Mary Beth Mihalakis PC

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2933 Linden Street • Bethlehem, PA 18017-3298 (610)865-6999

Welcome to our Practice

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____ (Last) _____ (First) ___ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ **SS#:** ___-__-____ **Prev. Visit:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ (Home) _____ (Mobile) _____ (Work) _____ (Ext) _____ (Fax) _____ (Other)

Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) ____-____ (Zip Code)

Employment Information

The following is for: ◯ the patient ◯ the person responsible for payment ◯ both ◯ not applicable

Employer Name: _____ **Phone:** _____

Employer Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) ____-____ (Zip Code)

Whom may we thank for referring you to our practice?

_____

In an emergency who should be notified? Please enter Name and Phone number below:

_____

_____

Responsible Party Information:

This only needs to be filled out if the insurance subscriber is other than patient, or you are the parent/guardian of the patient

The following is for: ◯ the patient's spouse ◯ the person responsible for payment ◯ both ◯ neither-not applicable

Name: _____ (Last) _____ (First) ___ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ **SS#:** ___-__-____ **DL#:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ (Home) _____ (Mobile) _____ (Work) _____ (Ext) _____ (Fax) _____ (Other)

Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) _____-____ (Zip Code)

Primary Dental Insurance:

Name of Insured: _____ (Last) _____ (First) ___ (MI)

Insured's Birth Date: _____ **ID #:** _____ **Group #:** _____

Insured's Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) _____-____ (Zip Code)

Insured's Employer Name: _____

Employer Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) _____-____ (Zip Code)

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) _____-____ (Zip Code)

Insurance Company Phone Number:

_____

_____

Insurance Authorization:

☐ **By checking this box,**
I authorize my insurance company to pay the dentist all insurance benefits rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.

Dental Information

Previous Dentist Name and Phone Number:

_____

_____

Date of most recent dental exam and dental x-rays:

_____

_____

I routinely see my dentist every:

☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

What is your immediate concern?

_____

_____

Is there anything about the appearance of your smile that you would like to change?

_____

_____

Check all that apply:

☐ Had complications from past dental treatment
☐ Had trouble getting numb
☐ Had any reactions to local anesthetic
☐ Had/have braces, orthodontic treatment
☐ Experience dry mouth
☐ Any teeth sensitive to hot, cold, biting, sweets or avoid brushing any part of your mouth
☐ Experienced popping and/or clicking of your jaw joint
☐ Get food trapped between your teeth
☐ Clench or grind your teeth
☐ Wear or have worn a bite appliance
☐ Gums bleed when brushing or flossing
☐ Treated for gum disease or were told you have lost bone around your teeth
☐ Experienced a burning sensation in your mouth
☐ Snore or wake up frequently during the night

Consent for Services and Financial Policy

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 1.5% per month (18% 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 six months 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 telephone me to discuss this statement or my treatment.

Patients Without Insurance

I understand that I am fully responsible for all dental fees and that these fees are due and payable at the time services are rendered; unless a prior financing arrangement has been made. In the event payments are not received within 60 days from the date of service, in accordance with said financial arrangements, a 1 ½% finance charge (18% APR) will be added to my account. I further understand that I am responsible for those fees incurred for delinquency and/or any other insufficiency (e.g.- those incurred by a collection agency, magistrate office, or an attorney).

☐ ***By checking this box, I understand the above information and agree with its contents.**

Cancellation Policy:

We understand that unplanned issues can come up and you may need to cancel an appointment. If that happens, we respectfully ask for scheduled appointments to be cancelled at least 24 hours in advance.

Our doctors & hygienists want to be available for your needs and the needs of all our patients. When a patient does not show up for a scheduled appointment, another patient loses an opportunity to be seen. Although we have always had a cancellation policy, circumstances have caused us to enforce a policy of charging for no-show appointments, and those appointments not cancelled within 24 hours. There will be a fee of $50.00 assessed if we do not receive a call to cancel an appointment.

Thank you for being a valued patient and for your understanding and cooperation. This policy will enable us to open otherwise unused appointments to better serve the needs of all patients.

☐ ***By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the Cancellation Policy.**

HIPAA Acknowledgement

Read before signing the Acknowledgement and Consent

This acknowledgement of notice and consent authorizes Mary Beth Mihalakis, D.M.D. to use and disclose information about you for treatment, payment and healthcare operation purposes.

Notice of Privacy Practices Mary Beth Mihalakis, D.M.D. has a Notice of Privacy Practices, which describes how we may use and disclose your protected health information and how you can access your protected health information and exercise other
rights concerning your protected health information. You may review our current notice prior to signing this acknowledgement and consent.

Amendments. We reserve the right to change our Notice of Privacy Practices and to make the terms of any change effective for all protected health/dental information that we maintain, including information created or obtained prior to the effective date of the change. You may obtain a revised notice by submitting a written request to our Privacy Officer.

How to contact our Privacy Officer
Mail: Mary Beth Mihalakis, D.M.D.
2933 Linden Street
Bethlehem, PA 18017
Attn: Privacy Officer
Telephone: (610) 865-6999
Facsimile: (610) 865-1708

☐ ***By checking this box, I understand the above information and agree with its contents.**

Communication Consent

It is the office policy of Mary Beth Mihalakis, D.M.D. and staff
not to release confidential and/or unauthorized information, without consent, on home telephone, answering machine, work telephone, voice mail, cell phone and/or pager. Whenever returning telephone calls and the answering machine pick up, we do not leave a message if the name or telephone number is not on the recorded message to identify the residence. Also, information will not be left with an unauthorized person who may answer the telephone.

