Main Street Dentistry

Patient Information: (All Fields Required) Date: _____

Legal First Name: _____ Last: _____ MI: _____

Preferred Name: _____ Date of birth: _____ SSN: _____

Address: _____ Apt? ____No ____Yes: Apt #: _____

City/State: _____ Zip: _____ Email: _____

Home Ph: _____ Cell: _____ Prefer Contact By: ☐ Call ☐ Text ☐ Email

Check one : ☐ Male ☐ Female | ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

How did you hear about us? ☐ Internet/Google ☐ Insurance ☐ Drive-By ☐ Family/Friend: _____

Patient is: ☐ Responsible Party ☐ Policy Holder

Responsible Party: (Fill ONLY if you are the spouse, parent, or guardian**)**

Legal First Name: _____ Last: _____ MI:_____

Preferred Name: _____ Date of birth: _____ SSN: _____

Address: _____ Apt? ____No ____Yes: Apt #: _____

City/State: _____ Zip: _____ Email: _____

Home Ph: _____ Cell: _____ Prefer Contact By: ☐ Call ☐ Text ☐ Email

Insurance Information:

Policy Holder: _____ Date of Birth: _____ SSN: _____

Employer: _____ Insurance Company: _____

Policy ID: _____Group #: _____Insurance Phone # :_____

Emergency Contact: _____ Ph #: _____

Dental Information/History:

What is the reason for your visit today? ☐ Consult ☐ Cleaning ☐ Tooth Pain ☐ Other: _____

Approximate date of your last dental cleaning (Month/Year)? _____

Please mark below if you would like to **discuss** any of the following with the doctor:

___	Bad Breath	___	Periodontal Treatment (Deep Clean)
___	Bleeding Gums	___	Sensitivity of your teeth
___	Orthodontics/ invisalign	___	Crowns or same day crowns
___	Tooth whitening	___	Dentures or implant dentures
___	Grinding your teeth	___	Cosmetic dentistry
___	Loose teeth	___	Frequent headaches or jaw pain
___	Dental implants	___	Dental pain
___	Gum Recession	___	Sedation dentistry

Are you happy with the way your smile looks? YES NO

Would you like whiter teeth? YES NO

Do you have any metal fillings/crowns that you want replaced? YES NO

Have you ever had any complications following dental treatment? YES NO

If yes, please explain: _____

Rate your dental health: 1(Worst) - 5(Best) 1 2 3 4 5

Rate your smile: 1(Worst) - 5(Best) 1 2 3 4 5

Which if any of the following would prevent you from completing necessary dental treatment?

☐ Fear of Pain ☐ Cost of Treatment ☐ Missing Work ☐ Lack of Comprehension

Patient

Main Street Dentistry

Name:

_____ Date of Birth: _____ Date: _____

Medical History | 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 mediations do affect our ability to perform treatment.

		(For all Yes's, you must provide details)
Are you under a physician's care now?	☐ No	☐ Yes: _____
Have you ever been hospitalized or had a major operation?	☐ No	☐ Yes: _____
Have you ever had a serious head or neck injury?	☐ No	☐ Yes: _____
Are you taking any medications, pills, or drugs?	☐ No	☐ Yes: _____
Do you take, or have taken, Phen-Fen or Redux?	☐ No	☐ Yes: _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	☐ No	☐ Yes: _____
Are you on a special diet?	☐ No	☐ Yes: _____
Do you use tobacco?	☐ No	☐ Yes: How many per day? ___Singles ___Packs

Women Only:

☐ Pregnant ☐ Trying to get pregnant ☐ Nursing ☐ Taking oral contraceptives ☐ None of the above

Allergies:

□ Aspirin □ Penicillin □ Codeine □ Acrylic □ Metal □ Latex □ Sulfa Drugs □ Local Anesthetics
□ None known drug allergies

Are you allergic to anything not listed above?	☐ No	☐ Yes: _____
Do you use controlled Substances?	☐ No	☐ Yes: _____
Others?	☐	: _____

Mark everything you have or have had only:

