321 N. Breiel Blvd., **Middletown**, OH 45042
513.424.3971
2309 Woodman Dr., **Kettering**, OH 45420
937.252.9070
9684 Cincinnati Columbus Rd., **West Chester**, OH 45241
513.777.5369

Patient Welcome Form

PERSONAL INFORMATION

Patient's Legal Name ______________________ Date of Birth ____________ ☐ Male ☐ Female

Preferred Name ______________ Home Phone # ______________ Cell Phone # ______________

Address: Street, Apt# ____________________ City______________ State ______ Zip code ________

Social Security Number ____________________ Driver's License Number ____________________

E-mail ______________________ ☐ Minor **Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed

If Student, name of School/College ________________ City, State ____________ ☐ Full-Time ☐ Part-Time

Patient/Guardian's Employer ____________________ Work #____________________

Spouse's Name ______________________ Spouse's Phone # ____________________

Spouse's Employer ____________________ Work #____________________

Do you have any other family members who are patients here? ______________________________

Who can we thank for referring you to our office? ______________________________

EMERGENCY CONTACT INFORMATION

Name ______________________ Relationship ____________________

Cell Phone # ______________ Home Phone #______________ Work Phone # ______________

INSURANCE AND FINANCIAL INFORMATION Do you have dental insurance coverage? ☐ NO ☐ YES

Insurance Company Name ____________________ Phone # ____________________

Insured Name ______________ SS# __________ Relationship to Patient: ☐ Self ☐ Spouse ☐ Guardian

Insured Birthdate ____________ ID# ______________ Group #______________

Employer (if different from above) ____________________ Employer Phone # ______________

Do you have secondary dental insurance coverage? ☐ NO ☐ YES

Insurance Company Name ____________________ Phone # ____________________

Insured Name ______________ SS# __________ Relationship to Patient: ☐ Self ☐ Spouse ☐ Guardian

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Dental/Medical History

Patient Name: ______________________

Former Dentist: ______________ City, State ______________ Last Dental visit date ______________

Date of last oral x-rays ____________ How often do you floss ____________ How often do you brush ____________

DENTAL Check all that apply:

Bad Breath	☐ Yes	Loose teeth or broken filling	☐ Yes	Sensitivity to sweets	☐ Yes
Bleeding gums	☐ Yes	Orthodontic Treatment	☐ Yes	Sensitivity when biting	☐ Yes
Blister on lip/mouth	☐ Yes	Pain around ear	☐ Yes	Frequent headaches	☐ Yes
Fingernail biting	☐ Yes	Periodontal Treatment	☐ Yes	Jaw, head or neck injuries	☐ Yes
Grinding teeth	☐ Yes	Sensitivity to cold	☐ Yes	Jaw clicking and/or pain	☐ Yes
Lip and cheek biting	☐ Yes	Sensitivity to heat	☐ Yes	Tooth pain	☐ Yes

MEDICAL:

1. Are you currently under medical treatment? ☐ Yes ☐ No
2. Have you ever had any serious illnesses or operations? ☐ Yes ☐ No
3. Are you currently taking medications? ☐ Yes ☐ No
   Please list your medications: ______________________
   ____
4. Do you smoke ☐ Yes ☐ No
5. Do you use cocaine or other illicit drugs? ☐ Yes ☐ No
6. Do you wear contact lenses? ☐ Yes ☐ No
7. (Woman only) are you:
   - Pregnant ☐ Yes ☐ No
   - Nursing ☐ Yes ☐ No
   - Taking Birth Control ☐ Yes ☐ No
8. Have you any allergic reactions to the following:
   - Local Anesthetics ☐ Yes ☐ No
   - Penicillin or other antibiotics ☐ Yes ☐ No
   - Sulfa Drugs ☐ Yes ☐ No
   - Barbiturates (sleeping drugs) ☐ Yes ☐ No
   - Sedative ☐ Yes ☐ No
   - Iodine ☐ Yes ☐ No
   - Aspirin ☐ Yes ☐ No
   - Latex ☐ Yes ☐ No

   Other: ______________________
   ____
   ____

Medical Physician's Name: ______________________ Date of last visit ______________

Check all that apply:

AIDS	☐ Yes	Diabetes	☐ Yes	Nervous Problems	☐ Yes
Anemia	☐ Yes	Emphysema	☐ Yes	Pacemaker	☐ Yes
Arthritis	☐ Yes	Epilepsy	☐ Yes	Psychiatric care	☐ Yes
Artifical Heart Valves	☐ Yes	Fainting/Dizzy	☐ Yes	Radiation	☐ Yes
Artifical Joints	☐ Yes	Glaucoma	☐ Yes	Respiratory	☐ Yes
Asthma	☐ Yes	Headaches	☐ Yes	Rheumatic Fever	☐ Yes
Back Problems	☐ Yes	Heart Murmur	☐ Yes	Scarlet Fever	☐ Yes
Bleeding abnormally	☐ Yes	Heart Problems	☐ Yes	Shortness of breath	☐ Yes
w/surgery/extractions	☐ Yes	Hepatitis	☐ Yes	Sinus Trouble	☐ Yes
Blood Disease	☐ Yes	Herpes	☐ Yes	Skin Rash	☐ Yes
Cancer	☐ Yes	High Blood Pressure	☐ Yes	Stroke	☐ Yes
Chemical Dependency	☐ Yes	HIV Positive	☐ Yes	Swelling of feet/ankles	☐ Yes
Chronic Fatigue Syndrome	☐ Yes	Jaw Pain	☐ Yes	Thyroid Problems	☐ Yes
Circulatory problems	☐ Yes	Kidney Disease	☐ Yes	Tonsillitis	☐ Yes
Congenital Heart Issues	☐ Yes	Liver Disease	☐ Yes	Tuberculosis	☐ Yes
Cortisone Treatment	☐ Yes	Low Blood Pressure	☐ Yes	Tumor/growth on head	☐ Yes
Cough-persistent	☐ Yes	Mitral Valve Prolapse	☐ Yes	Ulcer	☐ Yes
				Venereal Disease	☐ Yes

Please advise us in the future of any change in your dental or medical history or any medications you may be taking.

