PATIENT REGISTRATION

IDENTIFICATION			Today's Date	
PLEASE PRINT CLEARLY AND FILL IN ALL THE SPACES BELOW				
Patient Name (Last, First, Middle Initial):		Date of Birth	Social Security #	
Mailing Address		City	State	ZIP
Email address		Home Phone	Cell Phone	Work Phone
Employer		Occupation	How Long?	Gender
				M F
Responsible Party (if other than Patient)			Phone	
Family Physician	City	State	Phone	
Emergency Contact		Relationship to Patient	Phone	
Insurance Information				
Insurance Company			Phone	
Subscriber's Name (Last, First, Middle Initial):			Social Security Number	
Mailing Address		City	State	Zip
Subscriber ID		Group number	Date of Birth	
Employer			Relationship to Patient	

What is the best way to contact you?

How would you prefer to have your next appointment confirmed?

_____Please confirm by e-mail (soon to be available).
_____Please confirm by phone.
_____Please confirm by text message to my cell phone (when available).

How would you prefer to receive our quarterly newsletter?

_____Please send it by e-mail (soon to be available).
_____Please send it by mail.
_____Please do not send it to me.

GETTING TO KNOW YOU

Name: _____

1. How did you first learn about Mid-America Dental & Hearing Center? (check one):
   - ☐ Patient, Friend, or Relative (Name) _____
   - ☐ Newspaper or Magazine Ad (Name of Publication) _____
   - ☐ Highway Sign (General Location) _____
   - ☐ Other (Please Specify) _____

2. Why did you choose to use Mid-America? (check all that apply):
   - ☐ Affordable Prices ☐ Recommended by Someone ☐ Referred by other Provider
   - ☐ Close to home ☐ Other _____

3. Do you know someone who might be interested in any of our services? ☐Yes ☐No
   If Yes, Who? _____

DENTAL PATIENTS

1. When did you last see a dentist? _____
   What was done? _____
2. When was the last time dental x-rays were taken? _____
3. When was your last cleaning? _____
4. What concerns bring you here today? _____
5. Have you ever had any teeth removed? ☐Yes ☐No
   If Yes, have the teeth been replaced by any of the following (check all that apply)?
   ☐ Bridge ☐ Partial ☐ Denture ☐ Implants ☐ Not Replaced
6. Do your gums ever bleed? ☐Yes ☐No
7. Do you have any health problems that would put you at risk for infection? ☐Yes ☐No
8. Has your physician recommended you be pre-medicated for any heart trouble or joint replacements? ☐Yes ☐No
9. Are you interested in saving your natural teeth? ☐Yes ☐No

HEARING PATIENTS

1. When was your last hearing evaluation? _____
2. When did you first notice a problem with your hearing and understanding? _____
3. Have you seen a doctor about your hearing problem? ☐Yes ☐No
4. Have you noticed any ringing or other unusual noises in your ears? ☐Yes ☐No
5. Do you now or have you ever worn hearing aids? ☐Yes ☐No
   If Yes, how long have you worn them? _____ What brand? _____
6. Have you had any trauma/injury to your head or ears? _____
   If Yes, please describe _____
7. Are you now or have you been exposed to high level of noise at work or in other activities? ☐Yes ☐No
   If Yes, please describe _____
8. Is there a history of hearing loss in your family? ☐Yes ☐No
   If Yes, please describe _____

Medical History

Name:_____

In order to treat our patients both safely and effectively, an up to date and complete medical history is necessary. Please answer the following questions as accurately as possible.

Do you have or have you ever had:

Heart by-pass?*	☐Yes ☐No	Heart murmur? *	☐Yes ☐No
Mitral valve Prolapse?*	☐Yes ☐No	Bacterial endocarditis?*	☐Yes ☐No
Asthma?	☐Yes ☐No	Rheumatic fever?*	☐Yes ☐No
Sinus problems?	☐Yes ☐No	Tuberculosis?	☐Yes ☐No
Emphysema?	☐Yes ☐No	COPD?	☐Yes ☐No
Persistent cough?	☐Yes ☐No	Jaundice?	☐Yes ☐No
Pain in your jaw?	☐Yes ☐No	Hepatitis? A B C (circle all that apply)	☐Yes ☐No
Diabetes?	☐Yes ☐No	Pregnant? (Currently)	☐Yes ☐No
Stroke?	☐Yes ☐No	Nursing? (Currently)	☐Yes ☐No
HIV or AIDS?	☐Yes ☐No	High blood pressure?	☐Yes ☐No
Glaucoma?	☐Yes ☐No	Psychiatric treatment?	☐Yes ☐No
Anemia?	☐Yes ☐No	Epilepsy?	☐Yes ☐No

Lost or gained more than 15 lbs. in the last year? ☐Yes ☐No

Are you currently taking (or have had IV) blood thinners? (e.g. Aspirin, Plavix, Coumadin) ☐Yes ☐No

Are you currently taking medications for Osteoporosis? ☐Yes ☐No
(e.g. Actonel, Fosamax,Boniva, Reclast, Aredia, Zometa)

Artificial heart valves?*	☐Yes ☐No	If so, when? _____
Vascular stints (from angioplasty)?*	☐Yes ☐No	If so, when? _____
Artificial joints? *	☐Yes ☐No	If so, when? _____
Cancer?	☐Yes ☐No	If so, type? _____

