___________________ Zip ________________________

Sex: ❑ M ❑ F Status: ❑ Minor ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

Employer ____ Business Phone ___________________________

Business Address: ____ Occupation _______________________________

Who should we thank for referring you? ____

In case of emergency, who should we contact? ___________________________ Phone __________________________

PRIMARY DENTAL INSURANCE

Person Responsible for Account ____

Relationship to Patient ___________________ Birthdate ________________ Soc. Sec. # __________________________

Address ____ Phone ____________________________

City ____ State ____________ Zip __________________

Responsible Party Employed By ______________________________________ Business Phone _____________________

Business Address ____ Occupation ________________________

Insurance Company ____

Insurance Address ____

Subscriber I.D. # ____ Group # ___________________________

SECONDARY DENTAL INSURANCE

Insured Name ____
Last Name First Name Middle

Relationship to Patient _______________________ Birthdate ______________ Soc Sec. # _________________________

Address ____ Phone _____________________________

City ____ State ____________________ Zip __________________________

Insured Employed By ____ Business Phone ______________________

Insurance Company __________________________________ Address ____

Subscriber I.D. # _____________________________________ Group # ____

Tyngtown Dental
1445 Main St Wilton, ME 04294

DENTAL TREATMENT CONSENT

1. I authorize dental treatment including local anesthesia, examination, radiographs (x-rays) or diagnostic aids.
2. In general terms, dental treatment may include but is not limited to one or a number of the following:
    - Administration of local anesthesia
    - Cleaning of the teeth and application of topical fluoride
    - Scaling and root planning with local anesthesia
    - Application of sealants to the grooves of teeth
    - Treatment of disease or injured teeth with dental restorations. These restorations may either be amalgam (silver) or composite (white).
    - Stainless steel crowns for children. These are necessary in cases where a simple filling would not be the best long term restoration or in cases where there are large cavities.
    - The replacement of missing teeth with a dental prosthesis (crowns, partials, etc.)
    - Treatment disease or injured oral tissues (hard/or soft)
    - Treatment of malposed (crooked) teeth and/or development abnormalities.
    - Treatment of canal or pulp chamber that lies in the middle of the tooth and its root also knows as “endodontic” therapy or (root canal treatment)

Risks of Dental Procedures in General
Including (but not limited to) are complications resulting from the use of dental instruments, drugs, medicines, analgesics (pain killers), anesthetics and injections. These complications include pain, infection, swelling, bleeding, sensitivity, numbness and tingling sensations in the lip, tongue, chin, gums, cheeks and teeth, thrombophlebitis (inflammation of a vein), reactions to injections, change in occlusions (biting), muscle cramps and spasms, temporomandibular (jaw) joint difficulty, loosening of the teeth or restoration in the teeth, injury to other tissues, referred pain to the ear, neck, and head, nausea, allergic reactions, itching, bruising, delayed healing, sinus complications and further surgery.

Changes in Treatment Plan
I understand that during treatment, it may be necessary to change and/or all procedures because of Conditions found while working on the teeth that were not discovered during examination. Upon being informed I will give my permission to the dentist to make any/all changes and addition as necessary.

Fillings
I understand that I may experience hot and cold sensitivity, pain or discomfort following routine restorative procedures and that this is usually temporary and should settle without further treatment. If in the event that my condition does not get any better, I understand that I may need further dental treatment, the most common being root canal therapy, resulting in additional costs.

Crown (Caps) and Bridges
I understand that sometimes it is not possible to match the color of the natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept in place until the permanent crowns are delivered. I realize the final opportunity to make changes in any new crown or bridge (including shape, fit, size and color) will be before cementation. One cemented, I understand that any changes in shape, fit, size, or color will incur an additional charge.

Alternative Treatment
I understand that I have the right to choose on the basis of adequate information, from alternate treatment plans that meet professional standards of care.

By signing below, I consent to the general dental treatments and/or proposed treatment.

Signature of Patient, Parent or Guardian _____________________________________ Date ______________

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1445 Main St Wilton, ME 04294

Tyngtown Dental Financial Policies

Thank you for choosing Tyngtown Dental! In an effort to better serve you, we would like to take the time to explain the billing process at our office.

Payment is expected the day services are rendered. For patients with dental insurance, if you provide the office with your dental insurance information, we will contact your insurance company and verify your benefits. We will do our best to answer any questions you may have about your insurance coverage but always suggest that you contact them directly whenever possible.

As a courtesy to you, we will gladly submit the insurance claim to your insurance company on the day of service. We will collect the estimated copayment and deductible at each visit. We make every effort to determine your insurance benefits when you receive treatment, but consider your co-payment an **estimate** until we receive payment from your insurance company. Please remember that any information we provide relative to your insurance coverage is our best **estimate** and not a guarantee of the payment that will be received.

