MODERN DENTAL CONCEPTS

New Patient Packet

4817 Mahoning Ave NW, Warren, Ohio 44483 · (330) 847-0676 · moderndentalconcepts.com

Welcome to Modern Dental Concepts! Please complete this packet, including the Health History on the last pages, before your first visit. Your information is kept confidential in accordance with HIPAA and applicable laws. If a question does not apply to you, leave it blank or write "N/A."

1. Patient Information

Patient Name:		Preferred Name:	
Date of Birth:	Sex: ☐ M ☐ F ☐ Other	Marital Status: ☐ Married ☐ Single ☐ Minor	
Email:			
Address:			
City:		State:	ZIP:
Home Phone:	Cell Phone:	Preferred contact: ☐ Cell ☐ Home ☐ Email	
Occupation:		Employer:	
Have you ever served in the military? ☐ Yes ☐ No		Branch:	
How did you hear about us?		Whom may we thank for referring you?	
Emergency Contact (name & relationship):		Phone:	

2. Parent / Guardian Information (if patient is a minor)

Name:		Relationship to Patient:	
Date of Birth:		Phone:	
Address:			
City:		State:	ZIP:

3. Dental Insurance

Primary Insurance

Policyholder's Name:		Date of Birth:
Insurance Company:	ID #:	Group #:
Employer:		

Secondary Insurance

Policyholder's Name:		Date of Birth:
Insurance Company:	ID #:	Group #:

Employer:

4. HIPAA Release

Patient Name:

Appointment reminders — may we contact you by: Voicemail / answering machine? ☐ Yes ☐ No Email? ☐ Yes ☐ No Text? ☐ Yes ☐ No

Newsletters and offers — would you like to receive newsletters and offers from us by text or email? ☐ Yes ☐ No

Information about my treatment at Modern Dental Concepts can be given to the following people (do not include physicians):

Name:	Name:
Relationship:	Relationship:
Phone Number:	Phone Number:

Signature:	Date:
(If minor) Parent / Guardian Name:	

5. Acknowledgment of Receipt of Notice of Privacy Practices

Our Notice of Privacy Practices is posted in the waiting room and on our website, moderndentalconcepts.com. Ask us for a copy at any time.

I have viewed / received a copy of this office's Notice of Privacy Practices. I hereby authorize, as indicated by my signature below, Modern Dental Concepts to use and disclose my protected health information for any necessary clinical, financial, and insurance purpose.

You may refuse to sign this acknowledgment.

Signature:	Date:
(If minor) Parent / Guardian Name:	

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communication barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (please specify): _____

Staff initials: _____

6. Financial Policy

Thank you for choosing Modern Dental Concepts. We want the cost of your care to be clear and easy to manage, so this page explains how payment works in our office. If anything is unclear, please ask us.

Payment is due at the time of service.

- **Delta Dental:** we are in network with Delta Dental plans and send the claim for you. At your visit you pay your estimated share.
- **Other dental insurance:** we are out of network, but we still send the claim for you, and the insurance company pays us directly. At your visit you pay your estimated share.
- **Our estimate is not a guarantee.** We work it out from your plan's information, but your insurance company decides what it pays. If it pays more than we estimated, we credit your account or refund the difference. If it pays less, you owe the difference. If your insurance hasn't paid us within 60 days, the balance is yours to pay, and you can collect your benefits directly from your insurance company.
- **No insurance:** payment for each visit is due at that visit.

Ways to pay: cash; personal checks; Visa, Mastercard, Discover and American Express (credit or debit); HSA and FSA cards. Monthly payment plans are available through **CareCredit** and **Cherry**, third-party financing companies. Approval, rates and terms are set by them, not by us. Please read the fine print, and never feel rushed to complete an application.

Credit card surcharge. We add a **3% surcharge** to payments made with a credit card; you'll see the amount on the card reader before you pay. It is not more than what accepting credit cards costs us. There is **no surcharge** on debit cards, HSA or FSA cards, cash or checks.

Card on file. We keep a credit or debit card on file for your account. After your insurance has paid, any remaining balance of **$75.00 or less** is charged to that card automatically. For a larger balance we send you a statement, due when you receive it.

Returned checks. There is a **$40** fee for each returned check.

Unpaid balances. A finance charge of **18% per year** is added to any balance that is unpaid more than **60 days**.

Collections. If your account is not paid and is sent to a collection agency or an attorney, you agree to pay the collection agency's fees, equal to **30%** of the unpaid balance, plus reasonable attorney fees and any court costs.

Appointments and cancellations. Your appointment time is reserved just for you. If you need to cancel or move it, please call us at (330) 847-0676 at least **48 hours** ahead. For a **Monday** appointment, please call by **Friday**, because the office is closed on weekends.

- A **missed appointment** means not coming, or canceling or moving it with less notice than that.
- **First missed appointment:** the fee is waived, and we'll let you know that the fee applies the next time.
- **Every missed appointment after that: $75** each.
- **Emergencies:** there is no fee for a family emergency, such as a sudden illness, an accident or a death in the family. We may also waive the fee in other special circumstances.
- Missed appointments don't reset with time. If you keep your appointments on schedule consistently, we may give you a fresh start.

- If you often cancel at the last minute, we may ask you to pay your full estimated copayment as a deposit when you book. If you then miss that appointment, the $75 fee is taken from your deposit, and you pay the difference so your copayment is covered for your next visit.
- Insurance does not pay missed-appointment fees.

How we contact you. You agree that Modern Dental Concepts and its agents and service providers may contact you by phone call, voicemail, text message or email, including prerecorded or automated calls and messages, at any phone number or email address you give us now or in the future, including a cell phone, even if you are charged for the call or message. You can tell us at any time to stop texts or emails, or to use a different number or address.

My agreement. I have read this Financial Policy and agree to it. In return for the care given to the patient named below, I guarantee payment of the account as this policy describes.

Patient Name (please print):	Date:
Signature (patient, or parent or legal guardian if the patient is under 18):	
Relationship to patient (if not the patient):	

Health History

Your answers are for our records only and are kept confidential under HIPAA. You may be asked follow-up questions. This information is vital to your care and is never used to discriminate.

Patient Name:	Date of Birth:	Today's Date:
Patient ID (office use):	Height:	Weight:

7. Dental Information

Reason for your dental visit today:		
How do you feel about your smile?		
Former dentist:	City/State:	Date of last exam:
Date of last dental X-rays:	What was done at that time?	

	Yes	No	DK
Do your gums bleed when you brush or floss?	☐	☐	☐
Teeth sensitive to cold, hot, sweets, or pressure?	☐	☐	☐
Is your mouth dry?	☐	☐	☐
Have you had periodontal (gum) treatments?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Problems with previous dental treatment?	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐
Do you drink bottled or filtered water?	☐	☐	☐
Do you have earaches or neck pains?	☐	☐	☐
Clicking, popping, or discomfort in the jaw?	☐	☐	☐
Do you brux or grind your teeth?	☐	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐	☐
Do you wear dentures or partials?	☐	☐	☐
Do you participate in active sports?	☐	☐	☐
Do you have a strong gag reflex?	☐	☐	☐
Serious injury to your head or mouth?	☐	☐	☐
Currently experiencing dental pain or discomfort?	☐	☐	☐

8. Medical Information

Physician Name:	Phone:	City/State:

	Yes	No	DK
Now under the care of a physician? (Condition:)	☐	☐	☐
Are you in good health?	☐	☐	☐
Change in general health in the past year? (What:)	☐	☐	☐
Serious illness / operation / hospitalization in past 5 yrs? (What:)	☐	☐	☐
Taking any prescription or OTC medicine(s)?	☐	☐	☐

	Yes	No	DK
Do you wear contact lenses?	☐	☐	☐
Orthopedic total joint replacement? (Date/complications:)	☐	☐	☐
Antiresorptive for osteoporosis? (Fosamax, Actonel, Boniva, Reclast, Prolia)	☐	☐	☐
Since 2001, antiresorptive for bone pain/cancer? (Aredia, Zometa, XGEVA)	☐	☐	☐
Do you take a blood thinner? (e.g. warfarin/Coumadin, Eliquis, Xarelto, Plavix)	☐	☐	☐
Medicine that weakens your immune system, or an organ transplant?	☐	☐	☐
Do you use controlled substances (drugs)?	☐	☐	☐
Use tobacco? (Stop? ☐ Very ☐ Somewhat ☐ Not)	☐	☐	☐
Drink alcohol? (24 hrs: / per week:)	☐	☐	☐
Advised to take antibiotics before dental treatment? (Name/phone:)	☐	☐	☐

Unprescribed or illegal drugs can interfere with anesthesia. Please tell Dr. Singh about any use in the past 48 hours.

