

Welcome To Mangan Dental Group

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we will be glad to help you. We look forward to working with you in maintaining your dental health.

ABOUT YOU

Date: _____

Patient Name: _____
Last First MI

Nickname: _____ Male Female

Birthdate: _____ Age: _____ SS#: _____

Mailing Address: _____

City State Zip

Home Phone: (_____) _____

Work Phone: (_____) _____ Ext: _____

Cell Phone: (_____) _____

Email Address: _____

Referred By: _____

Employer: _____

Status: Minor Single Married Divorced Separated Widowed

Spouse's Name: _____

Do you have children? Yes No How many? _____

RESPONSIBLE PARTY

Person ultimately responsible for account such as parent or legal guardian.

Name: _____

Relation: _____

Billing Address: _____

City State Zip

Birthdate: _____ SS#: _____

Home Phone: (_____) _____

Work Phone: (_____) _____ Ext: _____

Cell Phone: (_____) _____

IN EVENT OF EMERGENCY

Whom should we contact? _____

Relation: _____

Home Phone: (_____) _____

Work Phone: (_____) _____ Ext: _____

Cell Phone: (_____) _____

INSURANCE INFORMATION

Primary Dental Insurance

Co. Name: _____

Address: _____

City State Zip

800#: (_____) _____

Insured's ID#: _____

Group #: _____

Insured's Name: _____

Relation: _____ Birthdate: _____

Insured's Employer: _____
or Self Insured Policy

Secondary Dental Insurance

Co. Name: _____

Address: _____

City State Zip

800#: (_____) _____

Insured's ID#: _____

Group #: _____

Insured's Name: _____

Relation: _____ Birthdate: _____

Insured's Employer: _____
or Self Insured Policy

I authorize Mangan Dental Group and its associates to furnish any information to my insurance company concerning my care as applicable and that the above information is true.

Patient or Guardian: _____ **Date:** _____

Dental History

What prompted you to seek dental care at this time?

- Routine Care, No Problems
 I have tooth pain
 I have gum problems
 I need to have teeth fixed or replaced
 Other, specify:

How long has it been since your last thorough dental exam?

- Less than 6 months
 6-12 Months
 1 - 2 Years
 Never/I don't know

Have you recently (within the past year or two) had any of the following?

Dental Cleaning	Bite wing x-rays	Full Mouth x-rays	Panoramic x-ray
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

How often do you go to the dentist for routine cleanings and examinations?

- Never
 Rarely
 Every few years
 Yearly
 Every 6 months
 More than twice per year

How often do you brush your teeth?

- Never
 Rarely
 Occasionally
 1 - 2 times weekly
 Daily
 More than once daily

How often do you floss your teeth?

- Never
 Rarely
 Occasionally
 1 - 2 times weekly
 Daily
 More than once daily

Please answer the following:

	Check One:	Explain "Yes" answers
Have you had any discomfort from your teeth or gums lately?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Are your teeth sensitive to hot or cold?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Would you like to change anything about your smile?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do your teeth need to be whiter?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do your gums bleed when you brush or floss?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Have your teeth shifted in position or alignment in the past year?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Does food often get stuck in between certain teeth?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Does your jaw pop when you open or close your mouth?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you habitually grind or clench your teeth?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you now wear or expect to wear dentures someday?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have missing teeth you want to get replaced?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you habitually chew on anything?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you frequently snack on sweets?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Does going to the dentist scare you?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you ever had a particularly bad experience at the dentist?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Check the dental procedures you have experienced:

<input type="checkbox"/> Cleanings	<input type="checkbox"/> Sealants	<input type="checkbox"/> Root Canals	<input type="checkbox"/> Extractions
<input type="checkbox"/> Fillings	<input type="checkbox"/> Bleaching	<input type="checkbox"/> Deep Scaling	<input type="checkbox"/> Other Oral Surgery
<input type="checkbox"/> Braces	<input type="checkbox"/> Crowns	<input type="checkbox"/> Periodontal Surgery	<input type="checkbox"/> TMJ Treatment
<input type="checkbox"/> Bonding/Veneers	<input type="checkbox"/> Bridges	<input type="checkbox"/> Bite Adjustment	<input type="checkbox"/> Dental Implants

Is there anything else about having dental treatment that you would like us to know?

Medical History

Vital Signs (Answer if known, otherwise leave blank)

Height:		Resting Pulse:		Total Cholesterol:	
Weight:		Respiratory Rate:		Fasting Blood Sugar:	

If female, please answer the following:

Are you taking Birth Control Pills?	
Are you pregnant?	If Yes, # of weeks
Are you nursing?	Due Date:

Physician (List your Primary Care Physician / Family Doctor)

