



Welcome!

Thank you for choosing our practice to provide your dental needs. It is our goal to provide you with the best care to maintain your dental health.

We pride ourselves in knowing that we use the best quality dental materials and laboratories for all of your dental needs and care. With that in mind, please be advised that we only do composite fillings (known as tooth colored) in our office because it is a better dental material. It is not always recognized by your insurance carrier as the best, and is therefore paid as an alternate benefit of an amalgam filling (know as silver), being paid at approximately 50% rather than 80%.

This is just an example of something that your insurance may call an alternate benefit with your plan, and there are often other limitations, exclusions, and frequency allowances. We ask that you obtain information regarding you benefits and inquire about any services you may need to schedule prior to scheduling, we do our best to be knowledgeable about some of your benefits, but is not possible to know everything about your individual plan.

Our office is more than happy to bill your insurance for you, but with you understanding that you are still responsible for all services. If after 90 days your insurance company does not pay, your dental claim will close, and you will receive a statement. You can inquire with you insurance company why they did not pay your claim.

At Murrayhill Dental we also do our best to get you in at your appointed time, and we ask that you be here on time as well as give us 48 hours notice of you are unable to keep your appointment.

We hope you will be satisfied with our office and feel confident that we will provide you and your family with the best quality care. If there is anything we can do for you please let us know. Please feel free to inform us of anything else we can of to make your visit more pleasant.

Thank you,

The Murrayhill Dental Team

## Patient Interview

Name: \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

In order to provide you with the highest standard of dental care, please let us know your dental concerns.

On a scale of 1-10, 10 being the best, where would you rate your smile?

Have you experienced any of the following problems?

Bleeding Gums	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Soreness in Jaw	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Sensitivity to hot and cold	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Grinding or clenching of jaw	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Food catching between teeth	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Oral surgery of any kind	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No

Have you ever had  Retainer  Night guard  Braces

Does having dental treatment make you afraid or nervous  Yes  No  
Are you interested in sedated dentistry? (Nitrous/ Anti-anxiety medication)  Yes  No

What about your smile would you like to change?

Teeth Whitening	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Replacement of missing teeth	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Straighter teeth	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Replacement of crowns	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Remove Silver/ Mercury Fillings	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Pain and sensitivity	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Fix broken teeth	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Everything	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No

Which are important to you when making your Dental Health Decisions?

<input type="checkbox"/> Finances	<input type="checkbox"/> Relationship with Dental Team
<input type="checkbox"/> What Insurance covers	<input type="checkbox"/> Detailed Treatment Explanations
<input type="checkbox"/> Comfort	<input type="checkbox"/> Quality of Care
<input type="checkbox"/> Time	<input type="checkbox"/> My Health
<input type="checkbox"/> Appearance	<input type="checkbox"/> Long Lasting Dentistry

What else can we do to make your visit a positive one?

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## Patient Information

Name: \_\_\_\_\_  
Last  MARRIED  MARRIED  SINGLE  MINOR  MALE  FEMALE  
First MI

Address: \_\_\_\_\_  
Street Apt# City State Zip

Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Email: \_\_\_\_\_  
MM DD YYYY

Telephone: (\_\_\_\_)\_\_\_\_ - (\_\_\_\_)\_\_\_\_ - (\_\_\_\_)\_\_\_\_ - \_\_\_\_\_  
Home# Work# Fax#

Employer: \_\_\_\_\_ SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Person Responsible For account:

PATIENT  GUARDIAN  FATHER  MOTHER

## Insurance Information

### Primary Insured

\_\_\_\_\_  
Last First MI

\_\_\_\_\_  
Street City State Zip

(\_\_\_\_) (\_\_\_\_) (\_\_\_\_)  
Home # Work # Fax #

\_\_\_\_\_  
Email

\_\_\_\_\_  
Birthdate MM/DD/YYYY Relationship to patient

\_\_\_\_\_  
Employer Dental Insurance Company

\_\_\_\_\_  
SS# Subscriber# Group #

### Secondary Insured

\_\_\_\_\_  
Last First MI

\_\_\_\_\_  
Street City State Zip

(\_\_\_\_) (\_\_\_\_) (\_\_\_\_)  
Home # Work # Fax #

\_\_\_\_\_  
Email

\_\_\_\_\_  
Birthdate MM/DD/YYYY Relationship to patient

\_\_\_\_\_  
Employer Dental Insurance Company

\_\_\_\_\_  
SS# Subscriber# Group #

### Emergency Contact

Name \_\_\_\_\_  
Address \_\_\_\_\_  
City/State/Zip \_\_\_\_\_  
Phone # \_\_\_\_\_

Have any of your family members been to our office?  Yes  No

If yes, Who? \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

### Authorization

I hereby authorize payment directly to Murrayhill Dental of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize Murrayhill Dental to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals

Signature of Patient, Parent, or Gaurdian \_\_\_\_\_ Date: \_\_\_\_\_

# Medical History

Name: \_\_\_\_\_ DOB \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

**Health problems that you may have, or medication you may be taking, could have an important interrelationship with the dentistry you will receive. The following questions will insure that we provide you with accurate care during your visit.**

Are you under a physician's care now?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	If yes, Please explain: _____
Have you ever been hospitalized or had a major operation?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	If yes, Please explain: _____
Have you ever had a serious head or neck injury?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	If yes, Please explain: _____
Are you taking any medications, pills, or drugs?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	If yes, Please explain: _____
Do you take, or have you taken, Phen-fen or Redux?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	If yes, Please explain: _____
Are you on a special diet?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	If yes, Please explain: _____
Do you use tobacco?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	If yes, Please explain: _____
Do you use controlled substances?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	If yes, Please explain: _____
Have you ever taken Fosamax/Bisphosphonates	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	If yes, Please explain: _____
Do you consider yourself a nervous patient?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	If yes, Please explain: _____
Have you ever used N2O or a sedative during Treatment?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	If yes, Please explain: _____

Comments: \_\_\_\_\_

### Women are you?

- Pregnant or Trying to Conceive
- Taking Contraceptives?
- Nursing
- Taking Estrogen Therapy?

### Are you allergic to any of the following?

- |  |  |
|--|--|
| <input type="checkbox"/> Aspirin                 | <input type="checkbox"/> Codeine           |
| <input type="checkbox"/> Latex                   | <input type="checkbox"/> Sedatives         |
| <input type="checkbox"/> Iodine                  | <input type="checkbox"/> Sulfur            |
| <input type="checkbox"/> Acrylic                 | <input type="checkbox"/> Metal             |
| <input type="checkbox"/> Penicillin/ antibiotics | <input type="checkbox"/> Local Anesthetics |
| <input type="checkbox"/> Other                   |  |

