MOHAWK DENTAL
FAMILY AND COSMETIC DENTISTRY

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frontdesk@mohawkdental.com

NEW PATIENT INFORMATION FORM

Today's Date: _____ Select one: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Other

Name: _____ Birthdate: _____ SS #: _____

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

Home phone: _____ Email: _____

Cell phone: _____ Occupation/Employer: _____

How did you first hear about Mohawk Dental? _____

If patient is a full-time student, name of school and location: _____

Name of person to contact in case of emergency: _____ Phone: _____

Dental Insurance Information

Insurance company: _____ Name of insured: _____

Date of birth of insured: _____ SS # of insured: _____

ID#: _____ Group #: _____ Group name: _____

Insurance address: _____ City: _____ State: _____ Zip: _____

Patient Dental Information

1. What is the reason for your visit today? _____
2. Date of last dental care: _____ Date of last cleaning: _____ Date of last X-rays: _____
3. Yes ◯ No ◯ Are you currently in pain?
4. Yes ◯ No ◯ Has a doctor ever told you that you require antibiotics before dental treatment?
5. Yes ◯ No ◯ Have you ever had treatment for periodontal disease?
6. Yes ◯ No ◯ Do your gums bleed while brushing or flossing?
7. Yes ◯ No ◯ Do you wear dentures or partials?
8. Yes ◯ No ◯ Are you teeth sensitive to hot or cold liquids/foods?
9. Yes ◯ No ◯ Are your teeth sensitive to sweet or sour liquids/foods?
10. Have you ever experienced any of the following jaw problems?
    - Yes ◯ No ◯ Clicking
    - Yes ◯ No ◯ Pain (joint, ear, side of face)
    - Yes ◯ No ◯ Difficulty opening or closing
    - Yes ◯ No ◯ Difficulty chewing

(Continued...)

11. Yes ☐ No ☐ Do you have any sores or lumps in or near your mouth?
12. Yes ☐ No ☐ Have you had any head, neck, or jaw injuries?
13. Yes ☐ No ☐ Do you have frequent headaches?
14. Yes ☐ No ☐ Do you clench or grind your teeth?
15. Yes ☐ No ☐ Do you bite your lips or cheeks frequently?
16. Yes ☐ No ☐ Do you ever catch food between teeth?
17. Yes ☐ No ☐ Have you ever had any difficult extractions in the past?
18. Yes ☐ No ☐ Have you ever had any prolonged bleeding following extractions?
19. Yes ☐ No ☐ Have you had any orthodontic work?
20. Yes ☐ No ☐ Have you ever had instruction on the correct method of brushing your teeth?
21. Yes ☐ No ☐ Have you ever had instruction on the care of your gums?
22. If you could change anything about your smile, what would you change? _____

_____

Patient Medical Information

23. Name of primary care physician? _____ City/Town _____
24. Have you ever been hospitalized for any surgical operation or serious illness? If yes, please explain:

_____

25. Do you have or have you had any of the following? <u>You must check either yes or no</u>.

Y ☐ N ☐ Anaphylaxis	Y ☐ N ☐ Emphysema	Y ☐ N ☐ Hyperthyroidism	Y ☐ N ☐ Respiratory Problems
Y ☐ N ☐ Anemia	Y ☐ N ☐ Fainting	Y ☐ N ☐ Hypoglycemia	Y ☐ N ☐ Rheumatic Fever
Y ☐ N ☐ Angina	Y ☐ N ☐ Frequently Tired	Y ☐ N ☐ Hypothyroidism	Y ☐ N ☐ Rheumatism
Y ☐ N ☐ Arthritis	Y ☐ N ☐ Glaucoma	Y ☐ N ☐ Kidney Disease	Y ☐ N ☐ Seasonal Allergies
Y ☐ N ☐ Asthma	Y ☐ N ☐ Hay Fever	Y ☐ N ☐ Leukemia	Y ☐ N ☐ Seizures / Epilepsy
Y ☐ N ☐ Cancer	Y ☐ N ☐ Heart Attack	Y ☐ N ☐ Liver Disease	Y ☐ N ☐ STD
Y ☐ N ☐ Chest Pain	Y ☐ N ☐ Heart Disease	Y ☐ N ☐ Low Blood Pressure	Y ☐ N ☐ Shingles
Y ☐ N ☐ Cold Sores/Fever Blisters	Y ☐ N ☐ Heart Murmur	Y ☐ N ☐ Mitral Valve Prolapse	Y ☐ N ☐ Stomach Problems / Ulcers
Y ☐ N ☐ Congenital Heart Problem	Y ☐ N ☐ Heart Surgery	Y ☐ N ☐ Nervous Problems	Y ☐ N ☐ Stroke
Y ☐ N ☐ Cortisone Treatments	Y ☐ N ☐ Hemophilia	Y ☐ N ☐ Osteoporosis	Y ☐ N ☐ Swollen Ankles or Feet
Y ☐ N ☐ Cough (Persistent)	Y ☐ N ☐ Hepatitis	Y ☐ N ☐ Pacemaker	Y ☐ N ☐ Tonsillitis
Y ☐ N ☐ Diabetes	Y ☐ N ☐ Herpes	Y ☐ N ☐ Psychiatric Treatment	Y ☐ N ☐ Tuberculosis
Y ☐ N ☐ Easily Winded	Y ☐ N ☐ High Blood Pressure	Y ☐ N ☐ Radiation Therapy	Y ☐ N ☐ Tumors
Y ☐ N ☐ Eating Disorders	Y ☐ N ☐ HIV or AIDS	Y ☐ N ☐ Recent Weight Loss / Gain	

