Mann Dental Care, LLC
Patient Registration Form

Welcome! Thank you for choosing our office. We strive to provide you with the most gentle, quality care possible. If you have any questions, or If we may help you in any way, please feel free to let us know.

Patient Information (Confidential)

Date: _____

Patient Name: _____ Birth Date: _____
Last First MI Preferred Name

**If patient is a child, Parent Guardian Name:* _____

Social Security #: _____ Gender: ☐ Male ☐ Female ☐ _____ Position: ☐ Married ☐ Single ☐ Child ☐ Other_____

Phone ***(Home #):*** _____ (***Cell #):*** _____ ***(Work #):*** _____ ***Ext:*** _____

Email Address: _____ *May we text message you? ☐ Yes ☐ No *May we email you? ☐ Yes ☐ No

Home Address: _____ /City _____ /State_____ /Zip _____

Driver's License #_____

Employer _____ /Occupation_____ /How long there? _____ /May we call? ☐ Yes ☐ No

Employer Address _____ /City _____ /State _____ /Zip _____

Spouse's Name (Or other parent/guardian): _____ Relationship to Patient: _____

Social Security #: _____ Birth Date: _____

Phone (#): _____ (Work #): _____ Ext: _____ (Cell #): _____ Best time to call: _____

Spouse's Employer _____/Occupation_____/How long there? _____/May we call? ☐ Yes ☐ No

Employer Address _____ /City _____ /State_____ /Zip _____

If patient is a student: Name of School/College: _____ City & State _____ Full Time or Part time? _____

How did you hear about our practice? _____

In Case of Emergency

The person to contact in case of an emergency

Name: _____ Gender: ☐ Male ☐ Female Relationship to Patient: _____

Phone (Home): _____ (Work): _____ Ext: _____ (Cell): _____ Best time to call: _____

Name and City of Primary Care Physician: _____ Phone #_____

Insurance Information

Primary Insurance	**Additional Insurance**
Subscriber Name: _____ DOB: _____	Subscriber Name: _____ DOB: _____
Subscriber SSN/ID: _____	Subscriber SSN/ID: _____
Subscribers Relationship to Patient: _____	Subscribers Relationship to Patient: _____
Subscriber Employer: _____	Subscriber Employer: _____
Insurance Company Name and State: _____	Insurance Co. Name and State: _____
Insurance Co. Phone # _____	Insurance Co. Phone # _____
Group Number: _____	Group Number: _____

Have you used your dental insurance this year or recently (Last 6 months)? ☐ Yes ☐ No

Dental History

Patient Name: _____ **DOB:** _____ **Date:** _____

Reason for seeking care today: _____
(Please describe)

Please check all that apply:

- ☐ Toothache
- ☐ Broken filling or tooth sensitivity to:
  - ☐ Cold
  - ☐ Hot
  - ☐ Sweets
  - ☐ Chewing
- ☐ Food catches
- ☐ Loose Teeth
- ☐ Floss breaks easily or hurts
- ☐ Bite or teeth have shifted
- ☐ Often bites cheeks
- ☐ Frequent dry mouth
- ☐ Concerned about breath
- ☐ Unhappy with previous dental work
- ☐ Gums bleed
- ☐ Gums tender
- ☐ Mouth sores, growths
- ☐ Cold sores, fever blisters
- ☐ Cracked, chapped lips
- ☐ Bad taste in mouth
- ☐ Sinus problems
- ☐ Mouth breathe – Difficulty breathing through nose
- ☐ Dry or strained eyes
- ☐ Pain in the Shoulder, Neck, or Head
- ☐ Clench or grind teeth
- ☐ Jaw joint pain
- ☐ Clicking or popping of joint
- ☐ Unable to open mouth wide
- ☐ Jaw gets tired easily
- ☐ Hold things between teeth (Pipe, pencils, nails, pins)
- ☐ Bite fingernails
- ☐ Unusual habits with teeth
- ☐ Wore braces
- ☐ Previous gum treatment
- ☐ Previous bite treatment
- ☐ Want Whiter teeth

Is there anything that bothers you (even just a little) about the appearance of your teeth or smile?
_____

Please rate 1-10 how anxious you are about dental treatment (1 = very relaxed) _____

Have you ever had a bad experience at the dentist? (Treatment? Staff? Billing?) _____

Why did you leave you previous dentist? _____

Medical History – Part 1

- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____
  City_____ State _____ Phone_____