### Do you have or have you had any of the following?

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> AIDS/HIV                  | <input type="checkbox"/> Diabetes                  | <input type="checkbox"/> Hepatitis B or C      | <input type="checkbox"/> Replaced Joints/Pins/Rods/Implants |
| <input type="checkbox"/> Alzheimer's               | <input type="checkbox"/> Drug Addiction            | <input type="checkbox"/> Herpes                | <input type="checkbox"/> Rheumatic Fever                    |
| <input type="checkbox"/> Anaphylaxis               | <input type="checkbox"/> Easily Winded             | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Rheumatism                         |
| <input type="checkbox"/> Anemia                    | <input type="checkbox"/> Emphysema                 | <input type="checkbox"/> Hives or Rash         | <input type="checkbox"/> Respiratory Problems               |
| <input type="checkbox"/> Angina                    | <input type="checkbox"/> Epilepsy/Seizures         | <input type="checkbox"/> Hypoglycemia          | <input type="checkbox"/> Scarlet Fever                      |
| <input type="checkbox"/> Arthritis/Gout            | <input type="checkbox"/> Excessive Bleeding        | <input type="checkbox"/> Immune Disorders      | <input type="checkbox"/> Shingles                           |
| <input type="checkbox"/> Artificial Heart Valve    | <input type="checkbox"/> Excessive Thirst          | <input type="checkbox"/> Irregular Heart Beat  | <input type="checkbox"/> Shortness of Breath                |
| <input type="checkbox"/> Artificial Joint          | <input type="checkbox"/> Fainting Spells/Dizziness | <input type="checkbox"/> Kidney Problems       | <input type="checkbox"/> Sickle Cell Disease                |
| <input type="checkbox"/> Asthma                    | <input type="checkbox"/> Frequent Cough            | <input type="checkbox"/> Leukemia              | <input type="checkbox"/> Sinus Trouble                      |
| <input type="checkbox"/> Blood Disease             | <input type="checkbox"/> Frequent Diarrhea         | <input type="checkbox"/> Liver Disease         | <input type="checkbox"/> Spina Bifidia                      |
| <input type="checkbox"/> Blood Transfusion         | <input type="checkbox"/> Frequent Headaches        | <input type="checkbox"/> Low Blood Pressure    | <input type="checkbox"/> Stomach/Intestinal Disease         |
| <input type="checkbox"/> Breathing Problem         | <input type="checkbox"/> Genital Herpes            | <input type="checkbox"/> Lung Disease          | <input type="checkbox"/> Stroke                             |
| <input type="checkbox"/> Bruise Easily             | <input type="checkbox"/> Glaucoma                  | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Swelling of Limbs                  |
| <input type="checkbox"/> Cancer                    | <input type="checkbox"/> Hay Fever                 | <input type="checkbox"/> Pain in Jaw Joints    | <input type="checkbox"/> Thyroid Disease                    |
| <input type="checkbox"/> Chemotherapy              | <input type="checkbox"/> Heart Attack/Failure      | <input type="checkbox"/> Parathyroid Disease   | <input type="checkbox"/> Tonsillitis                        |
| <input type="checkbox"/> Chest Pains               | <input type="checkbox"/> Heart Murmur              | <input type="checkbox"/> Prolonged Bleeding    | <input type="checkbox"/> Tuberculosis                       |
| <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Heart Pace Maker          | <input type="checkbox"/> Psychiatric Care      | <input type="checkbox"/> Tumors or Growths                  |
| <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Heart Trouble/Disease     | <input type="checkbox"/> Radiation Treatments  | <input type="checkbox"/> Ulcers                             |
| <input type="checkbox"/> Convulsions               | <input type="checkbox"/> Hemophilia                | <input type="checkbox"/> Recent Weight Loss    | <input type="checkbox"/> Venereal Disease                   |
| <input type="checkbox"/> Cortisone Medicine        | <input type="checkbox"/> Hepatitis A               | <input type="checkbox"/> Renal Dialysis        | <input type="checkbox"/> Yellow Jaundice                    |

If you have marked any of the illnesses above please explain:

\_\_\_\_\_

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 Gaurdian** \_\_\_\_\_ **Date:** \_\_\_\_\_

## **Use and Disclosure of Health Information Consent Form**

Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Consent:** By signing this form, you do consent to our use and disclose of your personal health information to carry our treatment, payment activities and other healthcare operations required by this office. You acknowledge you are aware of our need to share your protected personal health information and have received your patient rights notification explaining in detail our office privacy policy and information sharing policy.

**Right to revoke:** You have the right to revoke this consent at any time by giving us written notice. We will honor the request as of the day we receive your written notice. Please understand it will not affect any action taken before we received your revocation and we may decline to treat you or to continue treating you if you revoke this consent.

**Changes to Privacy Practices:** We reserve the right to change our privacy practices described in our Patients Rights Privacy Policy and Information Practices. If we change our practices we will issue a revised Patients Rights Privacy Policy and Information Practice Statement.

**Patient Responsibility:** We request timely notification of any changes to your personal information we maintain for you, such as but not limited to, health history information, address, telephone number, active insurance policy, change in employer.