Signature Patient/Guardian: ______________________ Date: ______________

Signature of Dentist: ______________________ Date: ______________

PATIENT FINANCIAL RESPONSIBILITY, ASSIGNMENT, AND RELEASE AGREEMENT

Dental treatment is an excellent investment in your and your family's health and wellbeing. We recognize that long range economy is of prime concern as well. The following rights and responsibilities are outlined below to aid in understanding our future dental relationship.

INSURANCE VERIFICATION AND ASSIGNMENT

- I certify that the information I have provided about my active dental insurance coverage is correct to the best of my knowledge.
- I authorize the release of any dental/medical records or other information including diagnosis and treatment rendered to me, as requested by my dental insurance carrier.
- I authorize the assignment of benefit payment(s) from my insurance carrier(s) directly to the assigned dental office and the practitioner who provided service(s) to me.

Patients Initials____________

FINANCIAL RESPONSIBILITY

I understand that PAYMENT IN FULL is expected at the time of my appointment. I understand that if I come on the day of my appointment without one of the acceptable forms of payment listed below, the office has the right to reschedule my appointment. We also believe financial considerations should not be an obstacle to obtaining treatment. In situations involving large treatment plans, we provide the following payment options.

CASH, PERSONAL AND BANK CHECKS, AS WELL AS ALL MAJOR CREDIT CARDS. Returned checks will be charged a $35.00 NSF fee on the patient account.

AFFORDABLE MONTHLY PAYMENT PLANS (SUBJECT TO APPROVAL). These are outside financing arrangements specifically designed for dentistry and related specialties – with AFFORDABLE MONTHLY payments.

- **NO initial payment with INTEREST-FREE OPTIONS**
- **Low, fixed rates ranging from 4.0% -12%**
- **NO prepayment penalty, terms up to 60 months**
- **Quick and easy application process with Same Day Approval**

In the event the charges incurred are not paid in full when due and collection action is instituted, I understand I am responsible for the additional costs associated with such collection activity. The collection costs may include and are not limited to collection agency fees, attorney fees, court costs and/or any other expenses incurred in its collection as allowable by law.

CANCELED AND MISSED APPOINTMENTS

I understand that if I find it impossible to keep a scheduled appointment, I must let the office know at least twenty-four hours in advance so that another patient may use the time reserved for me. There may be a charge for missed appointments or late cancellations.

PATIENTS WHO HAVE DENTAL INSURANCE BENEFITS

Payment is expected on the day of treatment unless other arrangements have been made prior to the appointment. As a COURTESY, we will submit the fees for your treatment to your insurance company on your behalf. However, the financial responsibility and legal obligation for any uncovered treatment remains with you, including any remaining balance, even though an estimated co-payment may be collected at the time of your appointment. We will attempt to gain as many benefits as possible from your insurance for the services provided but your insurance policy is a contract between you and your insurance company; we are not a party to that contract. We accept the assignment of benefits as a courtesy to our patients. Any claim not paid by your insurance carrier within 60 days will be billed to you, the patient.

If needed, a pre-treatment estimate will be sent to your insurance company to determine what benefit you may receive. Patients are responsible for any 'patient portion' not covered by insurance, which will be due at the time of service. Please be advised, this is an ESTIMATE and not a promise or guarantee of coverage from the insurance carrier.

RELEASE

I consent to clinical examination and the making of video, photographs, and x-rays before, during, and after treatment, and to the use of same by doctor in scientific papers or demonstrations. I certify I have read, or had read to me, the contents of this form and realize the risks and limitations involved.

______________________________   ______________________________

Patient/Responsible Party Signature   Date   Practice Representative   Date

Insured Birthdate ____________ ID# ____________ Group #____________

Employer (if different from above) ____________ Employer Phone # ____________

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RESPONSIBLE PARTY

Name of the person responsible for this account ____________ Relationship ____________

Social Security # ____________ ____ Home Address ____________

Home Phone #____________ Cell Phone #____________ Work Phone #____________

RELEASE INFORMATION

You may discuss my health care with.... Health Care Providers ☐NO ☐YES Insurance Companies ☐NO ☐YES

Others ____________

ASSIGNMENT AND RELEASE

Dental insurance is designed to help aid in attaining optimum dental health; it is not designed to be a "Pay-all". It is in your best interest to be sure that we have all of your current insurance information on file. We will do our best to answer any questions you have and are happy to process your claim forms at no charge.

We schedule your appointments to your convenience, and your punctuality is appreciated. If you need to reschedule your appointment, please provide us with two working days' notice, in which case no cancellation fee will be applied.

I understand that I am responsible for payment of services rendered and that payment is due in full at the time of treatment unless prior arrangements have been approved. I hereby authorize release for any information, either in print or electronic media, including the diagnosis and records of treatment or examination rendered, to my insurance company.

I hereby authorize payment directly to MK&C DENTAL GROUP for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or any provider or supplier in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature Patient/Guardian ____________ Date____________