Name:		City, State:	
-------	--	--------------	--

Conditions – Check all that are applicable, otherwise None

<input type="checkbox"/>	Abnormal Bleeding	<input type="checkbox"/>	Frequent Headaches	<input type="checkbox"/>	Seizures
<input type="checkbox"/>	Allergies	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	Shingles
<input type="checkbox"/>	Anemia	<input type="checkbox"/>	Heart Attach	<input type="checkbox"/>	Sickle Cell Disease
<input type="checkbox"/>	Angina Pectoris	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	Sinus Problems
<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	Heart Surgery	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	Artificial Heart Valve	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	Thyroid Problems
<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Hepatitis (A, B, or C)	<input type="checkbox"/>	Tobacco Use
<input type="checkbox"/>	Cancer – Chemotherapy	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	Chronic Cough	<input type="checkbox"/>	HIV+ AIDS	<input type="checkbox"/>	Ulcers
<input type="checkbox"/>	Colitis	<input type="checkbox"/>	Immunosuppressive Drugs	<input type="checkbox"/>	Venereal Disease
<input type="checkbox"/>	Congenital Heart Defect	<input type="checkbox"/>	Joint Replacement	Allergies - <input type="checkbox"/> None	
<input type="checkbox"/>	Congestive Heart Failure	<input type="checkbox"/>	Kidney Problems	<input type="checkbox"/>	Aspirin
<input type="checkbox"/>	Cosmetic Surgery	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	Codeine
<input type="checkbox"/>	Daily Alcohol Use	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	Dental Anesthetics
<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	Erythromycin
<input type="checkbox"/>	Difficulty Breathing	<input type="checkbox"/>	Pace Maker	<input type="checkbox"/>	Jewelry
<input type="checkbox"/>	Eating Disorder	<input type="checkbox"/>	Psychiatric Problems	<input type="checkbox"/>	Latex
<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	Radiation Therapy	<input type="checkbox"/>	Metals
<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	Recreational Drug Use	<input type="checkbox"/>	Penicillin
<input type="checkbox"/>	Fever Blisters	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	Tetracycline
<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	Other

Current Medications Information – List all medications or check None Taken

Medicine Name	Strength	Frequency	Taken for what condition?

Is there any disease, condition, or problem that you think this office should know about that is not covered above? *If yes, please describe below...*

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all of the questions to the best of my knowledge. I will notify the doctor of any change in my health or medication.

Patient or Guardian: _____ **Date:** _____

POLICIES OF MANGAN DENTAL GROUP

PAYMENT POLICY

I acknowledge that payment is due at the time of treatment, unless other arrangements have been made prior to treatment. I agree that parents, guardians or personal representatives are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges for services or items provided to me, to my minor/child, or to the patient for whom I have legal responsibility. I understand that filing a claim with my insurance company does not relieve me from my responsibility for the payment of all charges incurred.

Initial

DENTAL INSURANCE POLICY

Payment is due at the time of treatment, unless other arrangements have been made prior to treatment. Parents, guardians or personal representatives are responsible for all fees and services rendered for treatment of a minor/child or patient for whom you have legal responsibility. As a courtesy to our patients we will file most dental insurances with your insurance company. However, filing a claim with your insurance company does not relieve you from your responsibility for the payment of all charges. For some insurance we are able to estimate the benefits from your insurance plan and may require that you pay the estimated patient portion in lieu of the full treatment balance on the day of treatment. Our estimates are not a guarantee of payment and any balance resulting from a lower reimbursement from your insurance than initially estimated is due in full. In addition, if the insurance company fails to make payment within 60 days, the entire balance becomes due from the patient.

Initial

APPOINTMENT POLICY

In order to offer the best dental services to our patients our office reserves individual appointment times for every patient. Often, our practitioners spend significant time preparing for your scheduled appointment. Should something occur that requires you to break your scheduled appointment, we ask that you give a minimum of 24 hours notice for any appointment changes or cancellations, yet earlier notification is greatly appreciated. This gives other patients the opportunity to be scheduled in your place, and allows our practitioner's time to adjust their schedules. We ask that you arrive on time for your scheduled appointments. We reserve the right to charge for broken appointments when less than 24 hours notice is given. After 2 consecutive missed appointments, it is our policy to not reschedule you for any further appointments.

Initial

ROYALTY AND PUBLISHING RIGHTS RELEASE FOR MODELS, PHOTOS, ETC.

I authorize the doctor or his designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate to make a thorough diagnosis of my dental needs and to document my treatment. The doctor may use such items for obtaining insurance benefits, teaching, and publishing in professional literature, technique demonstration, marketing, and patient education without compensation or royalties.

Initial

CONSENT TO RECEIVE TREATMENT

Upon diagnosis I authorize the doctor to perform all recommended treatment mutually agreed upon and to employ such assistance as required to provide proper care. I agree to the use of any necessary anesthetics, sedatives, and other medications. I fully understand that using any medications can involve certain risks. I understand that I can ask for complete recital of any possible complications.

Initial

NOTICE OF PRIVACY POLICY

We care about your privacy and the privacy of your personal health information. By law we are required to maintain your privacy, and to give you notice of our privacy policies and practices. Our Privacy Policy is displayed in our office. It can also be viewed on our web site at www.mangandental.com and a printed copy is available upon request.

Initial

ACKNOWLEDGEMENT AND SIGNATURE OF ACCEPTANCE

I have read, understand and agree to the above initialed policies.

Patient or Guardian: _____ **Date:** _____

Printed Name: _____ **Relation:** _____