

Today's Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Please circle: F M Married Single Divorced  
Widowed

Birth Date: \_\_\_\_\_ SS No. \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email Address: \_\_\_\_\_

Home Phone No. \_\_\_\_\_

Work Phone No. \_\_\_\_\_

Cellular Phone No. \_\_\_\_\_

Emergency Contact Name & Phone Number?  
\_\_\_\_\_

Who may we thank for referring you to us?  
\_\_\_\_\_

**Responsible Party:** Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Relationship: \_\_\_\_\_

**Occupation:**  
\_\_\_\_\_

Here at Mclean Smiles we are committed to providing you with the best possible dental care. We do not treatment plan based on your insurance but your overall dental health.

Insurance Name: \_\_\_\_\_

Due to the many changes in insurance policies, it is no longer an easy task to interpret each individual policy.

Therefore, it is your responsibility to know your individual coverage. Failing to do so will result in you, the patient, being responsible for all costs incurred. Please remember that your insurance policy is between you and your insurance company, not between the insurance company and the dentist. If for any reason insurance does not pay in a reasonable time, payment will be expected from the patient. Most importantly, we are here to help in any way we can, and look forward to meeting your dental needs.

I understand and agree that regardless of my insurance coverage, I am ultimately responsible for the balance on my account.

Sign: \_\_\_\_\_

Date: \_\_\_\_\_

Welcome to Our Practice!

**Mc**cleanSmiles  


**ALLERGIES OR REACTION TO:**

Medication(s): \_\_\_\_\_ Latex: YES or NO

Other(s): \_\_\_\_\_

**PREMED REQUIRED? YES or NO Reason:** \_\_\_\_\_

**TAKING ANTICOAGULANTS (Blood thinners)? YES or NO Reason:** \_\_\_\_\_

**LIST ALL MEDICATIONS CURRENTLY USED (Prescription, over the counter and Herbal)**

MEDICATION	DOSAGE	FREQUENCY

**PAST AND CURRENT MEDICAL CONDITIONS (**

YES	NO	Under physician's care?	YES	NO	High Blood Pressure? BP:     /	YES	NO	Headaches?
		Hospitalization/Operations in the last 5 years?			Stomach:  Reflux? Ulcer?			Glaucoma?
		Head/neck/mouth injuries?			Artificial Joints?			Thyroid Disease?
		Women: Currently Pregnant?			History of Organ Transplant?			Alcohol/Chemical Dependency?
		Women: Currently Nursing?			Stroke?			Kidney Disease?
		Women: Oral Contraceptives?			Bleeding Problems			Dialysis?
		Heart trouble/Disease?			Hemophilia?			Eating Disorder?
		Rheumatic Fever?			Anemia?			Diabetes? Type: Controlled?
		Past use of Phenphen?			Leukemia?			Hepatitis?
		Heart Murmur?			Lung Disease?			AIDS/HIV Positive?
		Mitral Valves?			Emphysema?			Venereal Disease?
		Heart Surgery?			Shortness of Breath?			Fainting/Dizziness?
		Artificial Heart Valves?			Asthma?			Immunological Disease?
		Pacemaker?			Sleep Apnea?			Fibromyalgia?
		Indwelling Defibrillator?			Tuberculosis?			Autoimmune Disease?
		Cancer?			Radiation Treatment?			Arthritis or other joint disorders?

Yes	No	Chemotherapy?	Yes	No	Sinus Trouble?	Yes	No	Cerebral Palsy?
		Depression?			Psychiatric Disorders?			Neurologic Disease?
		Convulsions			Epilepsy/Seizures?			Not Listed:

Physician: \_\_\_\_\_ Phone No. \_\_\_\_\_

Date of Last Physical Exam: \_\_\_\_\_ Year of Last Blood Test: \_\_\_\_\_

Previous Dentist: \_\_\_\_\_ Number: \_\_\_\_\_ Last Visit: \_\_\_\_\_

**DENTAL HISTORY**

YES	NO	Fillings in the last 3yrs?	YES	NO	Have you had orthodontics (braces)?
		Family history of extensive decay?			Have you had oral surgery?
		If child, mother's history of decay?			Any dental implants places?
		Tx for periodontal (gum) disease?			Tx for temporomandibular disorders?
		History of periodontal disease?			Wear partial(s) or denture(s)?
		Dry mouth/excessive thirst?			Difficulty chewing?
		Sensitive Teeth? Hot/Cold			Food catches between teeth?
		Mouth odors/bad taste?			Teeth/filling breaks frequently?
		Cold sores/blisters/oral lesions?			Clenching or grinding habits?
		Aware of any swelling or lumps?			Jaw popping, clicking or snapping?
		Sore, bleeding gums?			Do you have jaw pain?
		Loose teeth?			Are you nervous about dental work?

**Health Insurance Portability and Accountability Act (HIPAA)**

I understand that I have the certain rights to privacy regarding my protected health information. Rights are giving to me under the Health Insurance Portability and Accountability Act of 1996(HIPAA). I understand that by signing this consent I authorize Mclean Smiles to 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 our 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 may revoke this consent, in writing at any time. However, any disclosure that occurred prior to the date I revoke this consent is not affected.

### **FINANCIAL POLICY**

Our Mission is to deliver the best and most comprehensive dental care available. An important part of our mission is making the cost of optimal care as easy and manageable for our patients as possible by offering payment options like the following;

- **Pay in Full**

1. Cash, Check or Credit (MC, Visa, Amex, Discover Accepted)

- **Care Credit**

1. Allows you to pay overtime with NO interest
2. Convenient, low monthly payment plans

- **Dental Insurance**

1. As a courtesy we will directly bill insurance companies for reimbursement
2. You will be responsible for any and all copayments/coinsurance .
3. A **1% late fee** will be charged on all balances over 30 days once insurance has paid.

**Mclean Smiles charges \$25 for returned checks.**

### **MISSED APPOINTMENT POLICY**

\*\*\*\*\*We will not tolerate frequent cancellations or constant short-notice changes. A \$60.00 charge will be made for failed cancelled appointment without prior notification of 24 hours. Patients booked for 1.5 hours or more, will be responsible for 50 percent of their copay upon making their appointment.

**Print Name:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_