MINT dentistry

DENTISTRY IN LUXURY

TELL US A LITTLE ABOUT YOU

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

Birthdate: _____ SS #: _____ Gender: M F Married: Y N

Work Phone: _____ Cell Phone: _____

Email: _____

Preferred contact method ☐HmPhone ☐WkPhone ☐WirelessPh ☐Email

Preferred contact method for confirmations ☐HmPhone ☐WkPhone ☐WirelessPh ☐Email

Preferred contact method for recall ☐HmPhone ☐WkPhone ☐WirelessPh ☐Email

Student status if dependent over 19 (for ins) ☐Non student ☐Fulltime ☐Parttime

What is your ethnicity?

_____

Medicaid # _____

Check box if same for entire family ☐

Address: _____

Address 2: _____

City_____ State_____ Zip Code_____

Home Phone: _____

INSURANCE POLICY 1

Your relationship to subscriber: ☐Self ☐Spouse ☐Child

Subscriber Name: _____ Subscriber ID#: _____

Insurance Company: _____ Phone: _____

Employer: _____ Group Name: _____ Group #: _____

INSURANCE POLICY 2

Your relationship to subscriber: ☐Self ☐Spouse ☐Child

Subscriber Name: _____ Subscriber ID#: _____

Insurance Company: _____ Phone: _____

Employer: _____ Group Name: _____ Group #: _____

Printed Name: _____ Signature: _____ Date: _____

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HEALTH HISTORY

Last Name: _____ First Name: _____ Birthdate: _____
Name of Medical Doctor: _____ City/State: _____
Emergency Contact: _____ Phone: _____ Relationship: _____

List all medications that you are now taking (includes: pills, drugs, blood thinners):

_____ _____ _____
_____ _____ _____
_____ _____ _____

Are you allergic to any of the following?:

Y		Y		Y		Y	
☐	Anesthetic	☐	Codeine	☐	Iodine	☐	Penicillin
☐	Aspirin	☐	Ibuprofen	☐	Latex	☐	Sulfa

Do you have any of the following medical conditions?:

Y		Y		Y		Y	
☐	Asthma	☐	Sinus Trouble	☐	Hives/Rash	☐	Scarlet Fever
☐	Bleeding Probelms	☐	Stroke	☐	Irregular Heartbeat	☐	Shingles
☐	Cancer	☐	Ulcers	☐	Kidney Problems	☐	Lung Disease
☐	Diabetes	☐	Rheumatic Fever	☐	Low Blood Pressure	☐	Parathyroid Disease
☐	Heart Murmur	☐	Drug Addiction	☐	Stomach/Intestinal Disease	☐	Renal Dialysis
☐	Heart Trouble	☐	Easily Winded Heart	☐	Thyroid Disease	☐	Spina Bifida
☐	High Blood Pressure	☐	Emphysema	☐	Tonsillitis	☐	Swelling of Limbs
☐	Joint Replacement	☐	Frequent Cough	☐	Tuberculosis	☐	Yellow Jaundice
☐	AIDS	☐	Frequent Diarrhea	☐	Tumors	☐	Radiation Treatments
☐	Alzheimer's Disease	☐	Hemophilia	☐	Veneral Disease	☐	Recent Weight Loss
☐	Anaphylaxis	☐	Hepatitis A	☐	Hypoglycemia	☐	Sickle Cell Disease
☐	Artificial Heart Valve	☐	Hepatitis B or C	☐	Leukemia	☐	Rheumatism
☐	Artificial Joint	☐	Chest Pains	☐	Congenital Heart Disorder	☐	Glaucoma
☐	Chemotherapy	☐	Cold Sores/Fever Blisters	☐	Excessive Bleeding	☐	Hay Fever
☐	Convulsions	☐	Angina	☐	Excessive Thirst	☐	Heart Pacemaker
☐	Cortisone Medicine	☐	Arthritis	☐	Fainting Spells/Dizziness	☐	Herpes
☐	HIV	☐	Blood Disease	☐	Genital Herpes	☐	Pregnancy
☐	Anemia	☐	Blood Transfusion	☐	Mitral Valve Prolapse	☐	Psychiatric Treatment
☐	Kidney Disease	☐	Breathing Problem	☐	Paint in Jaw Joints	☐	Bruise Easily
☐	Liver Disease						

Tobacco use? If so, what kind and how much?: _____ Do you snore?: _____
Have you ever been hospitalized or had a major operation?: _____
Reason for today's visit: _____ Are you in pain?: _____
Women, are you taking oral contraceptives?: _____ Are you nursing?: _____

Printed Name: _____ Signature: _____ Date: _____

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WHO CAN WE DISCUSS YOUR TREATMENT WITH?

