MCDONALD FAMILY DENTISTRY

Are you filling this form out for ☐ yourself or ☐ someone else?		
PATIENT INFORMATION		
First Name:	Last Name:	Middle Initial:
Date of Birth: / /	Gender: ☐ Male ☐ Female	SSN
Marital Status: ☐ Married ☐ Single	Email:	

ADDRESS:		
City:	State:	Zip
Mobile Number:	Is it okay if we *text* you appointment reminders? ☐ YES ☐ NO	
Email:	Is it okay if we *email* you Appointment reminders? ☐ YES ☐ NO	
Emergency Contact Person:	Emergency Contact Person's #:	

How did you hear about us?	
Who can we thank for referring you?	

DENTAL INSURANCE ☐ YES ☐ NO

SUBSCRIBER: _____

ID#: _____

GROUP #: _____

DATE OF BIRTH: _____

INSURANCE CO.: _____

COMPANY PHONE#: _____

ID#: _____

GROUP #: _____

DATE OF BIRTH: _____

INSURANCE CO.: _____

COMPANY PHONE#: _____

SECONDARY DENTAL INS. ☐ YES ☐ NO

SUBSCRIBER: _____

DENTAL HISTORY

Are you in any discomfort now? ☐ YES ☐ NO If yes, where and for how long?		
What is the reason for your appointment?		
How long has it been since you've seen a dentist? ☐ 6 months ☐ 1 year ☐ Over a year		
Do you play sports?	☐ YES	☐ NO
Is there a family history of cavities?	☐ YES	☐ NO
Has the patient ever had a bad experience at the dentist?	☐ YES	☐ NO
Has the patient ever had a bad reaction to dental anesthetic?	☐ YES	☐ NO
Have you had complications following dental work in the past?	☐ YES	☐ NO
Are any of your teeth sensitive to hot or cold?	☐ YES	☐ NO
Sweets?	☐ YES	☐ NO
Pressure?	☐ YES	☐ NO
Have you ever been diagnosed with periodontal disease?	☐ YES	☐ NO
Do you grind your teeth?	☐ YES	☐ NO
Are you aware of any sores or irritated areas in your mouth?	☐ YES	☐ NO
Have you ever been told to take a pre-medication prior to dental treatment?	☐ YES If yes, why?	☐ NO
Do you smoke?	☐ YES	☐ NO
Do you use chewing tobacco?	☐ YES	☐ NO
Do you use recreational drugs?	☐ YES	☐ NO
Does the dentist make you anxious or nervous?	☐ YES	☐ NO
Do your gums bleed when you brush or floss?	☐ YES	☐ NO
How often do you brush?		
How often do you floss?		
If there was anything you would like to change with your teeth/smile, what would that be?		

PRIMARY CARE PHYSICIAN INFO.

Primary Physician: _____

Phone #: _____

PHARMACY INFORMATION

What is your preferred pharmacy?

Name: _____Location _____

Phone #: _____

MEDICAL HISTORY

HEART OR CIRCULATORY

- ☐ Angina
- ☐ Artificial heart valve
- ☐ Arteriosclerosis
- ☐ Cardiovascular disease
- ☐ Congenital Heart Disease (CHD)
- ☐ Congestive heart failure
- ☐ Damaged heart valves
- ☐ Heart transplant
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Heart attack
- ☐ Heart murmur
- ☐ Infective endocarditis
- ☐ Mitral valve prolapse
- ☐ Pacemaker
- ☐ Pulmonary embolism
- ☐ Rheumatic heart disease

LUNG OR BREATHING

- ☐ Asthma
- ☐ Bronchitis
- ☐ COPD
- ☐ Cystic Fibrosis
- ☐ Emphysema
- ☐ Tuberculosis

DIGESTIVE/DIETARY

- ☐ Acid reflux/persistent heartburn
- ☐ Excessive urination
- ☐ Gastrointestinal disease
- ☐ Malnutrition
- ☐ Eating disorder
- ☐ Severe or rapid weight loss
- ☐ Special diet

NEUROLOGICAL

- ☐ Autism
- ☐ Brain aneurysm
- ☐ Brain injury
- ☐ Epilepsy
- ☐ Fainting
- ☐ Migraines/severe headaches
- ☐ Seizures
- ☐ Stroke

AUTOIMMUNE

- ☐ Ankylosing spondylitis
- ☐ Celiac disease
- ☐ HIV or AIDS
- ☐ Immune deficiency
- ☐ Lupus
- ☐ Multiple sclerosis
- ☐ Rheumatoid arthritis

ARE YOU ALLERGIC TO THE FOLLOWING?

