Chart #: ___________
FOR OFFICE USE ONLY

Patient Information

Patient Name: ____ Date: __________
Last, First MI (Preferred Name)

Birth Date: ___________ Gender: _____ Family Status: _________ Social Security # ______________

E-mail: ______________________________ Best time to call: ____________________

Phone (Home): ___________ (Work): ___________ Ext _______ (Cell): ______________

Preferred appointment times: ☐ Morning ☐ Afternoon ☐ Any Time ☐M ☐T ☐W ☐T ☐F ☐S

Address: ____
Street Apartment #

____
City State Zip Code

Health Information

Date of Last Dental Visit: _______________ Reason for this visit: ____________________

Have you ever had any of the following? Please check those that apply:

☐ AIDS/ HIV
☐ Allergies/ Hives
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Angina Pectoris
☐ Blood Disease
☐ Cancer
☐ Diabetes
☐ Dizziness
☐ Epilepsy/ Seizures
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Growths
☐ Hay Fever
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis A / B / C
☐ High Blood Pressure
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Pacemaker
☐ **Pregnancy**
Due date: _________
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ Tuberculosis (TB)
☐ Tumors
☐ Ulcers
☐ Anesthetic Allergy
☐ Codeine Allergy
☐ Latex Allergy
☐ Penicillin Allergy
☐ Sulfa Allergy
OTHER:
☐ ______________
☐ ______________
☐ ______________

- Have you ever had any complications during or following dental treatment? ☐ Yes ☐ No
  If yes, please explain: ____
- Are you having pain or discomfort at this time? ☐ Yes ☐ No
  If yes, please explain: ____
- Have you had a bad experience in the dental office? ☐ Yes ☐ No
  If yes, please explain: ____
- Have you been admitted to a hospital or needed emergency care or had any major surgeries, injuries or illnesses in the past two years? ☐ Yes ☐ No
  If yes, please explain: ____
- Are you currently taking medications? ☐ Yes ☐ No
- Are you allergic or made sick by any medication ☐ Yes ☐ No
  If yes, please explain: ____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: ____
- Name of Physician: ______________________________ Phone: ______________
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: ____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

______________________________ ______________ ______________________________
Signature of patient, parent or guardian Date Signature of Dentist

Dental History

- Do you floss and brush daily? ☐ Yes ☐ No
- Do your gums bleed when you brush? ☐ Yes ☐ No
- Have you ever been diagnosed with periodontal (gum) disease? ☐ Yes ☐ No
- Are your teeth sensitive to hot or cold? ☐ Yes ☐ No
- Do you have TMJ, pain or clicking when opening or closing your jaw? ☐ Yes ☐ No
- Do you clench or grind your teeth? ☐ Yes ☐ No
- Are you aware of any lumps or swelling in your mouth? ☐ Yes ☐ No
- Have you ever had orthodontic treatment (braces)? ☐ Yes ☐ No
- Are you happy with your smile? ☐ Yes ☐ No
- Do you take any herbal remedies (ginkgo biloba) or dietary supplements or alternative medicines? ☐ Yes ☐ No

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other ____________________

Name of person or office referring you to our practice: ____________________________________

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: ____________________________________

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other ____________

Social Security #: ______________________ Birth Date: ______________________

Phone (Home): ____________ (Work): ____________ Ext: ______ Best time to call: ____________

Address: ____________________________________
Street Apartment #

____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: ____________________________________

____________________________________ Occupation: ______________________

Address: ____________________________________
Street City. State Zip Code Phone

Insurance Information

Primary

Name of Insured: ____________________________________

Insured's Birth Date: ______________ ID #: ______________ Group #: ____

Insured's Address: ____________________________________
Street City State Zip Code

Insured's Employer Name: ____________________________________

Address: ____________________________________
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other ______________

Insurance Plan Name and Address: ____________________________________

____

Secondary

Name of Insured: ____________________________________

Insured's Birth Date: ______________ ID #: ______________ Group #: ______________

Insured's Address: ____________________________________
Street City State Zip Code

Insured's Employer Name: ____________________________________

Address: ____________________________________
Street City State Zip Code

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

In regard to release of information:

I authorize the dentist and staff to release any information including diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or other health practitioners. I authorize and request payment directly to Michael S. McKay, DMD, or his successors or assigns.

In regard to dental treatment and insurance:

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office is not responsible to know the limits of your dental contract and cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1 1/2% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding ninety (90) days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of three (3) months from the date of last examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assigner, at the time said services are rendered, or within thirty(30) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed within the time for payment thereof. I further agree that a waiver of any breach of any time or condition here under shall not constitute a waiver of any further term or condition and I further agree if my account becomes past due I agree to pay all costs of collection, including reasonable attorney fees if suit be instituted here under.

In regard to broken or canceled appointments: I understand and agree to the following:

I understand that a specific time was set aside for my scheduled appointment. Accordingly I agree to show up for my appointments. If for any reason I fail to show up or cancel my dental appointment without giving a reasonable time I will be charged.

If I must cancel or reschedule, I agree to give twenty-four (24) hours notice or a minimum of five (5) business hours.

(Hours Mon, Wed, Fri. 8:00 am - 5pm & Tues. 8:00am -6:00 pm) If I fail to do so I agree to pay a fee of a minimum of at least $50.00 for each broken or canceled appointment.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

________________________________ Date:__________ Relationship to Patient: _________

Signature of responsible party, parent or guardian

HIPAA PRIVACY FORM

Michael S McKay DMD MAGD

Acknowledgement of Receipt of Notice of Privacy Practices

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

****You may refuse to sign this acknowledgement****

I, ______________________________, have received a copy/explanation of this office's Notice of Privacy Practices.

____

{Signature of Patient and/or Guardian} {Date}__________________

(Relationship to Patient} Self or Other: ________________________

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers (such as a language barrier) prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgement at time of service
- ☐ Other (Please specify)

____