Marsh Cove
DENTAL & IMPLANT CENTER

# PATIENT INFORMATION

Name_____ Birth Date _____ Martial Status _____

Address _____ City _____ State _____ Zip_____

Home Phone _____ Cell Phone _____

Email Address _____ Soc. Sec. #. _____

Employer: _____ Business #: _____

Name of Spouse _____ Phone #_____

Name of Dentist _____PH: _____ Last Visit _____

Name of Physician _____PH: _____ Last Visit _____

*WHOM MAY WE THANK FOR REFERRING YOU TO THIS OFFICE* _____

Reason for Today's Visit: _____

Dental Ins: _____ Subscriber: _____ Subscriber #: _____

**PHARMACY NAME & LOCATION**:_____

## MEDICAL HISTORY

Are you currently being treated by a physician? _____ ☐YES ☐NO

Do you have to pre-medicate? If yes, which medication & why? _____ ☐YES ☐NO

Are you currently taking any medications? (**Including aspirin** and/or vitamins) _____ ☐YES ☐NO

Have you had surgery in the past 5 years? What kind? _____ ☐YES ☐NO

**Do you take medications for Osteoporosis? (Prolia, Fosamax, Boniva) If so, we will provide you with more information** ☐YES ☐NO

**Women**: Are you pregnant? ☐ YES ☐ NO ☐ UNSURE Do you take birth control medication? ☐YES ☐NO

### ARE YOU ALLERGIC TO ANY OF THE FOLLOWING MEDICATIONS OR HAVE ANY MEDICAL CONDITIONS?

☐ **CODEINE ALLERGY** ☐ **LOCAL ANESTHETICS ALLERGY** ☐ **ASPIRIN ALLERGY** ☐ **PENICILLIN ALLERGY**

☐ **LATEX ALLERGY** ☐ **OTHER: _____**

***Please check ALL that apply***

- ☐ **ACID REFLUX/ ☐ GERD**
- ☐ **AIDS/ ☐ HIV POSITIVE**
- ☐ **ALZHEIMER/ ☐ DEMENTIA**
- ☐ **ANAPHYLAXIS TO: _____**
- ☐ **ANEMIA**
- ☐ **ANGINA/ ☐ CHEST PAINS**
- ☐ **ARTHRITIS/ ☐ GOUT**
- ☐ **ARTIFICAL HEART VALVE**
- ☐ **ARTIFICIAL JOINTS: _____**
- ☐ **ASTHMA**
- ☐ **AUTOIMMUNE DISEASE: _____**
- ☐ **BLOOD DISEASE/ ☐ HEMOPHILIA**
- ☐ **BLOOD THINNERS**
- ☐ **BRUISE EASILY**
- ☐ **BYPASS SURGERY/ ☐ STENTS**
- ☐ **CANCER (DATE/TYPE): _____**
- ☐ **CHEMOTHERAPY/☐ RADIATION**
- ☐ **COLD SORES/ ☐ FEVER BLISTERS**
- ☐ **CORTISONE TREATMENTS**
- ☐ **CROHNS' DISEASE**
- ☐ **DEPRESSION**
- ☐ **DIABETES/ ☐ DIALYSIS**
- ☐ **DRUG ADDICTION**
- ☐ **EASILY WINDED**
- ☐ **EMPHYSEMA**
- ☐ **EPILEPSY OR SEIZURES**
- ☐ **EXCESSIVE BLEEDING**
- ☐ **EXCESSIVE THIRST**
- ☐ **FAINTING SPELLS**
- ☐ **FREQUENT COUGH**
- ☐ **GLAUCOMA/ ☐ CATARACTS**
- ☐ **HAY FEVER**
- ☐ **HEADACHES/ ☐ MIGRAINES**
- ☐ **HEART ATTACK/FAILURE**
- ☐ **HEART MURMUR/ ☐ MVP**
- ☐ **HEART TROUBLE/DISEASE**
- ☐ **HEPATITIS A/B/C (PLEASE CIRCLE)**
- ☐ **HIGH BLOOD PRESSURE**
- ☐ **HIGH CHOLESTEROL**
- ☐ **HIVES OR RASH TO: _____**
- ☐ **HYPOGLYCEMIA**
- ☐ **JAUNDICE**
- ☐ **KIDNEY PROBLEMS**
- ☐ **LEUKEMIA**
- ☐ **LIVER DISEASE**
- ☐ **LOW BLOOD PRESSURE**
- ☐ **MEDICAL MARIJUANA**
- ☐ **ORGAN TRANSPLANT: _____**
- ☐ **OSTEOPOROSIS/ ☐ PROLIA SHOTS**
- ☐ **PARATHYROID DISEASE**
- ☐ **PARKINSON'S**
- ☐ **PRE-MED FOR: _____**
- ☐ **RHEUMATIC FEVER**
- ☐ **SCARLET FEVER**
- ☐ **SHINGLES**
- ☐ **SMOKER**
- ☐ **STOMACH/ ☐ INTESTINAL ISSUES**
- ☐ **STROKE/ ☐ TIA**
- ☐ **THYROID DISEASE**
- ☐ **TUMORS**
- ☐ **ULCERS**
- ☐ **VERTIGO**
- ☐ **OTHER: _____**

