Welcome!

The benefits of a happy healthy smile are immeasurable! Our goal is to help you reach your maximum oral health. Please fill out this form completely.

Patient Information:

Last Name:	First:	MI:	Preferred:	
Gender: M F	Marital Status: Single	Married	Divorced	Widowed Separated
Date of Birth:	Social Security #:			
Address:				
City, State Zip:				
Email Address:				
Circle the number where it is best to reach you during the day:				
Home Phone:	Work Phone:			
Cell Phone:	Other Number:			
Employer:				
If emergency call: Name:	at Phone Number:			

If your are married please fill in SPOUSE Information:
If the patient is a child please fill in PARENT information:

Last Name:	First:	MI:	Preferred:	
Gender: M F	Marital Status: Single	Married	Divorced	Widowed Separated
Date of Birth:	Social Security #:			
Address:				
City, State Zip:				
Email Address:				
Circle the number where it is best to reach you during the day:				
Home Phone:	Work Phone:			
Cell Phone:	Other Number:			
Employer:				

Whom may we thank for referring you to our practice?

Yellow Pages	Work	Internet	Newspaper	Neighbor	Doctor
My Friend:					

If you have your insurance card we will make a copy of it,
otherwise we will need this information to file your insurance:

Primary Dental Insurance		Secondary Dental Insurance	
Insured's Name		Insured's Name	
DOB	SS#	DOB	SS#
Insured's employer		Insured's employer	
Insurance Co		Insurance Co	
Insurance Co Address		Insurance Co Address	
Phone #		Phone #	
Group #	Local #	Group #	Local #

Health History and Medical Information

Name: _____ Date of Birth: _____

Have you ever had any of the following? Please check those that apply:

☐ AIDS /HIV	☐ Fainting /Seizures	☐ Nervous Disorders	☐ Ulcers
☐ Anemia	☐ Glaucoma	☐ Pacemaker	☐ Venereal Disease
☐ Arthritis	☐ Growths	☐ Pregnancy	Other Medical Problems
☐ Artificial Joints	☐ Hay Fever	Due date:_____	☐ _____
☐ Asthma	☐ Head Injuries	☐ Prostate Problems	☐ _____
☐ Attention deficit disorder	☐ Heart Attack	☐ Radiation Treatment	☐ Allergy - Aspirin
☐ Back or Neck Problems	☐ Heart Disease	☐ Respiratory Problems	☐ Allergy - Codeine
☐ Blood Disease	☐ Heart Murmur	☐ Rheumatic Fever	☐ Allergy – Erythromycin
☐ Bronchitis	☐ Hepatitis A B C	☐ Rheumatism	☐ Allergy – Keflex
☐ Cancer	☐ High Blood Pressure	☐ Sinus Problems	☐ Allergy - Latex
☐ Depression	☐ High Cholesterol	☐ Stomach Problems	☐ Allergy - Penicillin
☐ Diabetes	☐ Jaundice	☐ Stroke	☐ Allergy – Sulfa
☐ Dizziness	☐ Kidney Disease	☐ Substance Abuse	☐ Allergy – Tylenol
☐ Emphysema	☐ Liver Disease	☐ Thyroid Problems	Other Allergies
☐ Epilepsy	☐ Mental Disorders	☐ Tuberculosis	☐ _____
☐ Excessive Bleeding	☐ Mitral Valve Prolapse	☐ Tumors	☐ _____

- Please list any prescription or over the counter medicine you are taking:

  _____

  _____

- Have you ever had any complications following dental treatment? If yes, please explain:

  _____

  _____

- Have you been admitted to a hospital or needed emergency care during the past five years? If yes, please explain: _____

  _____

  _____

- Are you now under the care of a physician? If yes, please explain:

  _____

  _____

- Name of Physician: _____ Phone:_____

- Do you have any health problems that need further clarification? If yes, please explain:

  _____

  _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctor at the next appointment without fail.

Signature of patient _____ Date: _____

Financial Policies & Consent for Services

Financial Policy for Emergency Patients

All emergency dental services provided to non continuing care patients, regardless of any insurance coverage, must be paid for in cash or credit/debit card at the time services are performed. Insurance claims will be filed for you and the insurance payment will come to the insured.

Financial Policy for Continuing Care Patients

For our continuing care patients, we ask that you pay the deductible and co-payment, which is the estimated amount not covered by your insurance company at the time we provide the service to you. Our office accepts cash, personal checks, MasterCard, Visa, and Discover. Outside financing via Care Credit is available upon request and approval.

Financial Policy for Insurance

As a courtesy to you we will help you process your insurance claims. Please understand that we will provide an insurance estimate to you, however it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits ultimately determine the amount paid. Your insurance policy is a contract between you, your employer, and your insurance company. All charges you incur are your responsibility regardless of your insurance coverage. Many insurance policies are written with clauses to help them get out of paying for your treatment. If you have questions concerning what your dental insurance covers, remaing benefits, or waiting periods; please contact your insurance company for details. If a problem with the insurance company occurs, we will provide the insurance company all the available information we have on file to resolve any unpaid claims. Insurance payments are ordinarily received within 30-60 days from the time of filing. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time. Parents with college age students must send the insurance company the student's full time schedule or they will not pay for your child's treatment.

General Policies

Returned checks will be subject to additional fees. In the case it becomes necessary for our office to enlist a collection service and/or legal assistance, you will be responsible for any collection and/or legal charges. A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts with balances over 90 days.

We respect your time and do not overbook our schedule and we ask you to respect our time as well. You are expected to call 24 hours in advance if you can't make an appointment. There is a fee for broken appointments and this fee is only charged, at our discretion, after multiple short notice cancellations and broken appointments. The current fee is $25 per appointment.

The divorced or separated parent who brings in the child is responsible for the bill. Please make arrangements for payment from an ex-spouse before dental treatment is rendered. We do not bill ex-spouses for children's treatment.

Delinquent accounts will be turned over for collection and if this is required the patient and their immediate family will be dismissed from the practice.

CONSENT:

I have read, understood, and agree to all the policies on this page. I authorize the Doctor or his representative to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that any fee estimates given for dental care are our best guess at that time and that the procedure and the fee may change based on the treatment and I will be responsible for the cost of the treatment performed. I hereby authorize the release of necessary records to file my insurance and the payment of the insurance directly to David Malin DDS. I also agree to the release of necessary records to specialists, other treating doctors, insurance company, attorney or future dentist involved in this case. I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form. I have reviewed and understood the HIPAA policy of this office. A photocopy of this Consent shall be considered as effective and valid as the original. I authorize the Doctor to initiate a complaint to the insurance commissioner for any reason on my behalf. I authorize the Doctor to deposit checks received on my account when made out to me.

Signature of Patient or Parent _____ Date: _____