Montauk Dental, PC

Patient Information

Date _____

Name _____ Preferred Name _____

☐ Married ☐ Single ☐ Child ☐ Male ☐ Female Pharmacy _____

Social Security # _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Email Address _____ Referred by _____

Patient Employer _____ Full Time Student: YES NO

Emergency Contact _____ Phone _____

Primary Dental Insurance Company _____ ID# _____ Group# _____

Policyholder Employer _____ Policy Holder SS# _____ DOB: _____

Secondary Dental Insurance Company _____ ID# _____ Group# _____

Policyholder Employer _____ Policy Holder SS# _____ DOB: _____

Authorization

I hereby authorize payment directly to Montauk Dental for the insurance benefits otherwise payable to me. I understand that I am responsible for all costs of my dental treatment. Any and all appeals to insurance will be handled by me. Non-insurance payments are due at the time of service. I hereby authorize Montauk Dental to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and my health history are correct to the best of my knowledge. I grant to this practice the right to release my records/health history and information about my dental treatment to third party payers and/or other health professionals by any method, including electronic transfer.

Patient or Responsible Party

Signature _____ **Date** _____

Montauk Dental, PC

Name _____ Date _____

Dental Health: Date of your last dental visit: _____

What was done at that time? _____

Are you experiencing any pain in your mouth?	YES	NO
Are your teeth sensitive to hot, cold, or sweets?	YES	NO
Do your gums bleed when brushing or flossing?	YES	NO
Have you had any periodontal (gum) treatments?	YES	NO
Do you clench or grind your teeth during the day or while sleeping?	YES	NO
Does your jaw "click" or "pop"?	YES	NO
Have you ever had TMJ (jaw joint) problems?	YES	NO
Do you snore?	YES	NO
Have you ever had a serious injury to your head or mouth?	YES	NO
Do you drink alcoholic beverages?	YES	NO
Do you use tobacco (smoking, snuff, chew)?	YES	NO
Do you use controlled substances (drugs)?	YES	NO
Do you wear dentures or partials?	YES	NO
Do you feel your teeth could be whiter?	YES	NO

Please share with us anything that will help to make you more comfortable during your dental appointment, including any special needs: _____

_____

General Health: Excellent ____ Good _____ Fair _____ Poor _____

Are you currently under the care of a physician? YES NO

If yes, what condition is being treated? _____

Physician Name: _____ Phone: _____

Address:_____

Date of your last physical exam: _____

Are you currently taking any prescription or over-the-counter medications? YES NO

If yes, please list all medications, including vitamins, natural, herbal, and dietary supplements:

_____

Have you had any serious illness, operation, or been hospitalized in the last 5 years? YES NO

If yes, please explain: _____

Have you ever had a total joint replacement (hip, knee, etc.)? YES NO If yes, when? _____

Has a physician or previous dentist recommended that you take antibiotics prior to dental treatment? YES NO

Have you ever taken anticoagulant medications (Coumadin, Heparin, Eliquis, Xarelto, aspirin, etc.)? YES NO
If yes, when did you start the medication? _____

Have you ever taken antiresorptive medications (Fosamax, Actonel, Boniva, Prolia, Zometa, XGEVA, etc.)? YES NO
If yes, when did you start the medication? _____

Allergies. Are you allergic to or have you had a reaction to any of the following?

- ☐ Local anesthetics
- ☐ Aspirin
- ☐ Penicillin or other antibiotics
- ☐ Sulfa Drugs
- ☐ Codeine or other narcotics
- ☐ Latex
- ☐ Barbiturates or sedatives
- ☐ Metals
- ☐ Iodine
- ☐ Other: _____

Medical Conditions. Please indicate any personal history of the following:

- ☐ Artificial (prosthetic) heart valve
- ☐ Previous infective endocarditis
- ☐ Damaged heart valves
- ☐ Congenital heart disease
- ☐ Cardiovascular disease
- ☐ Angina or chest pain upon exertion
- ☐ Arteriosclerosis
- ☐ Congestive heart failure
- ☐ Heart attack
- ☐ Heart murmur
- ☐ Low blood pressure
- ☐ High blood pressure
- ☐ Mitral valve prolapse
- ☐ Pacemaker
- ☐ Rheumatic heart disease or fever
- ☐ Bleeding Disorder
- ☐ Anemia
- ☐ Blood transfusion
- ☐ Hemophilia
- ☐ HIV infection or AIDS
- ☐ Arthritis
- ☐ Autoimmune disease
- ☐ Rheumatoid arthritis
- ☐ Systemic lupus erythematosus
- ☐ Asthma
- ☐ Persistent swollen glands in neck
- ☐ Severe headaches or migraines
- ☐ Severe or rapid weight loss
- ☐ Excessive urination
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Sinus problems
- ☐ Tuberculosis
- ☐ Benign tumors or growths
- ☐ Cancer or malignancy
- ☐ Chemotherapy or radiation treatment
- ☐ Chronic pain
- ☐ Diabetes: Type I or II
- ☐ Eating disorder
- ☐ Malnutrition
- ☐ Gastrointestinal disease
- ☐ GERD, reflux or persistent heartburn
- ☐ Ulcers
- ☐ Thyroid problems
- ☐ Stroke
- ☐ Glaucoma
- ☐ Hepatitis, jaundice or liver disease
- ☐ Epilepsy
- ☐ Fainting spells or dizziness
- ☐ Seizures or convulsions
- ☐ Neurological disorder
- ☐ Sleep disorder
- ☐ Mental health disorder
- ☐ Kidney problems
- ☐ Osteoporosis
- ☐ Organ transplant
- ☐ Hearing problems
- ☐ Other: _____

Please explain any history above, if applicable: _____
_____

Women Only. Are you:
Pregnant? YES NO If yes, when is your due date? _____
Nursing? YES NO

X _____ _____
Patient Signature (Parent or Guardian if under 18 years of age) Date

FINANCIAL POLICY

Payments

- Payments for examinations or procedures are due at the time of completion of that visit. Under special circumstances, payment arrangements can be made.
- It is the responsibility of the patient to request an estimate from the doctor for the amount of all fees prior to beginning treatment.

Insurance

- It is the responsibility of the patient to know whether their insurance plan requires a referral or pre-authorization for any procedures.
- Montauk Dental is not a provider for any insurer, although we will be happy to supply you with the proper forms or file your claim with your insurance company. However, anything done at this practice will be considered out of network and therefore, it is your responsibility to know the percentage your insurance company will cover for out of network providers. Any amounts not covered is the responsibility of the patient.
- Co-pays are expected at the time of service.

Non-Covered Services

- All patients are responsible for non-covered procedures if denied by your insurance carrier.

Insurance Request

- You are responsible for any insurance request for additional information that pertains to subscriber or covered dependent regarding personal information, i.e. DOB, social security number, etc. Failure to respond will result in a denied claim and the guarantor will be billed for the service.

Payment Plans

- **CareCredit** is a company that provides no interest or low interest payment plans. We can help arrange these services with the **CareCredit** company.
- **M&T Bank** is a bank that can provide loans for large dental treatment plans. We can help you contact the proper representative.

Overdue Balances

- Overdue accounts beyond 90 days are subject to applicable interest charges.

We would like to emphasize that as a healthcare provider, our relationship is with you and not your insurance company. Therefore, it is your responsibility to know your policy.

_____ _____

Signature of Patient/Guarantor *Date*