- ☐ Animals_____
- ☐ Barbiturates or sedatives
- ☐ Codeine or other narcotics
- ☐ Food _____
- ☐ Iodine
- ☐ Latex
- ☐ Local anesthetics
- ☐ Metals
- ☐ Antibiotics (Penicillin, Tetracycline, etc)
- ☐ Seasonal
- ☐ Sulfa drugs
- ☐ Other:_____

OTHER CONDITIONS

- ☐ Anemia
- ☐ Cancer
- ☐ Diabetes
- ☐ Glaucoma
- ☐ Bleeding disorder/Hemophilia
- ☐ Hepatitis
- ☐ Jaundice or Liver disease
- ☐ Osteoporosis
- ☐ Renal/Kidney problems
- ☐ Sleep Apnea
- ☐ Sexually transmitted disease
- ☐ Total joint replacement
- ☐ Pregnant or think you might be?
- ☐ Breastfeeding

Are there any other medical conditions we should know about?

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MEDICATION

DIABETES, CHOLESTOROL, OR BLOOD PRESSURE

- ☐ Avapro (Irbesartan)
- ☐ Coreg (Carvedilol)
- ☐ Coumadin (Warfarin)
- ☐ Crestor (Rosuvastatin)
- ☐ Amlodipine
- ☐ Klor-Con (Potassium Chloride)
- ☐ Lasix (Furosemide)
- ☐ Atorvastatin
- ☐ Lipitor (Atorvastatin Calcium)
- ☐ Lopressor (Metoprolol)
- ☐ Losartan (Cozaar)
- ☐ Metformin (Glucophage)
- ☐ Microzide (Hydrochlorothiazide)
- ☐ Norvasc (Amlodipine)
- ☐ Lisinopril
- ☐ Plavix (Clopidogrel)
- ☐ Prinivil (Lisinopril)
- ☐ Tenormin (Atenolol)
- ☐ Zestoretic (Lisinopril)
- ☐ Toprol XL (Metoprolol)

PAIN MEDICATION

- ☐ Aspirin
- ☐ Codeine
- ☐ Demerol (Meperidine)
- ☐ Hydrocodone (Vicodin/Lortan/Norco)
- ☐ Ibuprofen
- ☐ Percocet (Oxycodone)
- ☐ Ultram (Tramadol)
- ☐ Tylenol
- ☐ Tylenol #3
- ☐ Suboxone

ALLERGY

- ☐ Claritin (Loratadine)
- ☐ Flonase (Fluticasone)
- ☐ Singulair (Montelukast)
- ☐ Ventolin (Albuterol Inhaler)
- ☐ Zyrtec (Cetirizine)

ANTIBIOTICS

- ☐ Amoxicillin
- ☐ Clindamycin
- ☐ Ciprofloxacin
- ☐ Doxycycline
- ☐ Tetracycline
- ☐ Zithromax (Azithromycin)
- ☐ Penicillin

ANTIDEPRESSANTS, ANXIETY, OR BEHAVORIAL

- ☐ Adderall
- ☐ Ambien (Zolpidem)
- ☐ Celexa (Citalopram)
- ☐ Cymbalta (Duloxetine)
- ☐ Effexor (Venlafaxine)
- ☐ Lexapro (Escitalopram)
- ☐ Neurontin (Gabapentin)
- ☐ Oleptro (Trazodone)
- ☐ Prozac (Fluoxetine)
- ☐ Xanax (Alprazolam)
- ☐ Wellbutrin (Buproprion)
- ☐ Zoloft (Sertraline)

OTHER MEDICATION

- ☐ Aclasta/Reclast (Zoledronic Acid)
- ☐ Boniva (Ibandronate)
- ☐ Aspirin
- ☐ Cialis (Tadalafil)
- ☐ Cyclobenzaprine (Flexeril)
- ☐ Plavix
- ☐ Xarelto
- ☐ Didronel (Etidronate)
- ☐ Eliquis
- ☐ Fosamax (Alendronate)
- ☐ Pantoprazole (Protonix)
- ☐ Prednisone
- ☐ Medrol (Methylprednisolone)
- ☐ Meloxicam (Mobic)
- ☐ Synthroid (Levothyroxine)
- ☐ Prilosec (Omeprazole)

Any other medication we should know about:

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_____
_____
_____
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General Informed Consent

Examinations and x-rays

I understand that the initial visit may require radiographs in order to complete the examination, diagnosis, and treatment plan.