# DENTAL HISTORY

When was your last dental visit? _____

What was completed during your last dental visit? _____

Last dental x-rays? _____ How often do you have dental examinations? _____

How often do you brush your teeth? _____ How often do you floss? _____

What other dental aids do you use? (Electric Toothbrush, Water Flosser etc.) _____

Do you have any dental problems that you are aware of now? If yes, please describe. _____

_____

Do you feel nervous about dental treatment? If yes, what is your biggest concern? _____

_____

**ARE ANY OF YOUR TEETH SENSITIVE TO?**

Hot or cold?..... ☐YES ☐NO
Sweets?..... ☐YES ☐NO
Biting or chewing?..... ☐YES ☐NO
Have you noticed any mouth odors or bad taste?..... ☐YES ☐NO
Do you frequently get cold sores?..... ☐YES ☐NO
Do you frequently get oral ulcers?..... ☐YES ☐NO
Do your gums bleed or hurt?..... ☐YES ☐NO
Have you noticed any loose teeth?..... ☐YES ☐NO
Have your teeth shifted over the years?..... ☐YES ☐NO
Does food tend to become caught in between your teeth?..... ☐YES ☐NO

**DO YOU:**

Clench or grind your teeth while awake or asleep? Have tired jaws, especially in the morning?..... ☐YES ☐NO
Have a hard time opening wide?..... ☐YES ☐NO
Mouth breather while awake or asleep?..... ☐YES ☐NO
Hold foreign objects with your teeth (i.e. pencils, nails)? Chew ice often?..... ☐YES ☐NO

**HAVE YOU EXPERIENCED ANY OF THE FOLLOWING?**

Clicking or popping of the jaw?..... ☐YES ☐NO
Pain in the jaw joint area near the ear?..... ☐YES ☐NO
Difficulty in opening or closing your mouth?..... ☐YES ☐NO
Headaches, neck aches, or shoulder aches frequently?..... ☐YES ☐NO
Sore muscles in the neck or shoulders?..... ☐YES ☐NO

**I authorize Dr. Evgeny Titov, Dr. Volha Titov and Staff to take x-rays, study models, photographs and/or any other diagnostics aids deemed appropriate by the doctor to make a thorough diagnosis of my dental needs. I also authorize the doctor to perform any and all forms of treatments, medications and therapy that may be indicated. I also understand that my dental insurance is a contract between me and the insurance carrier, and not between the insurance carrier and the doctor. I also am fully responsible for all dental fees. These fees are due and payable at the time service is rendered unless prior financial arrangements have been made. I also assign all insurance benefits to the doctor, any payments received by the doctor from my insurance coverage will be credited to my account. I understand that my estimate treatment can be changed during the course of the treatment depending on clinical needs.**

_____ _____
Patient's Signature or Guardian Date

_____ _____
Dentist Signature Date

# Financial Policy

*Thank you for choosing our team of dental professionals to service your dental needs. We are committed to providing you with the highest quality care. We appreciate the confidence you have placed in us and will do everything possible to continue to warrant your confidence as we serve you. To continue providing outstanding care to all of our patients, we ask that you please understand and agree to the following office financial policy.*

**Insurance:**

We are out-of-network for all dental insurance plans.

- Your insurance policy is a contract between you and your insurance company.
- On your behalf, we will submit claims to your insurance company. We will include any necessary narratives, x-rays and/or periodontal chartings.
- Your insurance company will reimburse you directly. As an out-of-network provider, we will not receive any correspondence from your insurance company once the claim has been submitted.
- Filing insurance claims is a courtesy that we will gladly perform for you. However, you are responsible for any follow-up actions required by your insurance company. When requested, we will supply you with a copy of the claim with supportive information that we submitted for you to contact your insurance company directly.

