Dental History

1. Your current dental health is: _____good _____fair _____poor?
2. Have you ever had a serious/difficult problem with any previous dental work? Yes No
3. Have you ever had an injury to your face, jaw, or teeth? Yes No
4. Have you ever had radiation treatment to your face or jaw? Yes No
5. Does or has your jaw clicked or popped when chewing? Yes No
6. Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? Yes No
7. Do you have any sensitive or loose teeth? Yes No
8. Please check if you have received any of the following:
   _____ gum/periodontal treatment
   _____ orthodontic treatment
   _____ root canal/endodontic treatment
   _____ wisdom teeth removal
   _____ removal of other teeth
9. Are you wearing dentures or partial dentures? Yes No
10. Have you had teeth replaced with a fixed (cemented) bridge? Yes No
11. Do you like your smile? Yes No
12. Do your gums ever bleed? Yes No
13. Have you ever had an adverse reaction to nitrous-oxide (gas)? Yes No
14. Do you prefer to use nitrous-oxide (gas)? Hygiene or Treatment
15. Name of previous Dentist_____
    Address_____
    Phone number_____
16. Date of last dental visit_____
17. How did you hear about us?_____

Financial Statement

Payment is expected at time of service

If you are unable to keep your schedule appointment, we require a 48 hours cancellation notice to avoid a $50.00 fee. A fee of $50.00 will also be charged for any missed appointments.

We accept **cash, personal checks from local banks, money orders, Visa, MasterCard, Discover, American Express and Care Credit**. Charges not paid within 60 days will have a service charge of 1.5% per month (Annual 18%) added to the past due balance on each monthly statement thereafter.

I agree to be responsible for any charges not paid by my dental insurance company. I hereby authorize payment directly to the dentist from my dental insurance company.

_____ _____

Signed (patient or parent of minor) Date

Eaglesoft Medical History

Patient Name: Birth Date: Date Created:

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, c

Are you under a physician's care now?	○ Yes ○ No	If yes
Have you ever been hospitalized or had a major operation?	○ Yes ○ No	If yes
Have you ever had a serious head or neck injury?	○ Yes ○ No	If yes
Are you taking any medications, pills, or drugs?	○ Yes ○ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	○ Yes ○ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	○ Yes ○ No	If yes
Are you on a special diet?	○ Yes ○ No	
Do you use tobacco?	○ Yes ○ No	
Do you use controlled substances?	○ Yes ○ No	If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics

Other? ☐ If yes

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

AIDS/HIV Positive	○ Yes ○ No	Cortisone Medicine	○ Yes ○ No	Hemophilia	○ Yes ○ No	Radiation Treatments	○ Yes ○ No
Alzheimer's Disease	○ Yes ○ No	Diabetes	○ Yes ○ No	Hepatitis A	○ Yes ○ No	Recent Weight Loss	○ Yes ○ No
Anaphylaxis	○ Yes ○ No	Drug Addiction	○ Yes ○ No	Hepatitis B or C	○ Yes ○ No	Renal Dialysis	○ Yes ○ No
Anemia	○ Yes ○ No	Easily Winded	○ Yes ○ No	Herpes	○ Yes ○ No	Rheumatic Fever	○ Yes ○ No
Angina	○ Yes ○ No	Emphysema	○ Yes ○ No	High Blood Pressure	○ Yes ○ No	Rheumatism	○ Yes ○ No
Arthritis/Gout	○ Yes ○ No	Epilepsy or Seizures	○ Yes ○ No	High Cholesterol	○ Yes ○ No	Scarlet Fever	○ Yes ○ No
Artificial Heart Valve	○ Yes ○ No	Excessive Bleeding	○ Yes ○ No	Hives or Rash	○ Yes ○ No	Shingles	○ Yes ○ No
Artificial Joint	○ Yes ○ No	Excessive Thirst	○ Yes ○ No	Hypoglycemia	○ Yes ○ No	Sickle Cell Disease	○ Yes ○ No
Asthma	○ Yes ○ No	Fainting Spells/Dizziness	○ Yes ○ No	Irregular Heartbeat	○ Yes ○ No	Sinus Trouble	○ Yes ○ No
Blood Disease	○ Yes ○ No	Frequent Cough	○ Yes ○ No	Kidney Problems	○ Yes ○ No	Spina Bifida	○ Yes ○ No
Blood Transfusion	○ Yes ○ No	Frequent Diarrhea	○ Yes ○ No	Leukemia	○ Yes ○ No	Stomach/Intestinal Disease	○ Yes ○ No
Breathing Problems	○ Yes ○ No	Frequent Headaches	○ Yes ○ No	Liver Disease	○ Yes ○ No	Stroke	○ Yes ○ No
Bruise Easily	○ Yes ○ No	Genital Herpes	○ Yes ○ No	Low Blood Pressure	○ Yes ○ No	Swelling of Limbs	○ Yes ○ No
Cancer	○ Yes ○ No	Glaucoma	○ Yes ○ No	Lung Disease	○ Yes ○ No	Thyroid Disease	○ Yes ○ No
Chemotherapy	○ Yes ○ No	Hay Fever	○ Yes ○ No	Mitral Valve Prolapse	○ Yes ○ No	Tonsillitis	○ Yes ○ No
Chest Pains	○ Yes ○ No	Heart Attack/Failure	○ Yes ○ No	Osteoporosis	○ Yes ○ No	Tuberculosis	○ Yes ○ No
Cold Sores/Fever Blisters	○ Yes ○ No	Heart Murmur	○ Yes ○ No	Pain in Jaw Joints	○ Yes ○ No	Tumors or Growths	○ Yes ○ No
Congenital Heart Disorder	○ Yes ○ No	Heart Pacemaker	○ Yes ○ No	Parathyroid Disease	○ Yes ○ No	Ulcers	○ Yes ○ No
Convulsions	○ Yes ○ No	Heart Trouble/Disease	○ Yes ○ No	Psychiatric Care	○ Yes ○ No	Venereal Disease	○ Yes ○ No
						Yellow Jaundice	○ Yes ○ No

Have you ever had any serious illness not listed above? ○ Yes ○ No If yes

Comments:

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:

X

Date:_____

mandras dental

Dental History

- How is your current dental health? GOOD FAIR POOR
- Have you ever had a negative or traumatic dental experience? Yes No
- Have you ever had any trauma to your face, jaw, or teeth? Yes No
- Have you ever had radiation treatment to your face or jaw? Yes No
- Has your jaw popped when chewing? Yes No
- Have you experienced pain or discomfort in your joint (TMJ/TMD)? Yes No
- Do you have any sensitive teeth? Yes No
- Do you have any loose teeth? Yes No
- Are you satisfied with the appearance of your smile? Yes No

Name of previous dentist_____

Date of last dental visit_____

How did you hear about us?_____

mandras dental

At Mandras Dental, we reserve appointment times specifically for you and strive to provide timely, high-quality care for every patient. To serve all patients efficiently, we maintain the following cancellation and missed appointment policy:

Cancellation & Missed Appointment Policy
24-Hour Notice Required

Same-Day Cancellations & No-Shows

- We require at least 24 hours' notice to cancel or reschedule an appointment. Any same-day cancellation or failure to arrive for a scheduled appointment will be recorded as a missed appointment.

Missed Appointment Fee

- A $50 fee will be charged for each missed appointment or same-day cancellation. This fee is not billable to insurance. The fee must be paid before scheduling future appointments.

Multiple Missed Appointments

- Repeated missed appointments may result in: Limited scheduling options, or dismissal from the practice, at the discretion of Mandras Dental.

Emergencies

- We understand that emergencies can arise. Exceptions may be considered at the practice's discretion.

Acknowledgment

I have read, understand, and agree to abide by **Mandras Dental's Cancellation & Missed Appointment Policy**. I acknowledge that I am responsible for any fees associated with missed or same-day canceled appointments.

