Medical History

Date:_____ Name:_____

In order to treat our patients both safely and effectively, an up to date and complete medical history is necessary. Please answer the following questions as accurately as possible.

Do you have or have you ever had:

Heart by-pass?	☐Yes	☐No	Heart murmur?	☐Yes	☐No
Mitral valve Prolapse?	☐Yes	☐No	Bacterial endocarditis?*	☐Yes	☐No
Asthma?	☐Yes	☐No	Rheumatic fever?	☐Yes	☐No
Sinus problems?	☐Yes	☐No	Tuberculosis?	☐Yes	☐No
Emphysema?	☐Yes	☐No	COPD?	☐Yes	☐No
Persistent cough?	☐Yes	☐No	Jaundice or liver problems	☐Yes	☐No
Pain in your jaw?	☐Yes	☐No	Hepatitis? A B C (circle all that apply)	☐Yes	☐No
Diabetes?	☐Yes	☐No	Pregnant? (Currently)	☐Yes	☐No
Stroke?	☐Yes	☐No	Nursing? (Currently)	☐Yes	☐No
HIV or AIDS?	☐Yes	☐No	High blood pressure?	☐Yes	☐No
Glaucoma?	☐Yes	☐No	Psychiatric treatment?	☐Yes	☐No
Anemia?	☐Yes	☐No	Epilepsy?	☐Yes	☐No

Lost or gained more than 15 lbs. in the last year? ☐Yes ☐No

Are you currently taking medications for Osteoporosis? ☐Yes ☐No
(e.g. Actonel, Fosamax, Boniva, Reclast, Aredia, Zometa pills or injections)

Are you currently taking (or have had IV) blood thinners? ☐Yes ☐No
(e.g. Aspirin, Plavix, Coumadin, Warfarin, Xarelto)

Excessive Bleeding? ☐Yes ☐No If so, describe_____

Artificial heart valves?* ☐Yes ☐No If so, when? _____

Vascular stents (from angioplasty)? ☐Yes ☐No If so, when? _____

Artificial joints?* ☐Yes ☐No If so, when? _____

Cancer? ☐Yes ☐No If so, when? _____ type?_____

Head/Neck Radiation? ☐Yes ☐No If so, please describe: _____

Have you been hospitalized in the last 2 years? ☐Yes ☐No If so, please explain and include dates: _____

_____

Please circle or list any allergies not mentioned below:

None Penicillin Codeine Sulfa drugs Lidocaine / Novocaine Morphine

Acrylic / Plaster / Latex Adhesives (Tape) Other_____

List all medications & herbal supplements you take or have taken in the past year:
(including: aspirin, opioids, and marijuana)

_____

_____

Please describe any other significant medical history:_____

_____

***Health condition that may require pre-medication**

MID-AMERICA DENTAL & HEARING CENTER
PATIENT REGISTRATION

IDENTIFICATION			Today's Date	
PLEASE PRINT CLEARLY AND FILL IN ALL THE SPACES BELOW				
Patient Name (Last, First, Middle Initial):		Date of Birth	Social Security #	
Mailing Address		City	State	ZIP
Email address		Home Phone	Cell Phone	Work Phone
Employer		Occupation	How Long?	Gender
				M F
Responsible Party (if other than Patient)			Phone	
Family Physician	City	State	Phone	
Emergency Contact		Relationship to Patient	Phone	

How did you hear about us?

How did you first hear about us? (check one)

- ☐ Patient, Friend or Relative (Name):_____
- ☐ Newspaper or Magazine (Name):_____
- ☐ Highway Sign (Location):_____
- ☐ Other (Please Specify):_____

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DENTAL CENTERS / MID-AMERICA HEARING CENTER
PATIENT AUTHORIZATION FORM

Under the Health Insurance Portability & Accountability Act (HIPAA) you have certain rights regarding the use and disclosure of your protected health information (PHI) as specified below for the purposes and parties as designated below.

Parties to whom information may be disclosed:

Name:	**Relationship:**	**Phone: ( )**
Name:	**Relationship:**	**Phone: ( )**
Name:	**Relationship:**	**Phone: ( )**

I reserve the right to:

- Revoke this authorization in writing by submitting it to the attention of your Privacy Officer;
- Inspect or copy the protected health information to be used or disclosed;
- Refuse to sign this authorization knowing that you will not condition treatment or payment on my providing this authorization (except for research related treatment).

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by HIPAA.

I have been offered the privacy policy of Mid-America Dental & Hearing Center. This opportunity has been provided to me and I have elected to:

_____Review the policy in full and one has been provided to me

_____Not to review the policy

_____ _____

Signature Date

General Financial Policy

Our mission is to provide you **Our Best For Less, In A Day.** Dental services requiring laboratory processes may need to be remade for fit and function as the doctor deems necessary. These services include, but are not limited to dentures, partials, crowns, and bridges. In regard to our removable dental products – dentures and partials – if you are not completely satisfied you may be eligible for up to a 50% refund of the fees upon return of the removable product. **Please note that full payment is due at the time of service.** To assist you in receiving this care; we offer several payment options, they are:

Payment in full: We accept cash, check, Discover, Visa, MasterCard, American Express, and over 200 insurance carriers.

Care Credit Payment Plan:

- 6 Months No Interest Payment Plan (if paid within promotional period) ($700 or more)*
- Extended Payment Plan for 24/36/48/60 months ($1,000 or more)*

**** Subject to credit approval. Some restrictions apply***

Treatment Consent

I hereby authorize and request my provider to perform any type of treatment, medication and therapy on my behalf that may be indicated and agreed to by me in connection with my dental and hearing care. I understand prior to treatment, the provider or their staff will explain the procedure(s) involved in the suggested treatment. I authorize the taking of images for use in my evaluation/education and understand these images may be shared with third parties upon referral if additional treatment is needed from other healthcare professionals. I realize that among those who attend to patients are healthcare professionals in training that are participating in my care as part of their education. I am aware the practice of dentistry and the fitting of hearing instruments is not an exact science, and understand no promise, guarantee or warranty has been made regarding the results of the examination or treatment I receive. I authorize Dental Centers and /or Mid-Amercia Hearing Center to affix my name to all insurance submissions, documents, and/or information requested by my insurance company(s). I also authorize my provider to file a complaint with the insurance commission on my behalf, if necessary.

I, the undersigned patient or responsible party, have read the above policies and fully understand them.

_____ _____

Print Patient's Name Relationship to Patient

_____ _____

Signature Date