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

- ☐ AIDS/HIV+
- ☐ ADHD
- ☐ Alcohol Abuse
- ☐ Alzheimer's Disease
- ☐ Autism
- ☐ Seasonal Allergies/Hay Fever
- ☐ Anemia
- ☐ Arthritis
- ☐ Rheumatoid
- ☐ Osteoarthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Cancer
- ☐ CPAP user
- ☐ Crohn's Disease
- ☐ Chemotherapy
- ☐ Drug Dependency
- ☐ Diabetes
- ☐ Dementia
- ☐ Dizziness
- ☐ Epilepsy/Convulsive or Seizure Disorder
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths/Tumors
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Heart Surgery
- ☐ Hepatitis_____
- ☐ High Blood Pressure
- ☐ Hormonal Replacement
- ☐ Hip/Joint Replacement
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Undergoing Dialysis
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Lupus
- ☐ Mental Disorders
- ☐ Osteoporosis
- ☐ Nervous Disorders
- ☐ Oral Contraceptives
- ☐ Organ Transplant
- ☐ Pacemaker
- ☐ Pregnant
  - ☐ Due date: _____
- ☐ Trying to Get Pregnant
- ☐ Breast Feeding
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ Sickle Cell/Sickle Cell Trait
- ☐ Shortness of Breath
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tobacco in any Form
  - ☐ Smoke
  - ☐ Chew/Snuff
  - ☐ Vape
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Aspirin Allergy
- ☐ Dental Anesthetic Allergy
- ☐ Codeine Allergy
- ☐ Tylenol Allergy
- ☐ Penicillin Allergy
- ☐ Latex Allergy
- ☐ Metal Allergy

Please list any other CURRENT HEALTH PROBLEMS that you have that are not listed above? _____
_____
_____
_____

Medical History – Part 2

Patient Name: _____ DOB: _____ Date: _____

- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No

If yes, please explain: _____

Are you currently taking any of the following medications?

- ☐ Antibiotics
- ☐ Thyroid Medications
- ☐ High Blood Pressure Medications
- ☐ Steroids
- ☐ Bisphosphonates/Osteoporosis Medications
- ☐ Stomach Medication (Antacids)
- ☐ Pain Relievers
- ☐ Vitamins/Herbal Drugs
- ☐ Blood Thinners
- ☐ Antihistamines/Decongestants
- ☐ Heart Medication
- ☐ Anti-Depressants
- ☐ Cholesterol Medication
- ☐ Diet Pills
- ☐ Recreational Drugs including Marijuana

Please List All Medications That You Are Currently Taking in the Space Below:

Please List Below All Allergies That You Have (Medication, Food, Materials, etc.).

What Pharmacy Do You Most Commonly Use?

Name of Pharmacy (i.e.- CVS on North Westover Blvd): _____

If available, Pharmacy Phone #: _____

➢ ***I hereby certify that I have read and understood the patient registration/medical/dental questionnaire and that it is accurate and true to the best of my knowledge. If I ever have any change in my registration information or my health, I will inform the doctors at the next appointment without fail. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.***

_____ ***Date:*** _____

Signature of patient/ Signature of parent or guardian

Consent for Services

I hereby certify that I have read and understand the registration/medical/dental questionnaire and that it is accurate and true to the best of my knowledge. To the best of my knowledge, all the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health. I understand that dental treatment and local anesthesia entail risks such as bleeding, infection, nerve damage, or fracture of teeth or bone.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate. I authorize Mann Dental Care to utilize my photos, models, and radiographs to better understand my current dental condition and to help others understand their treatment options when deemed necessary.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners.

I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided whether or not they are covered by insurance, as well as any additional collection costs if this office determines they are necessary. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any). I authorize this office to charge my credit card or bank account for any unpaid balances, including those after insurance payment. I understand that in certain circumstances, my credit report may be requested.

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 0.75% per month (9% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that any fee estimate for this dental care can only be extended for a period of thirty (30) days from the date of the patient examination.
In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to contact me to discuss this statement or my treatment.

I grant my permission to the dental practice to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured web site for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the dental practice web site with my ID and password. I also agree to immediately notify the dental practice of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns.

I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

NOTICE OF PRIVACY PRACTICES: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this consent. We encourage you to read it carefully and completely before signing this Consent.