Unless you are a minor, Mint Dentistry cannot discuss or share information about your dental treatment with any third party unless we have permission/consent in writing from you to do so. In section "A" please list any person you give Mint Dentistry permission/consent to discuss or share with your protected health information, information such as x-rays, account information, treatment,etc

If you do not wish to give consent to any person, please check section "B" below, sign and date the bottom portion of this form. You must choose one option.
If the patient is a minor, we will discuss dental treatment with either parent or guardian.

☐ I hereby give permission/consent to Mint Dentistry to discuss any and all dental information with the named individuals below.

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

☐ I do not wish Mint Dentistry to discuss any of my dental treatment with anyone other than me.

Printed Name: _____

Signature of Patient/Responsible: _____

Date: _____

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DENTISTRY IN LUXURY

EVERYTHING YOU NEED TO KNOW ABOUT PAYING US

OFFICE FINANCIAL POLICY

In an effort to maintain treatment fees at a minimum while maintaining a high level of professional care, we have established the following financial policy for our office. Please feel free to discuss our fees with us at any time. Before any dental treatment has begun, the patient and/or responsible party will receive a consultation regarding treatment plan and cost.

We require payment in full for the portion, not covered by dental insurance, of dental services to be rendered. For procedures that take multiple appointments to complete, payment may be split up over the number of appointments required. We accept Cash, American Express, Visa, MasterCard, Discover, and outside financing through Care Credit. Outside financing credit applications to help assist with the cost of your dental treatment are available upon request. Personal checks are not accepted at Mint Dentistry.

By signing below the Patient agrees, there is an understood "Assignment of Benefits" to Mint Dentistry (and affiliated companies). In some instances, the assignment of benefits is sometimes mistakenly overlooked by insurance companies and mailed to patients; and in that scenario the patient is responsible for signing the check over to Mint Dentistry. And the balance will be the patient's responsibility.

As a courtesy to our patients with insurance, we will file your insurance claim, allowing you to pay only your deductible and/or **estimated** co-payment as services are rendered. Please remember that the contract is between you and you insurance company. We make every effort to give you an accurate estimate of what your portion of our fees will be, based on the information provided to us. However, we have no way to guarantee the actual terms of your policy. Any dispute coverage or the amount of reimbursement is between you and your insurance carrier. **By agreeing to this policy you agree to all such conditions.**

At Mint Dentistry we schedule our appointments to provide each patient with our undivided attention. In order to accomplish this, we require a **24 hour confirmation** on all appointments. **Please be advised that you will be charged for cancellations with less than 24 hours' notice** at the rate of $50.00 for examination/hygiene appointments and $75.00 for dental procedures appointments. Also note that payment for services that are provided by patients for Mint Dentistry will be applied to patient balances. Should the patient change their mind for whatever reason during treatment, patient will still be responsible for full payment. Mint Dentistry guarantees cosmetic crowns and posterior crowns from breaking with a replacement crown for as long as the patient returns every six months for their regular cleaning.

We appreciate your confidence in choosing our practice. Please do not hesitate to inquire with a staff member should you have any questions regarding this policy.

☐ **I have read, understood and agree to the Office Financial Policy stated above.**

Signature: _____ Date: _____

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ASSIGNMENT OF BENEFITS

I hereby assign, convey and transfer all dental benefits directly to which I am entitled to Mint Dentistry. I hereby authorize and direct all my insurance carrier(s), including Medicaid, private insurance and any other health/medical plan, to issue payment directly to Mint Dentistry. This assignment includes the right to pursue all associated administrative remedies, claims and/or lawsuits against such policies and/or plans, including and express and knowing assignment of ERISA, breach of fiduciary duty claims and any other administrative claims. I authorize Mint Dentistry to initiate a complaint with the Texas Department of Insurance and/or Insurance Commissioner on my behalf.

I understand that I am financially responsible to Mint Dentistry for any and all charges regardless of any applicable insurance or health care benefits, and any payment received from these policies and/or plans will be applied to the amount I have agreed to pay for the services rendered. It is my responsibility to notify Mint Dentistry of any changes in my health care coverage. I understand by signing this form I am accepting financial responsibility for payment for all products and services received.

In certain circumstances, insurance companies may send a check for services provided by Mint Dentistry directly to the patient. In such cases, the patient agrees to endorse and send such check to Mint Dentistry within 10 days of receipt of the check.

I hereby authorize Mint Dentistry to: (1) release any information necessary to insurance carriers, adjusters, or attorneys regarding my diagnosis and treatment; (2) process insurance claims generated in the course of examination and treatment; (3) and allow a photocopy of my signature and/or electronic signature and this form to be used to process insurance claims. This authorization will remain in effect until revoked by me in writing.

I have requested dental services from Mint Dentistry on behalf of myself and/or my dependents and understand by making this request that I am fully financially responsible for any and all charges incurred in the course of treatment authorized.