I authorize Mary Beth Mihalakis. D.M.D. and/or their staff to leave medical information pertaining to my care by the following methods and will assume responsibility to notify them whenever this information changes:

Check all that apply:

☐ Home Telephone ☐ Work Telephone ☐ Voice Mail, Home, Cell ☐ Email ☐ Text

If you would like to have information released to someone other than yourself please complete the following: Please list the names of authorized persons:

_____

_____

☐ ***By checking this box, I understand the above information and agree with its contents.**

Consent for Treatment:

I, the undersigned, certify that the information on these pages is correct and accurate. I hereby authorize any treatment necessary, related to the dental care of the patient whose name appears on this history form and grant authority to administer anesthetics, analgesics and to perform such procedures, deemed necessary or advisable in the diagnosis and treatment of this patient. I understand that there are possible adverse effects of the procedure, anesthetics and / or drugs to be employed.

☐ ***By checking this box, I understand the above information and agree with its contents.**

Medical History

Name, phone number and relationship of emergency contact:

_____

_____

Name of your physician(s) and phone number (please include your PCP, cardiologist and orthopedic specialist if you have them).

_____

_____

_____

Please provide the name and phone number of your preferred pharmacy.:

_____

_____

Indicate which of the following conditions you have or have had. By checking the box it will indicate a "YES" response, leaving blank will indicate a "NO" response.

- ☐ Acid Reflux
- ☐ Allergy - Amoxicilli
- ☐ Allergy - Codeine
- ☐ Allergy - Latex
- ☐ Allergy - NSAIDS
- ☐ Allergy - Sulfa Drug
- ☐ Alzheimers/Dementia
- ☐ Artificial Joints
- ☐ Blood Disorders
- ☐ Depression
- ☐ Emphysema
- ☐ Glaucoma
- ☐ Heart Attack
- ☐ Hepatitis
- ☐ Kidney Problems
- ☐ Mitral Valve Prolaps
- ☐ Other Health Issues
- ☐ Respiratory Problems
- ☐ Smoker
- ☐ Stroke
- ☐ Tumor/Growths
- ☐ ADHD/ADD
- ☐ Allergy - Asprin
- ☐ Allergy - Erythromyc
- ☐ Allergy - Meds
- ☐ Allergy - Nuts
- ☐ Allergy - Tylenol
- ☐ Anemia
- ☐ Asthma
- ☐ Cancer
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Heart - A-Fib
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Liver Problems
- ☐ Nerve disorder
- ☐ Pacemaker
- ☐ Rheumatic Fever
- ☐ STD
- ☐ Thyroid Disorder
- ☐ Alcohol Abuse
- ☐ Allergy - Augmentin
- ☐ Allergy - Flagyl
- ☐ Allergy - Metals
- ☐ Allergy - Other
- ☐ Allergy - Zithromax
- ☐ Anxiety
- ☐ Bleeding - Excessive
- ☐ Celiac Disease
- ☐ Dizziness/Fainting
- ☐ Fibromyalgia
- ☐ Heart Arrhythmia
- ☐ Heart Murmur
- ☐ High Cholesterol
- ☐ Low Blood Pressure
- ☐ NO HEALTH ISSUES
- ☐ Parkinsons
- ☐ Sinus Problems
- ☐ Stomach Ulcer
- ☐ Tobacco - Chewing
- ☐ Allergies- Seasonal
- ☐ Allergy - Cephalospo
- ☐ Allergy - Keflex
- ☐ Allergy - Novocaine
- ☐ Allergy - Penicillin
- ☐ Allergy -Clindamycin
- ☐ Arthritis
- ☐ Blood Clots
- ☐ Crohns
- ☐ Drug Abuse
- ☐ Frequent Headaches
- ☐ Heart Artif. Valve
- ☐ Heart Surgery
- ☐ HIV/AIDS
- ☐ Mental Disorders
- ☐ Osteoporosis
- ☐ Pregnancy -Currently
- ☐ Sleep Apnea
- ☐ Stomach/ GI Problems
- ☐ Tuberculosis

If you checked OTHER Please explain

_____

_____

Have you been hospitalized (illness or injury) in the last 2 years? ◯ Yes ◯ No

If yes please explain

_____

_____

Are you REQUIRED to take ANTIBIOTIC PREMEDICATION for your dental visits? * ◯ Yes ◯ No

If yes please check the reason

◯ Joint replacement (knee, hip, shoulder, etc.) ◯ Mitral valve prolapse ◯ Artificial heart valve

◯ Rheumatic fever ◯ Other

Are you currently TAKING a BLOOD THINNER? * ◯ Yes ◯ No

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment.

_____

_____

_____

Please list any medications you are currently taking.

_____

_____

_____

IF YOU HAVE OSTEOPOROSIS OR OSTEOPENIA OR CANCER:

Have you taken any medications for BONE DENSITY and ANTIANGIOGENIC (as part of a cancer therapy, It is EXTREMELY important that you inform us of:

-The name of the medications
-The dates that they were taken or injected
-The prescribing doctor of the medication

You should know that there is a risk of future severe complications that may occur with dental treatment.

Examples of Osteoporosis/Osteopenia and Antiangiogenic medications are:

Alendronate (Fosamax), Pamidronate (Aredia), Bevacizumab (Avastin)
Risedronate (Actonel), Zolendronate (Zometa), Sunitinib (Sutent)
Ibandronate (Boniva), Etidronate (Didronel), Sorafenib (Naxavar)
Zoledronic Acid (Reclast), Tiudronate (Skelid), Sirolimus (Rapamune)
Raloxifene (Evista), Denosumab (Prolia, Xgeva), Teriparatide (Forteo)

_____

_____

Are you currently taking or have you been on any Bisphosphonate Therapy? * ◯ Yes ◯ No

☐ ***By checking this box, I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health. This will serve as my electronic signature.**

_____

Response Date: _____