PLEASANT STREET
DENTAL ASSOCIATES

DENTAL RECORDS RELEASE FORM

Patient Name to transfer: _____

Date of Birth: _____ Phone number: _____

Other family members to transfer: _____

Previous Dentist or Practice Name: _____

Address: _____

City/St/Zip: _____

Phone number: _____ Fax: _____

Please forward any of the following information that you have: x-rays, probing depth chart, charting, and photographs to Pleasant Street Dental Associates.

I hereby give you permission to release any and all of my dental records to Dr. Moshier.

_____ _____

Patient Signature (parent if a minor) Date

If records are digital, please email to:
PSD@Pleasantstreetdental.net

Or mail to:
Pleasant Street Dental Associates
53 Pleasant Street
Brunswick, ME 04011

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PATIENT INFORMATION

First Name: _____ Last Name: _____
Address: _____
_____
Phone: H: _____ W: _____ C: _____
Social Security Number: _____ - _____ - _____
Date of Birth: _____ - _____ - _____
E-mail Address _____
Emergency Contact: _____ Number: _____
Date of Last Dental Visit: _____ - _____ - _____
Date of Last X-rays: _____ - _____ - _____
Referred By: _____

RESPONSIBLE PARTY

First Name: _____ Last Name: _____
Address: _____
_____
Phone: H: _____ W: _____ C: _____

DENTAL INSURANCE INFORMATION

Name of Insured: _____
Relationship to Patient: _____ Date of Birth: _____ - _____ - _____
Home Phone: _____ Social Security Number: _____ - _____ - _____
Name of Employer: _____
Insurance Company:_____
Address: _____
_____
Group Number: _____ Subscriber ID: _____

DO YOU HAVE ADDITIONAL DENTAL INSURANCE? ◯ YES ◯ NO
If yes, please complete the following:

Name of Insured: _____
Relationship to Patient: _____ Date of Birth: _____ - _____ - _____
Home Phone: _____ Social Security Number: _____ - _____ - _____
Name of Employer: _____
Insurance Company:_____
Address: _____
_____
Group Number: _____ Subscriber ID: _____

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MEDICAL HISTORY

Patient Name: _____
Date of Birth: _____ - _____ - _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	YES	NO
If yes, please explain: _____		
Have you ever been hospitalized or had a major operation?	YES	NO
If yes, please explain: _____		
Have you ever had a serious head or neck injury?	YES	NO
If yes, please explain: _____		
Are you taking any medications, pills, or drugs?	YES	NO
If yes, please explain: _____		
Do you take, or have you taken, Phen-Fen or Redux?	YES	NO
If yes, please explain: _____		
Are you on a special diet?	YES	NO
Do you use tobacco?	YES	NO
Do you use controlled substances?	YES	NO

Women: Are you pregnant/trying to conceive?	YES	NO
Are you taking oral contraceptives?	YES	NO
Are you nursing?	YES	NO

Are you allergic to any of the following:

◯ Aspirin ◯ Penicillin ◯ Codeine ◯ Acrylic ◯ Metal ◯ Latex
◯ Local Anesthetics ◯ Other

If yes, please explain: _____

Do you have, or have you had, any of the following? (Please circle yes or no.)

AIDS/HIV Positive	YES	NO	Cortisone Medicine	YES	NO	Hemophilia	YES	NO
Renal Dialysis	YES	NO	Diabetes	YES	NO	Hepatitis A	YES	NO
Alzheimer's Disease	YES	NO	Drug Addiction	YES	NO	Hepatitis B or C	YES	NO
Rheumatic Fever	YES	NO	Easily Winded	YES	NO	Herpes	YES	NO
Anaphylaxis	YES	NO	Emphysema	YES	NO	High Blood Pressure	YES	NO
Rheumatism	YES	NO	Epilepsy or Seizures	YES	NO	Hives or Rash	YES	NO
Anemia	YES	NO	Excessive Bleeding	YES	NO	Hypoglycemia	YES	NO
Scarlet Fever	YES	NO						
Angina	YES	NO						
Shingles	YES	NO						
Arthritis/Gout	YES	NO						
Sickle Cell Disease	YES	NO						
Artificial Heart Valve	YES	NO						
Sinus Trouble	YES	NO						

