Marsh Cove Dental 

Patient Information Form

Name_____**Date of Birth:**_____

Address_____

Address on File with my Insurance:_____

Home Phone:_____ **Work:**_____ **Mobile:**_____

Email Address:_____ **SS #**_____

Emergency Contact:_____**(Relationship)**_____**Phone #:**_____

How did you hear about our office?_____

Pharmacy Name:_____**Phone #:**_____

Primary Insurance Company: _____

Subscriber's Name:_____**Date of Birth**_____

Employer's Name_____ **Member ID or SS #**_____

Secondary Insurance Company:_____

Subscriber's Name:_____**Date of Birth:**_____

Employer's Name_____ **Member ID or SS #**_____

Release of Information and Assignment of Benefits

I hereby assign benefits and authorize payment of dental insurance benefits to Marsh Cove Dental/John E. Tiano DDS if applicable. I hereby authorize marsh Cove Dental to administer such medical, diagnostic, and therapeutic procedures as may be necessary for proper dental care. I affirm that the information I have given is correct to the best of my knowledge. It is my responsibility to inform the office of any changes in my medical status.

Responsible Party Signature: _____Date: _____

Marsh Cove Dental Staff Signature: _____Date: _____

Marsh Cove Dental

Authorization to Release Dental Information

I hereby authorize you to use or disclose the specific information described below, only for the purposes and parties also described below.

Description of Information to be discussed:

Appointment Dates/Times

Planned Dental Treatment

Finances

Dental Concerns

Patient Name: _____ Date of Birth_____

Information may be shared with:

Name_____
Relationship_____
Address_____
Phone number_____
Email_____

This authorization may remain in effect:

_____ (specify expiration date)

No Expiration Date

I understand that:

I may inspect or copy the protected health information to be used or exposed

I may revoke this authorization in writing by contacting Marsh Cove Dental

This authorization is giving Marsh Cove Dental the right to discuss any Dental information with the people listed above.

Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected by HIPAA.

Signature: _____ Date: _____

Relationship to patient

(If signed by personal representative of patient) _____

John E.Tiano DDS,PA

MEDICAL HISTORY

PATIENT NAME _____ **Birth Date** _____

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, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Please mark your responses with an "x"

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

Women: Are you
Pregnant/Trying to get pregnant? O Yes O No **Taking oral contraceptives? O Yes O No** **Nursing? O Yes O No**

Are you allergic to any of the following?

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

☐ Other If yes, please explain _____

Do you have, or have you had any of the following? (Please circle)

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 Problem	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	Veneral Disease	Yes / No
						Yellow Jaundice	Yes / No

Have you ever had any serious illness not listed above? O Yes O No _____

Comments: _____

_____

_____

_____

To the best of my knowledge, the questions on his 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 _____ **DATE** _____

Marsh Cove Dental
Medications List

PATIENT NAME _____ **Birth Date** _____

Please list all current Medications:

Medication	MG / Dose	What Condition is the Medication Treating

Marsh Cove Dental 

Notice of Privacy Practices

This Notice describes how health information about you may be used and disclosed and how you can get access to this Information
Please Review It Carefully
The Privacy of Your Health Information Is Important To us

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. **For Example:**

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you, or to family and friends you approve.

Payment: We may use or disclose your health information to obtain payment for services we provide you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. You also have the right to request restrictions on disclose of PHI (Personal Health Information), or alternative means of communication to ensure privacy.

Marketing Health-Related Services: We will not use your health information for marketing communications without written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law or national security activities.

Abuse or Neglect: We may disclose your health information to appropriate authorities when we suspect abuse or neglect.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENTS RIGHTS

Access: You have the right to look at or get copies of your dental records with limited exceptions. If you request copies, we will charge $25.00 to locate and copy your information, and postage if you want the copies mailed to you.

Amendment: You have the right to request that we amend your health information.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us with the U.S. Department of Health and Human Services.

A Privacy/Contact Officer has been designated for this office. Please ask our front desk personnel and they will; direct you to the Privacy/Contact Officer.

PATIENT ACKNOWLEDEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT FOR NECESSARY USE OF PERSONAL HEALTH INFORMATION

Print Patient's Name Date

I, _____, have received a copy of this office's NOTICE OF PRIVACY PRACTICES as required by Federal Law.

I,_____, consent to use and disclosure of my personal health information by using your office during treatment, billing/payment and dental Office Operations as outlined in the Notice of Privacy practices.