### **Minor Children also covered by this consent**

Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

I have read and understand the above information. I understand that by signing this form I am giving my consent for Murrayhill Dental to use and disclose my protected health information to carry out treatment, payment activities and health care operations.

Signature of Patient, Parent, or Gaurdian \_\_\_\_\_ Date: \_\_\_\_\_

## Credit Policy

Name: \_\_\_\_\_ DOB \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**This policy is an explanation and agreement to our financial terms. The following points will be clarified so you will have a better understanding as to what you are responsible for and when payment is expected. This is so we will avoid any confusion and be able to provide you with quality service. Our fees reflect our professional commitment to you as we use quality materials and outstanding laboratories.**

- Payment for any service provided to you by Murrayhill Dental is your responsibility. We will submit all and any claims to your insurance company we have on file, all remaining and unpaid claims are to be paid in full, (Including claims under legal action, example..... motor vehicle, workmen's comp, children of divorcing parents and or Insurance disputes). Failure to pay any outstanding balances will result in accrued finance charges and can be forwarded to collections.
- Patients with insurance are required to pay the estimated portion, in which we assume insurance will not cover, at time of service.
  - Current proof of insurance must be presented at each visit to insure correct billing. It is your responsibility to provide any updated information regarding your insurance company. This includes any changes in Benefits, Carrier, Addresses or phone numbers. Failure to do so may result in prepayment of future services and/or possible rescheduling of your appointment. Statements are mailed out monthly with all pending insurance claims and/or balances owed. Any claims not paid by the insurance company within 60days will be closed and billed to the patient.
  - Any account balances remaining after insurance claims have been submitted and received are the patient's responsibility. The balance due is to be paid in full with in 60 days from the date of service. Any questions you may have regarding your insurance coverage can be found in your handbook provided by your insurance provider.
- Patients without insurance are required to pay full balance due at time of service.
- Statements are mailed out monthly with all pending insurance claims and/or balances owed. Any claims not paid by the insurance company within 60 days will be closed and billed to the patient
- Accounts with a balance over 60 days will be charges 1 3/4 % interest per month
- Payments can be made with Personal checks, Money order, Cash, MasterCard, a Visa card or a Discover card. We also for you convince have outside financing available. We offer Capitol One or Care Credit Financing. If other arrangements are necessary we ask that they be made ahead of time prior to your appointment with our administrator. We regret that this courtesy will only be extended to our established patients.
- We offer separate discounts for seniors as well as for non-insured cash payments.

I have read the above credit policy and understand that I am fully responsible for payment of my account, regardless of any insurance policy that I may have. I agree that if it becomes nessesary to turn my account over for collection proceedings, I will pay all such costs incurred, such as attorney fees, court and collection costs.

Signature of Patient, Parent, or Gaurdian \_\_\_\_\_ Date: \_\_\_\_\_

## **No Show/ Late Arrival Policy**

Name: \_\_\_\_\_ DOB \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Your appointment time is reserved for you.

If you find it is necessary to reschedule an appointment, a minimum of **48 hours** notice is required. This will allow us to make that time available for another patient that is in need. For appointments that are cancelled or missed with less than the minimum notice, or late arrival, a fee could be assessed to the account of **\$50.00-\$150.00/hr** depending on the type of service and length of the appointment. An appointment is considered late if a patient arrives more than **15 minutes** after the scheduled visit time. We understand that Emergencies do arise, and the fee may be waived (ie; Sudden illness or injuries).

*Insurance will not reimburse for cancellation fees and therefore will not be billed.* This will be solely the patient's responsibility to pay and may result in cancellation of future appointments or cash deposit to hold future appointments for the patient.

I have read the above no show and late arrival policy and understand that I am fully responsible for any changes regarding my appointment. I agree that if it becomes necessary I will be billed a cancellation fee and may have to provide a deposit to hold an appointment opening on my behalf.

Signature of Patient, Parent, or Gaurdian \_\_\_\_\_