GETTING TO KNOW YOU AS OUR PATIENT

PATIENT NAME	SOCIAL SECURITY NUMBER	HOME PHONE ( )
Home Address	City, State, Zip	Birthdate / /
Marital Status ❑ Single ❑ Married ❑ Divorced ❑ Separated	❑ M ❑ F EMAIL	CELL PHONE

Responsible Party		
NAME	SOCIAL SECURITY NUMBER	HOME PHONE ( )
Home Address	City, State, Zip	Birthdate / /
Marital Status ❑ Single ❑ Married ❑ Divorced ❑ Separated	Relationship to Patient	
Responsible Party's Employer	Occupation	Work Phone ( )
Business Address	City	State Zip
Spouse's Name		Birthdate / /
Spouse's Employer	Spouse's Occupation	Spouse's Work Phone ( )
Spouse's Business Address	City	State Zip

In the event of an emergency, please contact:

Name _____ Relationship _____ Phone _____
Name _____ Relationship _____ Phone _____

How did you hear about our Office?
(check only one)

Who selected this Office? ❑ Self ❑ Spouse ❑ Parent ❑ Employer

Where did you find the phone number to this Office? _____

❑ Referred by a friend ❑ Yellow Pages ❑ Relative ❑ Insurance Plan ❑ TV/Radio Ad ❑ Newspaper Ad

❑ Other _____

If you were referred, whom may we thank for referring you? _____

CONSENT

I will answer all health questions on this form to the best of my knowledge. _____
(initial here)

TERMS AND CONDITIONS

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits or another dentist.

I authorize and consent to the taking of photographs before, during, and after treatment. I further give permission for the use of those photographs for the purpose of research and education.

I understand that I am responsible for all costs of dental treatment.

I hereby authorize payment of insurance benefits directly to the dentist or dental group.

I attest that the above information is complete and accurate.

MAC Dental does not accept any patients with insurance through the State of Wisconsin (such as Badger Care, Medical Assistance, Title 19, Forward, etc.). By signing this form, I am stating that I am not covered under any state dental plan.

Signed _____ Date _____

There may be a charge for any missed appointments or appointments not cancelled 24 hours before the appointment time.

PATIENT'S DENTAL HEALTH

Why have you come in to see us today? (e.g. pain, check-up, etc.) _____

Previous Dentist _____ Last Visit _____ Date of last cleaning _____

Reason for changing dentists: _____

What problems have you had with past dental treatment? _____

Are you nervous about seeing a dentist? ❑ Yes ❑ No If Yes, please tell us why: _____

How often do your brush? _____ Do you floss? ❑ Yes ❑ No If Yes, how often? _____

(please circle each)

Y N I clench or grind my teeth during the day or while sleeping.
Y N My gums bleed while brushing or flossing.
Y N I like my smile.
Y N I prefer tooth-colored fillings.
Y N I avoid brushing part of my mouth due to pain.
Y N I want my teeth whiter.
Y N My gums feel tender or swollen.
Y N I have problems eating.
Y N I have had orthodontics.
Y N I have had a facial or jaw injury.
Y N I want my teeth straight.

What are your dental priorities? (e.g.: dental health, financial considerations, etc.) _____

_____

PATIENT'S MEDICAL HISTORY

I consider my health to be (please check one) ❑ Excellent ❑ Good ❑ Fair ❑ Poor

Are you under a physician's care now? ❑ Yes ❑ No If YES, please explain: _____

_____

Have you ever been hospitalized or had a major operation? ❑ Yes ❑ No If YES, please explain: _____

_____

Have you ever had a serious head or neck injury? ❑ Yes ❑ No If YES, please explain: _____

_____

Have you ever taken bone-loss drugs during cancer treatment? ❑ Yes ❑ No

Do you use tobacco? ❑ Yes ❑ No

Do you use controlled substances? ❑ Yes ❑ No

For Office Use Only:
Blood Pressure: _____

WOMEN ONLY: Are you ❑ Pregnant/Trying to get pregnant? ❑ Nursing? ❑ Taking oral contraceptives?

Are you allergic to any of the following?
❑ Aspirin ❑ Ibuprofen ❑ Sulfa Drugs/Sulfites/Sulfides ❑ Penicillin ❑ Codeine ❑ Latex, Metals, Plastics

❑ Local Anesthetics (Novocaine) ❑ Other – which ones? _____

Do you or have you had any of the following?

❑ AIDS/HIV Positive
❑ Alzheimer's Disease
❑ Anaphylaxis
❑ Anemia
❑ Angina
❑ Arthritis/Gout
❑ Artificial Heart Valve
❑ Artificial Joint
❑ Asthma
❑ Blood Disease
❑ Blood Transfusion
❑ Breathing Problem
❑ Bruise Easily
❑ Cancer
❑ Chemotherapy
❑ Chest Pains
❑ Cold Sores/Fever Blisters
❑ Congenital Heart Disorder
❑ Convulsions
❑ Cortisone Medicine
❑ Diabetes
❑ Drug Addiction
❑ Easily Winded
❑ Emphysema
❑ Epilepsy or Seizures
❑ Excessive Bleeding
❑ Excessive Thirst
❑ Fainting Spells/Dizziness
❑ Frequent Cough
❑ Frequent Diarrhea
❑ Frequent Headaches
❑ Glaucoma
❑ Hay Fever
❑ Heart Attack/Failure
❑ Heart Murmur
❑ Heart Pace Maker
❑ Heart Trouble/Disease
❑ Hemophilia
❑ Hepatitis A
❑ Hepatitis B or C
❑ Herpes
❑ High Blood Pressure
❑ High Cholesterol
❑ History of Osteoporosis
❑ Hives or Rash
❑ Hypoglycemia
❑ Irregular Heartbeat
❑ Kidney Problems
❑ Leukemia
❑ Liver Disease
❑ Low Blood Pressure
❑ Lung Disease
❑ Organ Transplant
❑ Osteoporosis
❑ Pain in Jaw Joints
❑ Parathyroid Disease
❑ Psychiatric Care
❑ Radiation Treatment
❑ Recent Weight Loss
❑ Renal Dialysis
❑ Rheumatic Fever
❑ Rheumatism
❑ Shingles
❑ Sickle Cell Disease
❑ Sinus Trouble
❑ Snoring
❑ Spina Bifida
❑ Stomach/Intestinal Disease
❑ Stroke
❑ Swelling of Limbs
❑ Thyroid Disease
❑ Tonsillitis
❑ Tuberculosis
❑ Tumors or Growths
❑ Ulcers
❑ Venereal Disease
❑ Wear CPAP
❑ Yellow Jaundice

Have you ever had any serious illness not listed above? ❑ Yes ❑ No If yes, please explain: _____

_____

Please list all medications you are currently taking:

Medicine _____ Condition _____
Medicine _____ Condition _____
Medicine _____ Condition _____
Medicine _____ Condition _____
Medicine _____ Condition _____

Patient Name: _____ Birth Date: _____
Last, First MI

DENTAL CARE

Office Policies

Financial Policy Agreement

- ☐ Payment is expected at the time when services are provided. If you have insurance, the estimated patient portion of the fee is due at the time of service. Any other payment arrangement must be made in advance of services.
- ☐ We allow extra time for the insurance company to pay their estimated portion.
- ☐ If the insurance company has not fully paid a claim after a reasonable period of time, (usually 30 days) you will be required to pay that remaining portion.
- ☐ As a courtesy, we are happy to verify your benefits and bill your insurance. Information received is not a guarantee of benefits or payment from the insurance company, we use this information to estimate as closely as possible your insurance coverage.

- ☐ I understand that any costs incurred during treatment are my responsibility. I realize that insurance may help pay part of my treatment and that the estimates quoted to me are only *estimates*. I will be responsible for any fees unpaid by the insurance company. I understand that there may be monthly interest (1.5%) applied to the balance, and any additional costs of collection will be applied to the balance.

Cancellation Policy Agreement

- ☐ I understand that if I fail to give 24 hours notice to cancel a scheduled appointment, that I may be charged a fee up to the amount of the scheduled appointment procedure.

Notice of Privacy Practices Acknowledgement

- ☐ Under the *Health Insurance Portability & Accountability Act of 1996* (HIPAA) I have certain rights to privacy regarding my protected health information. This information is used to conduct to your treatment, obtain payment from third party payers, and other various uses. I acknowledge that I have received your *Notice of Privacy Practices* containing a complete description of the uses of my health information and how I may restrict the use of this information.

Consent for Treatment

- ☐ I give consent for dental treatment by the doctor and staff.
- ☐ I understand that with each procedure there are particular risks and benefits. Possible risks for even routine treatment (such as fillings, crowns, root canals, and extractions) can be sensitive teeth, infection, paresthesia, traumatized pulp (nerve). Additional procedures may be required to treat any further complication.
- ☐ The practice of dentistry is not an exact science, and although we strive to give best care possible, guarantees can not be made concerning the results of the treatment.
- ☐ I consent to the use of local anesthetics, antibiotics, nitrous oxide (laughing gas), and analgesics (pain medications) as needed to complete treatment.
- ☐ I understand that I may ask questions at any time regarding the risks and benefits and alternatives for any recommended treatment.

Signature of patient, parent or guardian	Date	Relationship to Patient
Signature of guarantor of payment/responsible party	Date	Relationship to Patient