Drugs, medication, and sedation

I understand that antibiotics, analgesics, and other medications can cause allergic reactions such as redness, swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). They may cause drowsiness and lack of awareness and coordination, which can be increased by the use of alcohol or other drugs. I understand that and fully agree not to operate any vehicle or hazardous device for at least 12 hours or until fully recovered from the effects of the anesthetic medication and drugs that may have been given me in the office for my treatment. I understand that failure to take medications prescribed for me in the manner prescribed may offer risks of continued or aggravated infection, pain, and potential resistance to effect treatment of my condition. I understand that antibiotics can reduce the effectiveness of oral contraceptives.

Changes in treatment

I understand that during treatment, it may be necessary to change or add procedures due to conditions found while working on teeth, the most common being root canal therapy following

routine restorative procedures. I give my permission to the dentist to make these changes as necessary.

Temporomandibular joint dysfunctions

I understand that symptoms of popping, clicking, locking and pain can intensify or develop in the joint of the lower (near the ear) subsequent to routine dental treatment wherein the mouth is held in the open position. However, symptoms of TMJ associated with dental treatment are usually transitory in nature and well tolerated by most patients. I understand that should the need for treatment arise, I will be referred to a specialist for treatment, the cost of which is my responsibility.

With any dental treatment, there is a possibility of injury to the nerves of the lips, jaws, teeth, tongue or other oral or facial tissues. The resulting numbness that could potentially occur is usually temporary, but in rare instances it could be permanent. I understand that every reasonable effort will be made to ensure that any condition is treated appropriately. No guarantee or assurance has been given to me by anyone that any proposed treatment or surgery will cure or improve any conditions.

By signing, you are agreeing to the terms above.

Signature: _____ Date: _____

Office Policy

Cancellations and Missed Appointments

Your appointment time is reserved specifically for you and for you only. Because of this, missed appointments or late cancellations are extremely detrimental to our day. As a result, we request at least 48-hour advance notice if you will not be able to make your appointment. Repeated missed appointments or late cancellations may result in fees or dismissal as a patient.

Payment

Payment in full for your treatment is due no later than when services are rendered. Acceptable forms of payment include cash, Visa, Master Card, American Express, Discover, and assigned insurance benefits. In the event there is a shortage due to insurance underpayment, it is our

policy to charge finance fees at 1.5% for outstanding patient balances after the balance has been outstanding for more than 30 days after you have been notified of a balance due. Payments returned due to non-sufficient funds will be subject to an NSF fee of $25.00.

By signing, you are agreeing to the terms above.

Signature: _____ Date: _____

Acknowledgement of Receipt of Notice of Privacy Practices

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

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information (protected health information) used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

- Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment and health care operations.
- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. Examples of treatment would include crowns, fillings, teeth cleaning services, etc.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be billing your dental plan for your dental services.
- Health Care Operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would include a periodic assessment of our documentation protocols, etc.

In addition, your confidential information may be used to remind you of an appointment (by phone, text, email or mail) or provide you with information about treatment options or other health- related services including release of information to friends and family members that are directly involved in your care or who assist in taking care of you. We will use and disclose your protected when we are required to do so by federal, state or local law. We may disclose your protected health information to public health authorities that are authorized by law to collect information, to a health oversight agency for activities authorized by law included but not limited to: response to a court or administrative order, if you are involved in a lawsuit or similar proceeding, response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

We will release your protected health information if requested by a law enforcement official for any circumstance required by law. We may release your protected health information to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs. We may release protected health information to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor. We may use and disclose your protected health information when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

We may disclose your protected health information if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities. We may disclose your protected health information to federal officials for intelligence and national security activities authorized by law.

We may disclose your protected health information to correctional institutions or law enforcement HIPAA officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals or the public.

We may release your protected health information for workers' compensation and similar programs.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing, and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have certain rights in regard to your protected health information, which you can exercise by presenting a written request:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to request to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to access, inspect and copy your protected health information.
- The right to request an amendment to your protected health information.
- The right to receive an accounting of disclosures of protected health information outside of treatment, payment, and health care operations.

- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices.

We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office. You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
877-696-6775 (tollfree)

By signing, you are agreeing to the terms above.

Signature: _____ Date: _____