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Artificial Joint	YES	NO	Excessive Thirst	YES	NO	Irregular Heartbeat	YES	NO
Spina Bifida	YES	NO	Fainting Spells/Dizziness	YES	NO	Kidney Problems	YES	NO
Asthma	YES	NO	Frequent Cough	YES	NO	Leukemia	YES	NO
Stomach/Intestinal Disease	YES	NO	Frequent Diarrhea	YES	NO	Liver Disease	YES	NO
Blood Disease	YES	NO	Frequent Headaches	YES	NO	Low Blood Pressure	YES	NO
Stroke	YES	NO	Genital Herpes	YES	NO	Lung Disease	YES	NO
Blood Transfusion	YES	NO	Glaucoma	YES	NO	Mitral Valve Prolapse	YES	NO
Swelling of Limbs	YES	NO	Hay Fever	YES	NO	Pain in Jaw Joints	YES	NO
Breathing Problem	YES	NO	Heart Attack/Failure	YES	NO	Parathyroid Disease	YES	NO
Thyroid Disease	YES	NO	Heart Murmur	YES	NO	Psychiatric Care	YES	NO
Bruise Easily	YES	NO	Heart Pace Maker	YES	NO	Radiation Treatments	YES	NO
Tonsilitis	YES	NO	Heart Trouble/Disease	YES	NO	Recent Weight Loss	YES	NO
Cancer	YES	NO						
Tuberculosis	YES	NO						
Chemotherapy	YES	NO						
Tumors or Growths	YES	NO						
Chest Pains	YES	NO						
Ulcers	YES	NO						
Cold Sores/Fever Blisters	YES	NO						
Venereal Disease	YES	NO						
Congenital Hearth Disorder	YES	NO						
Yellow Jaundice	YES	NO						
Convulsions	YES	NO						

Have you ever had any serious illness not listed above? YES NO

If yes, please explain: _____

_____

_____

_____

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Here at Pleasant Street Dental, our goal is to help you establish excellent oral health. We are committed to helping you determine the most appropriate treatment for your dental needs and desires. We welcome any questions you might have concerning your treatment, procedure sequences or fees. Please feel at ease to ask for clarification before treatment begins.

Our financial policy is as follows:

- Payment is due at time of service – patient is 100% responsible.
- We have three financial options available:
    1) pre-pay
    2) all major credit cards including Master Card, Visa, American Express, and Discover
    3) Care Credit and Springstone (please ask us for more information if you are interested)

If you have dental insurance, your copayment will be required when services are rendered. Dental insurance is a contract between your employer and the insurance company. It is not a contract between our office and your insurance company. We are happy to assist you by filing your dental claim. We cannot be responsible for payment by your insurance company. The responsibility for payment belongs to you, the patient.

We will provide estimated balances between the cost of service and copayment of your insurance. Again, it is only an estimation not a guarantee. When your insurance company's final payment has been received, we will reconcile your account and we will bill or refund you any difference.

Extended treatment plans will be outlined so that appropriate payments may be made as each phase of treatment is begun.

Treatment requiring laboratory fees will require a deposit at time of service and the balance on completion.

We will notify you of the balance unpaid by your insurance and you will have 30 days to take care of your balance. There will be a monthly finance charge of 1.5% added to any unpaid balances after 60 days from date of service. Should your insurance plan be denied, full payment is expected at the time of services. Please remember that you are responsible for a timely payment of your account.

I have read and understand the above policy and agree to the terms herein.

_____ _____

Individual patient/Parent/Guardian/Responsible Party Date

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APPOINTMENT CANCELLATION POLICY

We understand that circumstances can arise and may prevent you from keeping the appointment. If that happens and you find it impossible to keep an appointment, we respectfully ask for a 24 hour notice in advance. Our doctors & hygienists want to be available for your needs and the needs of all our patients. When a patient does not show up for a scheduled appointment, another patient loses an opportunity to be seen, with prior notification this will allow us time to offer your appointment slot to another patient waiting to be seen. Thank you for being a valued patient and for your understanding and cooperation as we institute this policy. This policy will enable us to better serve the needs of all patients.

The policy is as follows:

- 1st Short Notice Cancellation* or No Show is complimentary
- 2nd Short Notice Cancellation* is a $35 charge or No Show is a $50 charge
- 3rd Short Notice Cancellation* or No Show is ground for dismissal from the practice

I have read and understand the above policy and agree to the terms herein.

_____ _____

Individual patient/Parent/Guardian/Responsible Party Date

*Short Notice Cancellation = less than 24 hours notice

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that Pleasant Street Dental Associates has the right to change its Notice of Privacy Practices from time to time and that I may contact you at any time to obtain a current copy of the Notice of Privacy.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____