Printed Name: _____

Signature of Patient/Responsible: _____

Date: _____

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ARBITRATION AGREEMENT

In the event any dispute arises relating to any services provided by Mint Dentistry you agree you will attempt to resolve the dispute with the Mint Dentistry Patient Experience Director for 60 days. You agree that there will be no assignment of any claim that you may have arising out of this Agreement. You agree that the dispute will be submitted to binding individual arbitration before the American Arbitration Association (AAA) under the Federal Arbitration Act subject to the laws of the State of Texas and that you waive your right to sue in a court of law before a jury and are instead accepting the use of arbitration. It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or services provided by Mint Dentistry including any spouse or heirs of the patient at the time of the occurrence giving rise to any claim.

Informal Resolution; Mail a Notice of Dispute First. If you have a dispute and our patient care representatives cannot resolve it, you must send a notice of dispute by U.S. Mail to Mint Dentistry, ATTN: Compliance, 5656 North Central Expressway, Suite 400 Dallas, TX 75206. Tell us your name, address, how to contact you, what the problem is, and what you want. You will be notified in writing at the address provided in the new patient paperwork if we have a dispute with you. If any dispute is not resolved within 60 days, either party may initiate an arbitration if the dispute is unresolved.

Arbitration Procedure. The Parties agree to conduct the arbitration with the American Arbitration Association the ("AAA") using one arbitrator under its Consumer Arbitration Rules. The parties agree that Texas state law shall govern with regard to any claims made in the arbitration, including any claims for medical malpractice. For more information, please see www.adr.org or call 1-800-778-7879. To initiate an arbitration, you must submit an arbitration demand to the AAA and mail a copy to Mint Dentistry. In a dispute involving claims of $25,000 or less, you agree that any hearing will be telephonic unless the arbitrator finds good cause to conduct an in-person hearing instead. Any in-person hearing will take place in our principal place of business, Dallas, Texas.

Disputes Covered. Both you and Mint Dentistry understand and agree that any dispute as to medical/dental malpractice, including, but not limited to whether any medical/dental services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by federal law and not by a lawsuit or resort to court process—except to the extent that state and federal law allow for judicial review of arbitration proceedings. Both parties to this agreement, by entering into it, are giving up their legal right to have any such dispute decided in a court of law before a jury and instead are accepting the use of arbitration. Both you and Mint Dentistry also understand and agree that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, will also be determined by submission to binding arbitration. It is the intention of the parties to this agreement that the agreement bind all parties as to all claims, including those claims that "arise out of" or "relate to" the treatment or services provided by Mint Dentistry. This agreement is intended to bind and cover Mint Dentistry, all of Mint Dentistry's independent contractors and employees, including those who now or in the future treat the patient while employed by, working or associated with Mint Dentistry. This agreement covers all claims for monetary damages, exceeding the jurisdictional limit of the small claims court against Mint Dentistry and/or Mint Dentistry's associates, association, corporation, partnership, employees, agents, and estate must be arbitrated including, without limitation, claims for medical negligence, loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages. If a claim falls within the jurisdiction of small claims court in your county of residence, you and Mint Dentistry retain the right to seek relief in that court.

Arbitration Expenses. You and Mint Dentistry understand and agree that you each shall equally pay, at a rate of fifty percent each (50%), the fees, costs, and expenses of the AAA arbitrator appointed to resolve any dispute covered by this Agreement. Both You and Mint Dentistry understand and further agree that each of you will also pay their own individual fees, costs, and expenses for legal representation, experts, and witnesses during the arbitration proceeding. With these exceptions, the arbitrator may award the same damages to you individually as a court could.

Joinder of Individual Claims into a Single Proceeding and Waiver. All individual claims based upon the same incident, transaction, or related circumstances between you and Mint Dentistry, shall be arbitrated in one proceeding. A claim shall be waived and forever barred if: (1) on the date that notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures identified herein with reasonable diligence.

Prohibition against Punitive Damages and Class Waiver. You and, Mint Dentistry, understand and agree that the arbitrator is not authorized to award punitive or other damages not measured by the prevailing party's actual damages. You and Mint Dentistry understand and agree that each may bring claims against the other only in an individual capacity and not as a plaintiff or class member in any purported class or representative action. Unless both You and Mint Dentistry agree, no arbitrator or judge may consolidate more than one person's claims or otherwise preside over any form of a representative or class proceeding.

Continuation of Medical Services: Your failure to sign this agreement will not prevent you from receiving medical care.

Severability: If any part of this Agreement is held to be invalid or unenforceable, the remaining provisions will remain in full force and will not be affected by the invalidity of any other provision.

By my signature below, I acknowledge that I am entitled to receive a copy of this agreement and may print a copy of this agreement after my electronic review and signature of the Agreement or elect to be provided with a copy upon my arrival for services or treatment at Mint Dentistry.

Printed Name: _____

Signature of Patient/Responsible: _____

Date: _____