**Payment Policy:**

As a condition of your treatment by this office, financial arrangements must be made in advance. We depend upon payment from our patients for the costs incurred in their care and the financial responsibility on the part of each patient must be determined before the treatment. We will discuss financial options with you before rendering treatment.
By signing below, you are agreeing to all the terms contained in this financial policy, including the following:

- Payment is due in full at time of service unless prior written financial arrangements have been made.
- We reserve the right to charge a missed appointment fee for no-shows or cancellations with less than 24 hours' notice. Cancellation fee can range from $25-$150.
- We offer a courtesy adjustment to patients who pay for their treatment in full prior to their initial treatment.
- I understand and agree that any account balance not paid within 90 days will be subject to collection activity. I understand that Marsh Cove Dental may retain the services of an attorney to assist with the collection of outstanding balances.
- I understand and agree that I will owe an attorney's fee of an additional 33 ½% of the amount I owe to Marsh Cove Dental 1 ½ % per month (18% per annum) on the unpaid balance owed, plus court costs on any account not paid within 90 days of the last date of service.
- I understand and agree that, ultimately, I am responsible for payment on my account. As guarantor, I am responsible for any outstanding balances for other family members listed on the same account.

**Payment Options:**

Marsh Cove Dental has the following payment methods to choose from:

- Cash, Check or Money Order
- Visa, Mastercard, Discover and American Express

By signing below, I understand and agree with the financial policies of Marsh Cove Dental.

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_____ _____

Signature (patient or guardian) Date

## PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH IMFORMATION (PHI)
## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this consent by requesting a copy from the receptionist. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

I acknowledge that I have been provided with MARSH COVE DENTAL, "Notice of Privacy Practice", and I am giving my consent for the use and disclosure of Protect Health Information as required and/or permitted by law.

Name of Patient:_____

Signature of Patient or Legal Guardian _____ Date _____
(Patients 18 and over must complete this form)

## EMAIL/TEXT MESSAGE TO MOBILE CONSENT FORM

Purpose: This form is used to obtain your consent to communicate with you by email/mobile text messaging regarding your Protected Health Information. Marsh Cove Dental offers patients the opportunity to communicate by email/mobile text messaging. Transmitting patient information by email/mobile text messaging has a number of risks that patients should consider before granting consent to use email/mobile text messaging for these purposes. Marsh Cove Dental will use reasonable means to protect the security and confidentiality of email/mobile text messaging information sent and received. However, Marsh Cove Dental cannot guarantee the security and confidentiality of email/mobile text messaging communication and will not be liable for inadvertent disclosure of confidential information.

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with communication of email/mobile text messaging between Marsh Cove Dental and myself, and consent to the conditions outlined herein. Any questions I may have, been answered by Marsh Cove Dental.

My consented Email Address is: _____
My consented Phone Number for Mobile Texting: _____

Signature of Patient or Legal Guardian _____ Date _____
(Patients 18 and over must complete this form)

## PATIENT CONSENT TO USE OF SURVEILLANCE CAMERAS

Marsh Cove Dental uses surveillance videos cameras in its common areas, including but not limited to the exterior of the building, waiting room, reception areas, hallways, operatories and x-ray areas. Surveillance Equipment will never be used in private spaces, such as restrooms. All cameras are positioned in appropriate places within and around the premises. The cameras run continuously, 24 hours per day, seven days per week. The DVR device that records the video is only accessible by the owners of Marsh Cove Dental. There may arise situations wherein the recorded material is necessarily used in the reporting and investigation of theft, assault and other reportable incidents. During these investigations, your privacy as a patient may be compromised. If the recorded material is ever used in the reporting and investigation of reportable incidents, documentation will be made of the persons who view the recorded segments and their credentials. Also, all patients visible in the reviewed segments of recorded material will be notified that they were present in the viewed segments and given the names of all persons who viewed the segments. Marsh Cove Dental will continuously monitor the surveillance policies and procedures to reduce the risk of breeches of privacy.

I, a patient of Marsh Cove Dental, understand that in order to promote the safety of employees and patients, as well as the security of its facilities, Marsh Cove Dental will conduct camera surveillance. I hereby give my consent to such surveillance monitoring at all times. I, hereby release Marsh Cove Dental from all liability, including liability for negligence, associated with the enforcement of these policies and/or searches or surveillance undertaken pursuant to these polices.

Signature of Patient or Legal Guardian _____ Date _____
(Patients 18 and over must complete this form)