Date of last physical exam:	List all medications, vitamins, herbal preparations & supplements:

9. Allergies

Check any you are allergic to; note the reaction where known.

☐ Local anesthetics	☐ Aspirin	☐ Penicillin / antibiotics
☐ Barbiturates / sedatives	☐ Sulfa drugs	☐ Codeine / narcotics
☐ Metals	☐ Latex (rubber)	☐ Iodine
☐ Hay fever / seasonal	☐ Animals	☐ Food

Other allergies:	Describe any reactions:

10. Medical Conditions

Check any of the following that you have or have had.

Heart & Circulation

☐ Cardiovascular disease	☐ Angina	☐ Arteriosclerosis	☐ Congestive heart failure
☐ Damaged heart valves	☐ Heart attack	☐ Heart murmur	☐ Low blood pressure
☐ High blood pressure	☐ Congenital heart defects	☐ Mitral valve prolapse	☐ Pacemaker
☐ Rheumatic fever	☐ Rheumatic heart disease		

Blood & Immune

☐ Abnormal bleeding	☐ Anemia	☐ Blood transfusion (date:)	☐ Hemophilia
☐ AIDS or HIV infection	☐ Arthritis	☐ Autoimmune disease	☐ Rheumatoid arthritis
☐ Systemic lupus (SLE)			

Respiratory

☐ Asthma	☐ Bronchitis	☐ Emphysema	☐ Sinus trouble
☐ Tuberculosis (TB)			

General & Other

☐ Cancer / Chemo / Radiation (incl. head or neck)	☐ Chest pain on exertion	☐ Chronic pain	☐ Diabetes (I or II)
☐ Eating disorder	☐ Malnutrition	☐ Gastrointestinal disease	☐ Acid reflux / heartburn
☐ Ulcers	☐ Thyroid problems	☐ Stroke	☐ Glaucoma
☐ Hepatitis / jaundice / liver	☐ Epilepsy	☐ Fainting spells / seizures	☐ Neurological disorder
☐ Sleep disorder	☐ Do you snore?	☐ Mental health disorder	☐ Recurrent infections
☐ Kidney problems	☐ Night sweats	☐ Osteoporosis	☐ Swollen glands in neck
☐ Headaches / migraines	☐ Rapid weight loss	☐ Sexually transmitted disease	☐ Excessive urination

Heart conditions that may require antibiotics before dental treatment

☐ Artificial (prosthetic) heart valve	☐ Previous infective endocarditis
☐ Damaged valves in transplanted heart	☐ Unrepaired cyanotic congenital heart disease (CHD)
☐ CHD repaired in last 6 months	☐ Repaired CHD with residual defects

11. For Women

	Yes	No	DK
Are you pregnant? (Weeks:)	☐	☐	☐
Taking birth control or hormone replacement?	☐	☐	☐
Are you nursing?	☐	☐	☐

12. Anything Else?

Any disease, condition, or problem not listed above we should know about? ☐ Yes ☐ No
If yes, please explain:
Is there anything you'd like to discuss with Dr. Singh privately? ☐ Yes ☐ No

13. Authorization & Acknowledgment

I certify that the information on this form is accurate. I understand the importance of a truthful health history and that my dentist and staff will rely on it in treating me. I will not hold my dentist or any staff member responsible for any action taken or not taken because of errors or omissions I have made. I will notify Modern Dental Concepts of any change in my health status. This information is kept confidential under HIPAA.

Signature of Patient / Legal Guardian:	Date:
Printed Name:	Relationship to Patient:

For office use only — Dentist Signature: _____ Date: _____ Reviewed/Updated: _____