In order to provide quality dental care in a timely manner, we have a cancellation and no show policy. This policy enables us to better utilize available appointments for our patients in need of dental care.

CANCELLATION OF AN APPOINTMENT

In ordered to be respectful of other patient's needs, please be courteous and call our office promptly if you are unable to keep your appointment. This time will be given to someone who is in urgent need of treatment. We ask that you notify us 48 business hours in advance, in order to cancel or reschedule any appointments.

NO SHOW POLICY

A "no show" is an appointment that was not cancelled in advance (48 business hours). No shows inconvenience other patients who need dental care. A no show for a scheduled appointment will be charged $80.00.

LATE ARRIVALS

If you are running late for your appointment, please call the office. If you are more than 15 minutes late to your scheduled appointment, you may be asked to reschedule.

I have read and understand the appointment policy at Tyngtown Dental. I have also read and understand the billing procedures at Tyngtown Dental. I agree to be responsible for full payment of all charges for dental service performed on me. If for any reason the insurance does not pay its estimated portion, I agree that I will be responsible for the account balance. In the event that my account is placed with a third party collection agency or attorney, I will be assessed any fees relating to this action.

Print Name _________________________________ __

Signature _____________________________________ Date ______________________________

Tyngtown Dental
1445 Main St Wilton, ME 04294

CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

1. Permission to Use and Disclose My Health Information. By signing this form, I give Tyngtown Dental permission to use and/or disclose my health information to carry out treatment, payment or health care operations.

2. Right to Refuse. I have the right not to sign this consent. If I refuse to sign this consent Tyngtown Dental will not provide me with treatment until I consent. However, treatment required by law, such as emergency care, can be provided to me whether or not I sign this consent.

3. Changes to the Privacy Notice Tyngtown Dental may change the Notice of Privacy Practices as needed. I may obtain a current copy of Tyngtown Dental Notice of Privacy Practices by contacting Tyngtown Dental.

4. Right to Request Restrictions on Use/Disclosure. I have the right to request that Tyngtown Dental restrict how he uses and/or discloses my protected health information for the purpose of providing treatment, obtaining payment for services, and/or conducting health care operations. Tyngtown Dental is ***not required*** to agree to any restriction I request. If Tyngtown Dental does decide to agree to my request, it must restrict their use and/or disclosure of my health information the way I asked. Because of the number, complexity, and nature of the services we deliver, Tyngtown Dental will rarely agree to requests to restrict uses and disclosures of my health information for the purposes of treatment, payment, and healthcare operations. If I wish to request restrictions I can contact Tyngtown Dental. Tyngtown Dental will notify me of his decision to accept or decline my restrictions.

5. Right to Withdraw Consent. I have the right to withdraw this consent at any time. I must do this in writing. If I want to withdraw this consent, I can contact Tyngtown Dental at Tyngtown Dental 1445 Main St Wilton, ME 04294. Note that my withdrawal of this consent will ***not*** be effective for uses and/or disclosures that have already been made based on my prior consent. If I withdraw this consent, then Tyngtown Dental, by law, is unable to provide me with further treatment or follow-up, other than required emergency services.

6. Effective Period. This consent is active unless and until I withdraw it in writing.

7. References to “I” or “me”. References to “I” or “me” in this Consent include the individual for whom the signing party is authorized to sign. If I am signing this consent on behalf of another person, it is because I am the legal guardian, parent, or agent under an active Power of Attorney for Health Care, and am legally authorized to sign this Consent on behalf of the individual.

I acknowledge that I have been provided a copy Tyngtown Dental’s Notice of Privacy Practices, which has an effective date of 09/23/2013, and which describes how my health information may be used and disclosed. I understand that you have the right to change the Notice of Privacy Practices at any time, that I will be provided a copy of any updated version, and that I may contact you at any time to request a current Notice of Privacy Practices.

Patient Signature: ____

Date: _______/_________/__________

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) ____

Eaglesoft Medical History

Patient Name: Birth Date: Date Created:

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

Question	Answer	
Are you under a physician's care now?	○ Yes ○ No	If yes
Have you ever been hospitalized or had a major operation?	○ Yes ○ No	If yes
Have you ever had a serious head or neck injury?	○ Yes ○ No	If yes
Are you taking any medications, pills, or drugs?	○ Yes ○ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	○ Yes ○ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	○ Yes ○ No	If yes
Are you on a special diet?	○ Yes ○ No	
Do you use tobacco?	○ Yes ○ No	

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics

Other?	☐	If yes
Do you use controlled substances?	○ Yes ○ No	If yes

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

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

Have you ever had any serious illness not listed ○ Yes ○ No If yes

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 patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_________