Welcome to Majestic Dental

MEDICAL HISTORY AND CONSENT FORM
NEW PATIENT

PATIENT'S INFORMATION

Patient's Name	Marital Status (S M W D SEP)	Date of Birth / /	Age	Sex	Social Security #
Street Address	City, State, Zip				
Home Phone #	Cell Phone #	Email			
Patient's Employer	Occupation (Indicate if Student)	How Long Employed	Work Phone #		
Employer's Street Address	City, State, Zip				
Spouse's Name	Spouse's Employer	Occupation	How Long Employed	Cell Phone #	
Spouse's Employer's Street Address	City, State, Zip	Work Phone #			
Referred By:	Street Address	City, State, Zip			
Name of Nearest Relative Not Living at Home	Phone	Relationship to Patient			

IF THE PATIENT IS A MINOR OR STUDENT

Father's Name	Street Address, City, State, Zip	Home Phone #
Father's Employer	Occupation / How Long Employed	Work Phone #
Father's Employer Street Address	City, State, Zip	Cell Phone #
Mother's Name	Street Address, City, State, Zip	Home Phone #
Mother's Employer	Occupation / How Long Employed	Work Phone #
Mother's Employer Street Address	City, State, Zip	Cell Phone #
Person Responsible for Payment, if Not Above	Street Address, City, State, Zip	Home Phone #

INSURANCE INFORMATION

Primary Insurance Co. _____ Subscriber Name _____ Subscriber Birthdate ____ / ____ / ____

Policy ID # _____ Group # _____

Secondary Insurance Co. _____ Subscriber Name _____ Subscriber Birthdate ____ / ____ / ____

Policy ID # _____ Group # _____

As a service to our valued patients, we submit to all insurance company plans and file all insurance claims for you electronically. The responsibility of the insurance company is to you and it is important that you ensure you are reimbursed properly. Fees for services provided to insured patients are the usual and customary fees charged to all patients for similar services. Your policy may base its allowance on a fixed fee schedule determined solely by your insurance company. The percentage of the fee paid may therefore be different than the percentage stated by your insurance company or different than the percentage listed in your benefit booklet. Majestic Dental has developed fees based on services provided and do not participate with insurance carriers in determining appropriate fees. In deciding whom they should serve, the doctors have selected you. We will do our very best to be certain that you receive all of the benefits due to you from your insurance carrier. If you have questions, please contact our insurance department at extension #5.

I have read the above and completely agree to the arrangements stated.

SIGNED _____

DATE _____

THIS CONFIDENTIAL INFORMATION WILL HELP US PREPARE FOR YOUR VISIT.

Why have you made this dental appointment? _____

_____

Date of your last dental visit _____

Why have you decided to leave your previous dental office?

_____

_____

PLEASE CHECK ONE BOX PER SECTION

- ❑ **My mouth is very comfortable.**
- ❑ **My mouth is moderately comfortable.**
- ❑ **My mouth is uncomfortable.**

- ❑ **I think the appearance of my smile is excellent.**
- ❑ **I am satisfied with the appearance of my smile.**
- ❑ **I would like to change my smile.**
- ❑ **I am unconcerned about the appearance of my smile.**

- ❑ **I will do whatever I must to keep my teeth.**
- ❑ **I want to keep my teeth, but only within a certain budget of time and money.**
- ❑ **I am indifferent about keeping my teeth.**

- ❑ **I think my present state of dental health is excellent.**
- ❑ **I think my present state of dental health is good.**
- ❑ **I think my present state of dental health is poor.**

The information present on these pages is true to the best of my knowledge. The undersigned authorizes the doctor to take x-rays, study models, photographs or other diagnostic materials deemed appropriate by the doctor to make a thorough diagnosis of my dental health condition. I authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated in connection with the services required for my dental health. I understand that the doctor will discuss treatment before it is initiated. I further authorize and consent that the doctor choose and apply such assistance as deemed fit.

I understand that the responsibility for payment for professional services provided in this office for myself or my dependents is mine, due and payable at the time of services rendered unless written financial arrangements have been made and signed by me. My percentage of the charges will be paid at each appointment. After the insurance carrier pays, any credit balance will be promptly refunded. In the event of default I promise to pay interest on the indebtedness, together with any collection costs and attorney fees as may be required to affect collection.

All past due amounts are assessed a 1.5% per month.

MAJESTIC DENTAL FINANCIAL POLICY

Payment is expected as services are rendered.
For your convenience, we accept VISA, MASTERCARD and DISCOVER.
Appointments broken without 72-hour notice may incur a minimum charge.
Further information regarding financial options may be obtained from our Treatment Coordinator.

SIGNED _____

DATE _____