26. Do you have any disease, condition or problem not listed above that you think we should know about?

_____

27. Are you taking any medication(s) including non-prescription medicine? If yes, what medication(s)?

_____

_____

28. Are you allergic to or have you had any reactions to the following?

Yes ☐ No ☐ Local Anesthetics	Yes ☐ No ☐ Barbituates	Yes ☐ No ☐ Metals
Yes ☐ No ☐ Penicillin	Yes ☐ No ☐ Sedatives	Yes ☐ No ☐ Latex
Yes ☐ No ☐ Codeine	Yes ☐ No ☐ Iodine	Other: _____
Yes ☐ No ☐ Sulfa drugs	Yes ☐ No ☐ Aspirin	_____

29. Yes ☐ No ☐ Have you ever taken Fosamax, Boniva, Actonel, or medications containing bisphosphonates?
30. Yes ☐ No ☐ Do you or have you used tobacco?
31. Yes ☐ No ☐ Do you or have you used controlled substances?

(Continued...)

32. Yes ☐ No ☐ Do you use alcohol?
33. Yes ☐ No ☐ Are you wearing contact lenses?
34. *Women Only*:
    - 34.a. Yes ☐ No ☐ Are you pregnant or think you may be pregnant?
    - 34.b. Yes ☐ No ☐ Are you nursing?
    - 34.c. Yes ☐ No ☐ Are you taking birth control pills?

Our Practice Policies

If there is any change in my medical status, I will inform my provider immediately. I understand that providing incorrect information can be dangerous to my health. I authorize Mohawk Dental to perform any necessary services needed during diagnosis and treatment. I authorize release of my treatment records, as well as my child's, to third party payers and health practitioners involved in my care.

I understand that I am required to provide 48 hours' notice of any appointment change or cancellation. Because the practice does not double-book patients, I understand that a $50 fee will be charged for any appointment changed, canceled, or missed without providing 48 hours' notice. Appointments 90 minutes or longer will have a higher cancellation fee of $50 per 30 minutes of appointment length.

If I have dental insurance, Mohawk Dental will submit my insurance claim as a courtesy and will accept assignment of benefits on my behalf. Regardless of what Mohawk Dental may estimate my insurance company to pay, it is only an estimate, and I am liable for the entire cost of treatment. If I am unable to pay my entire estimated co-pay on the date of service, I will complete an Installment Payment Agreement. I am responsible for payment of all services rendered to me and my dependents, regardless of their age.

I understand that balances over 30 days old, without a signed Installment Payment Agreement, are considered delinquent, and will incur 6% interest until paid. I agree to be responsible for all attorney fees, collection agency fees, interest, and other documented expenses incurred during the collection of my account.

Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used and disclosed to carry out treatment and payment of health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I have read and understand these policies and agree to abide by their terms. All of my questions at this time have been answered. I understand these policies may be amended by the practice at any time. I consent to do business electonically and to receive emails, text messages, and automated phone calls from the practice.

X _____ _____

Signature of Patient / Parent of Minor / Legal Guardian Date

Printed name of person filling out this form: _____