☐ AIDS/HIV Positive	☐ Cortisone Medicine	☐ Hepatitis A	☐ Renal Dialysis
☐ Alzheimer's Disease	☐ Diabetes	☐ Hepatitis B or C	☐ Rheumatic Fever
☐ Anaphylaxis	☐ Drug Addiction	☐ Herpes	☐ Rheumatism
☐ Anemia	☐ Easily Winded	☐ High Blood Pressure	☐ Scarlet Fever
☐ Angina	☐ Emphysema	☐ High Cholesterol	☐ Shingles
☐ Arthritis/Gout	☐ Epilepsy or Seizures	☐ Hives or Rash	☐ Sickle Cell Disease
☐ Artificial Heart Valve	☐ Excessive Bleeding	☐ Hypoglycemia	☐ Sinus Trouble
☐ Artificial Joint	☐ Excessive Thirst	☐ Irregular Heartbeat	☐ Spina Bifida
☐ Asthma	☐ Fainting Spells/Dizziness	☐ Kidney Problems	☐ Stomach/Intestinal Disease
☐ Blood Disease	☐ Frequent Cough	☐ Leukemia	☐ Stroke
☐ Blood Transfusion	☐ Frequent Diarrhea	☐ Liver Disease	☐ Swelling of Limbs
☐ Breathing Problems	☐ Frequent Headaches	☐ Low Blood Pressure	☐ Thyroid Disease
☐ Bruise Easily	☐ Genital Herpes	☐ Lung Disease	☐ Tonsillitis
☐ Cancer	☐ Glaucoma	☐ Mitral Valve Prolapse	☐ Tuberculosis
☐ Chemotherapy	☐ Hay Fever	☐ Osteoporosis	☐ Tumors or Growths
☐ Chest Pains	☐ Heart Attack/Failure	☐ Pain in Jaw Joints	☐ Ulcers
☐ Cold Sores/Fever Blisters	☐ Heart Murmur	☐ Parathyroid Disease	☐ Venereal Disease
☐ Congenital Heart Disorder	☐ Heart Pacemaker	☐ Psychiatric Care	
☐ Convulsions	☐ Heart Trouble/Disease	☐ Radiation Treatments	
☐ Yellow Jaundice	☐ Hemophilia	☐ Recent Weight Loss	

Have you ever had any serious illness not listed above? ☐ No ☐ Yes: _____

Comments (list medication taken here if any):

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian: _____ Date: _____

705 Main Street SW, Los Lunas NM 87031 P: 505-865-3395 | F: 505-865-1414

Main Street Dentistry

Affordable Financial Options

Helping You Save Money on Quality Care

Thank you for choosing our office for your dental needs. Our primary mission is to deliver the best service and most comprehensive dental care available. We are focused on your complete oral health and everything we do is centered on this philosophy. An important part of this mission is making the cost of optimal care as easy and manageable for our patients as possible.

Your Insurance: We must emphasize that as a dental care provider, our relationship is with YOU and NOT your insurance company. Our office policy is to provide the highest quality dentistry for each our patients, regardless of insurance limitations. We are an In-Network Provider for most insurance, which means that we have contracted with your insurance company so that you will receive the highest quality care at the lowest possible fees and receive the maximum amount of insurance coverage.

Please be aware that some services may not be covered under the provisions of your insurance plan. You will be responsible for any difference. We require that all deductible, co-pays, and/or any percentage of the bill that your insurance does not cover to be paid at the time of service. If, after 45 days of nonpayment from the insurance company, the balance is the patient's responsibility and payment is due within 30 days.

Payment Options: The office requires payment on the date of your treatment unless other written financial arrangements have been made. We accept Cash, Check, Visa, MasterCard, American Express, Discover and CareCredit.

Late & Missed Appointment: We pride ourselves on seeing all our patients On-Time, and in order to help us stay On-Time, we follow a strict 10-minute late appointment policy. If you arrive late for your appointment, we reserve the right to reschedule the appointment. A fee of $50 is charged for patients who miss or cancel more than once in a calendar year without prior 48-hour notification. For any surgery time scheduled, cancellation fee can range from $50-$200 in last minute cancellation fees. This also includes the deposit paid to schedule surgery.

Returned Check: Our office charges $45 for returned checks.

Default on Payment: If your account is turned over to our collection agency, you will be responsible to pay a service fee of $125, any collection agency fees, court and attorney fees in addition to the balance owed.

Patient Name (Please Print)	Parent/Guardian if applicable (Please Print)
Patient, Parent or Guardian Signature	Date

Main Street Dentistry

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect immediately, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Main Street Dentistry

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $50 for each set of x-rays and $20 per hour for staff time to copy your health information, and postage if you want the copies mailed to you. If you request an alternative format(via email), we will charge a cost-based fee of $25 for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)***Note: This is dictated by the US Government and is part of the Privacy Act.***

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Eric Winterton DDS

Telephone: 505-865-3395

E-mail: 705msd@gmail.com

Address: 705 Main Street SW, Los Lunas NM 87031

Patient(s)_____

Responsible Party Signature_____Date_____

(Parent/Guardian if patient is a minor)