RIGHT TO REVOKE: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed on the following page. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:
CONTACT PERSON: Brian Mann, D.D.S.
TELEPHONE: 229-435-6627
FAX: 229-435-6628
E-MAIL: MannDentalCare@yahoo.com
ADDRESS: 1403 S. Slappey Blvd.
Albany, GA 31701

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent, or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party

Edited 01/13/2017

Financial Policy

Thank you for choosing our office for your dental needs. We realize that every person's financial situation is different. For this reason, we have worked hard to provide a variety of payment options to help you receive the dental care you need and deserve that allows you to enjoy a healthy, beautiful smile with respect to your budget. Dental treatment is an excellent investment in an individual's medical and psychological care. We are always available to answer your questions or assist you in any way we can.

Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of your or any insurance company's determination of what is usual and customary.

Payment Methods

FULL PAYMENT IS DUE AT TIME OF SERVICE. WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, DISCOVER AND AMERICAN EXPRESS CREDIT CARDS, AND DEBIT CARDS. WE ALSO OFFER VARIOUS **3rd PARTY FINANCING OPTIONS** WHICH ARE EXTENDED PAYMENT PLANS.

Optional Payment Terms:

1. **Full Pay Cash Discount**: We offer a 5% accounting courtesy for all treatment that is paid in full (cash or check) at the time of service. We will still file your insurance and the re-imbursement payment will go directly to you, the patient. *
2. **Major Service - Two Payment Option**: We offer a two-payment option for particular Implant, Crown, Bridge, and Denture treatments. We ask that you pay one-half of your payment/co-payment at the first appointment and the second half at the delivery date appointment.
3. **Term Loan**: We pay several 3rd Party Financing Companies to offer our patients, upon approval, an interest-free term loan (up to 12 months) with little to no down payment or annual fee, and no prepayment penalty. Please ask for an application.

**Some restrictions may apply.*

Patient Minors

Minors accompanied by the parent or legal guardian: The parent or legal guardian accompanying a minor, who has consented to treatment, is responsible for full payment at time of service.

Unaccompanied Minors: The parent or legal guardian is responsible for full payment at time of service. Treatment consents and payment arrangements with the parent or legal guardian must be made prior to appointment or treatment may be denied.

Do You Have Dental Insurance?

If you do, whether you have purchased it or your employer has provided it for you, you are fortunate. Though your dental insurance is your responsibility we can help! We will go the extra mile to help you maximize your benefits. As a courtesy, we will help by filing your insurance forms, which will save you considerable time and trouble. We accept payments from most insurance companies, which reduces your immediate out-of-pocket expense.

Regardless of what we may calculate your insurance company to pay, it is only ***an estimate***. Our estimate is based on limited information obtained from your insurance company. ***You must understand, we cannot forecast what they will pay.***

We must stress that you are responsible for the total treatment fee. Your dental insurance is not designed to pay the entire cost of your treatment, but it is intended to help cover a certain portion of the cost. A better term for dental insurance may be "dental assistance".

Please remember, however, the financial obligation for dental treatment is between you and this office, and is not between this office and your insurance company.

Dental insurance companies normally do not require a "predetermination" or "prior authorization". If the insurance company does we will be happy to submit a treatment plan to them.

It often takes us a considerable amount of time to try to collect your insurance payment for you. We often need your help to discuss your situation directly with your insurance.

Missed Appointment (s) and Cancellations:

Our goal is to provide treatment in a timely manner with as few visits as necessary. In order to provide the best services to our patients, we require at least a 24-hour notice for cancellations or for re-scheduling your appointments. We understand that unforeseen circumstances may arise, which may result in canceling or missing your appointment. A charge may be assessed for multiple missed, short notice or cancelled appointments. Multiple failed appointments may result in being dismissed from the dental practice.

Billing

Balances which are 60 days old or older will incur a monthly 0.75% finance charge with equals an 9% per annum rate unless previously written financial arrangements are satisfied. There is also a $30 returned check fee.

Refunds

Refunds for overpayment will be sent after all treatment is completed and insurance has been collected.

Collections

Any account that has not received payment in 60 days will be handed over to a collection agency that will pursue the responsible party for reimbursement. This will negatively impact your credit history and limit the treatment you can receive at our office. Court, attorney, and/or additional fees may also be added to the outstanding balance.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns. We look forward to providing the highest quality dental care in a relaxing and caring atmosphere.

I have thoroughly read the Financial Policy. I understand and agree to this Financial Policy.

_____ Date: _____ Relationship to Patient: _____

Signature of patient, parent or guardian