Are you currently undergoing cancer treatment? ☐Yes ☐No

If so, describe?_____

Have you been hospitalized in the last 2 years? If so, please explain and include dates ☐Yes ☐No

_____

Excessive bleeding? ☐Yes ☐No

If so, describe? _____

Please circle any allergies:

None Penicillin Codeine Sulfa drugs Lidocaine/Novocaine Morphine
Acrylic, Plaster or latex Adhesives (Tape)

Please list any other allergies:

_____

_____

List all medications & herbal supplements you take or have taken in the past year: (include aspirin)

_____

_____

Please describe any other significant medical history:

_____

_____

**Health condition that may require pre-medication*

Dental Centers

Financial Policy and Treatment Consent

Mid America Hearing Center

located at:

Mid-America Dental & Hearing Center
558 Mt. Vernon Blvd. & 1050 W. Hayward Dr.
Mt. Vernon, MO 65712

Thank you for choosing us for all your dental and hearing needs.

PLEASE READ CAREFULLY BEFORE SIGNING:

Our mission is to provide you ***Our Best For Less, In A Day***. Dental services requiring laboratory processes may need to be remade for fit and function as the doctor deems necessary. These services include, but are not limited to dentures, partials, crowns, bridges, bite splints, night guards, weighted dentures and custom posts. In regard to our removable dental products – dentures and partials – if you are not completely satisfied you may be eligible for up to a 50% refund of the fess upon return of the removable product.

General Financial Policy
Please note that full payment is due at the time of service.

Our goal is to provide you with optimal care based on your individual needs. To assist you in receiving this care, we offer several payment options. Payment options are cash, check, and major credit cards. Also, we offer a NO Interest Payment Plan (if paid within promotional period) and Extended Payment Plans through CareCredit, a division of GE Consumer Finance.

Please indicate below the form of payment you choose:

Payment in Full (*Circle all that apply)*
We accept cash, check, Discover, Visa, MasterCard, American Express, Delta Dental and over 200 other insurance carriers.

CareCredit Payment Plan
6 Months No Interest Payment Plan (if paid within promotional period) ($700 or more)*
Extended Payment Plan for 24/36/48/60 months ($1,000 or more)* (see reverse for rates)
* *Subject to credit approval. Some restrictions apply*

Credit Card on File
As a convenience to you, we will be glad to keep your credit card on file for payments or shipments. Note that Credit-Card-On-File may be required if you assign insurance benefits from some plans.

I hereby authorize the practice to retain my credit card information on file.

If any remaining balance is not paid within 60 days after the service, I hereby authorize the practice to charge the remaining balance to the credit card.

I certify that the information given by me in applying for payment is correct.

I certify that I have read the policies above, I understand them, and agree to these policies.

Treatment consent
I hereby authorize my provider (dentist – hygienist – audiologist - hearing instrument specialist) to perform any type of treatment, medication and therapy that may be indicated in connection with my dental or hearing care. I understand that prior to treatment, the provider or their staff will explain the procedure(s) involved in my treatment of the patient. I further authorize and consent that the providers choose and employ such assistance as they deem fit. I agree to pay for all services on the day on which they are rendered.

I, the undersigned patient or responsible party, have read the above policies and fully understand them.

Signature	Relationship to Patient	Date

PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this_____day of _____ 20_____

Print Patient Name: _____

Relationship to Patient: _____

Signature: _____

DENTAL CENTERS

2 Locations

Dr Hildreth & Associates
Located at:

MID-AMERICA DENTAL & HEARING CENTER-HWY.

1050 W. Hayward Dr.
Mt. Vernon, MO 65712
(417) 466-7196
(800) 354-1905

Dr. Hildreth & Associates
Located at:

MID-AMERICA DENTAL & HEARING CENTER-LOOP

558 E. Mt. Vernon Blvd.
Mt. Vernon, MO 65712
(417) 466-4554
(800) 372-4554

MID-AMERICA HEARING CENTER

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PATIENT AUTHORIZATION FORM

This authorization sets forth your right to use or disclose my protected health information as specified below for the purposes and parties as designated below.

Description of specific information authorized:

If the office staff is unable to reach me, I give them permission to disclose medical information to the parties listed below.

Description of the specific purposes for use and disclosure:

If the office staff is unable to reach me, I further give them permission to disclose medical information by leaving a message on my answering machine.

Parties requesting information and authorized to use and disclose the information:

DENTAL CENTERS and/or MID-AMERICA HEARING CENTER, INC.

Parties to whom information may be disclosed:

Name:	**Relationship:**	**Phone: ( )**
Name:	**Relationship:**	**Phone: ( )**
Name:	**Relationship:**	**Phone: ( )**

I reserve the right to:

- Revoke this authorization in writing by submitting it to the attention of your Privacy Officer;
- Inspect or copy the protected health information to be used or disclosed;
- Refuse to sign this authorization knowing that you will not condition treatment or payment on my providing this authorization (except for research related treatment).

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by HIPAA.

This authorization is effective immediately and will remain in effect until I notify you.

Print Patient Name: _____ ____

Relationship (if other than patient): _____

Signature:_____

Paula Lush, Privacy Officer
Dental Centers and/or
Mid-America Hearing Center, Inc.
1050 W. Hayward Dr.
Mt. Vernon, MO 65712

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