Marsh Cove Dental 

Marsh Cove Dental Financial Policy

Understanding your financial responsibility is an essential component in establishing and maintaining a strong patient/practice relationship. In order to achieve this, we offer the following information regarding our insurance and financial policies.

Patient without Insurance assistance need to know.... The fee for treatment provided must be paid in full on the day of service.

Patients with Insurance coverage need to know.....Your insurance is a contract between your insurer and you. It is your responsibility to know and understand the terms, guidelines and limitations of your plan. It is also your responsibility to advise us of any changes in your insurance, your address, or your employer. The estimated patient copay and deductible for the treatment rendered must be paid in full on the day of service. Please understand that you are ultimately responsible for all fees generated by your treatment.

Contracted Insurance plans..... If you are a member of a Dental Insurance plan that we participate with, we will submit your claim to your Insurance company. Our staff will verify your benefits and collect any co-payment, co-insurance and/or deductible at the time services are rendered as required by your Insurance carrier. You will be billed in full for any services that your Insurance plan deems as "not a benefit" or a "non-covered service", or chooses to pay only for an alternate/downgraded benefit.

Non-Contracted Insurance Plans.....If we do not participate with your Insurance carrier, payment in full will be required by you at the time services are rendered. Our billing department will file a claim to your insurance company as a courtesy to you.

Minors.....A parent or legal guardian must accompany all patients under the age of 18 to authorize treatment and financial arrangements. If this is a custodial; parent, we can submit the charges to another parent's Insurance, however the parent presenting the child for care will be billed for the balance not covered by the insurance. Any patient over 18 will be held financially responsible for all charges incurred.

Missed Appointments.....Missed appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. Cancellations must be made 48 hours in advance of the scheduled appointment or we reserve the right to assess a fee of $30.

Appointment Time: We thank you for helping our office run smoothly and efficiently as possible for all patients, and by arriving for your dedicated appointment on time.

The nature of our practice is to give our patients the utmost in dental care and service in a sterile and professional environment. We make every attempt to see you at your reserved appointment time. However, since we are sometimes faced with emergencies during the day, we may run behind schedule.

This happens only on occasion, so please excuse any delays. We promise to give you the same careful attention and dedicated time.

We accept Visa, Mastercard, Discover Card, American Express, Checks and Cash for payment due.

If you need assistance with paying for your treatment, we have an In-House Dental plan and Care Credit is also an available option.

Collection Fees.... Statements are sent out monthly for patients with personal balances. Payment is due upon receipt of the statement. If you are unable to pay the balance in full, please contact our office. Personal balances over 90 days from the date of service will be sent to our Collection agency or settled in small claims court. **In the event it is turned over to a collection agency or settled in small claims court, the patient will be responsible for any and all fees including court costs, attorney fees, and collection agency charges.**

Returned check fees.... An additional fee in the amount of whatever the bank charges incurred will be added to your account balance in addition to the amount of the check returned for insufficient funds. This total must be paid by cash or credit card within 14 days.

This is an agreement between John E. Tiano DDS, as creditor, and the Patient/Debtor named on this form. By executing this agreement, you consent to treatment by John E. Tiano DDS and his staff and agree to pay for all services that are received. Once you have signed this agreement, you agree to all the terms and conditions contained herein and the agreement will be in full force and effect.

Patient's Name: _____

Responsible Party (if patient is under 18 years old):

_____

Signature: _____ **Date:** _____

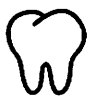
Marsh Cove Dental

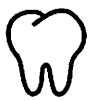
Patient Communication Consent Form

As part of the implementation of a new Practice management System, Marsh Cove Dental now has the advantage of communicating appointment reminders via text message and emails with our patients.

I authorize Marsh Cove Dental to send text messages and emails as appointment reminders to me on my provided cell phone and or Email address. I understand I may reply with various commands to receive account information. By accepting these terms, I agree to receive text messages and emails from the practice. Text charges from your cell phone carrier may occur.

My signature below indicates that I represent and warrant that I am the person legally responsible for use of the account, and that I agree to the terms and conditions for the use of text messaging services and email services. I understand I may opt out of either of these types of communications at any time.

 Accept

 Decline

(___)_____ _____

Mobile Phone number Email Address

_____ _____

Patient Signature Date

My Preferred Method of Contact is:

 Home Phone  Mobile Phone  Email