Patient/Guardian Signature: _____

Printed Name: _____

Relation (if not patient): _____

Date: _____

Payment Policy Agreement

mandras dental

Patient Name: _____
Todays Date:_____

At Mandras Dental, we are committed to providing high-quality dental care and clear communication regarding financial responsibilities. Please review and sign the payment policy below.

- **Payment Due at Time of Service**

  Payment for all services--whether preventive, restorative, cosmetic, or emergency--is due in full at the time treatment is provided unless prior arrangements have been made with our office.

- **Accepted Forms of Payment**
  - All major credit cards
  - CareCredit
  - HSA and FSA cards
  - Cash or debit cards
- **Insurance Information**
  - As a courtesy, we will help submit dental insurance claims on your behalf.
  - Any portion not covered by insurance, including deductibles, copays, or non-covered services, is the patient's responsibility at the time of service.
  - Final insurance payment amounts are determined by your insurer. Any remaining balance after insurance processes a claim is your responsibility.
- **Billing & Balances**

  Any balance not paid at the time of service or after insurance claim completion is due upon receipt. Past-due accounts may be subject to late fees and may affect future scheduling.

Acknowledgment

I have read, understand, and agree to Mandras Dental's Payment Policy. I acknowledge that I am responsible for all charges incurred for my treatment and that payment is due at the time services are rendered.

Patient/Guardian Signature: _____
Printed Name: _____
Relation (if not patient): _____
Date of Birth: _____

mandras dental

2265 Livernois Suite 406 Troy, Mi 48083

Acknowledgement of Receipt of Notice of Privacy Practices

You may refust to sign this acknowledgement

I, _____, have received a copy of this offices Notice of Priacy Practices.

_____

Please Print Name

_____

Signature

_____

Date

For office Use ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices BUT acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other: please specify

mandras dental

Dr. Jonathan Mandras
2265 Livernois, Suite 406, Troy, Mi 48083
248.362.5055

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INORMATION. PLEASE REVIEW IT CAREFULLY.

We respect our legal obligations to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting ups an appointment for you. Examining your teeth, prescribing medications and faxing/emailing them to be filled, referring you to another doctor or clinic for other health care or services, or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are; asking you about your health or dental care plans, or other sources of payment, preparing and sending bills or claims, and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits, internal quality assurance, personnel decisions, participation in managed care plans, defense of legal matters, business planning, and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us, some may never come up at our office at all. Such uses or disclosures are:

- When a state or federal law mandates that certain health information be reported for a specific purpose
- For a public health purposes, such as contagious disease reporting, investigation or surveillance, and notices to and from the federal Food and Drug Administration regarding drugs or medical devises
- Disclosures to government authorities about victims of suspected abuse, neglect or domestic violence
- Uses and disclosures for health oversight activities, such as for the licensing of doctors, for audits by Medicare or Medicaid, or for investigation of possible violations of health care laws
- Disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies
- Disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime, to provide information about a crime at our office, or to report a crime that happened somewhere else
- Disclosure to a medical examiner to identify a dead person or to determine the cause of death, or to funeral directors to aid in burial, or to organizations that handle organ or tissue donations
- Uses or disclosures for health-related research
- Uses and disclosures to prevent a serious threat to health or safety
- Uses or disclosures for specialized government functions, such as for the protection of the President or high-ranking government officials, for lawful national intelligence activities, for military purposes, or for the evaluation and health of members of the foreign service
- Disclosures of de-identified information
- Disclosures relating to workers compensation programs
- Disclosures of a "limited data set" for research, public health, or health care operations
- Incidental disclosures that are an unavoidable by-product of permitted uses or disclosures
- Disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your dental care.

PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name:

Responsible Party (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Soc Sec: Drivers Lic:

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: Address 2:

City: State / Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Gender: ☐ Male ☐ Female ☐ Unknown Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: Age: Soc Sec: Drivers Lic:

E-mail: ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg:

Section 3

Cell Phone

Other Phone Numbers

Primary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Secondary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct: