# McCartney Dental

Welcome to our office. We appreciate the confidence you place with us to provide your dental services. Please complete the form below, this information is important to your dental health. If there have been any changes in your health please let us know. Please let us know if you have any questions.

Patient Name: _____ DOB: _____ Sex: _____

Florida Address: _____ City: _____ State: _____ Zip: _____

Northern Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

E-Mail: (Please Print) _____

SS #: _____ Employer: _____

Spouse's Name: _____ Spouse's Phone Number: _____

Primary Dental Insurance: _____ Member#_____ Phone #_____

Subscriber's Name: _____ DOB: _____ SS #: _____

Name of medical doctor: _____ Date of last physical: _____

Name of previous dentist: _____ Date of last dental visit: _____

How did you hear about us: Website Insurance Advertisement Facebook Friend: _____

Other: _____ (name)

Pharmacy/location: _____ Pharmacy Phone Number: _____

Patient/Parent Signature: _____ Date: _____

# Dental Health History

**Patient Name: _____ Date: _____**

(Please Circle Yes or No)

| | | | | | |
|---|---|---|---|---|---|
| Do you gag easily? | Y | N | Do you want complete dental care? | Y | N |
| Do you wear Dentures? | Y | N | Are you dissatisfied with the appearance of your teeth? | Y | N |
| Does food catch between your teeth? | Y | N | Do you experience any clicking, popping, or pain in jaw? | Y | N |
| Do you have difficulty chewing food? | Y | N | How often do you brush? _____ | | |
| Do you prefer to save your teeth? | Y | N | | | |
| Do your gums bleed easily? | Y | N | | | |
| Do your gums bleed when you floss? | Y | N | How often do you floss? _____ | | |
| Are your gums swollen or tender? | Y | N | Have you been told that you have gum disease? | Y | N |
| Are your teeth sensitive? | Y | N | | | |

# Medical Health History

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Chest Pain? | Y | N | Shortness of breath? | Y | N | Blood pressure problem? | Y | N |
| Heart murmur? | Y | N | Artificial heart valve? | Y | N | Taking heart medication? | Y | N |
| Rheumatic fever? | Y | N | Pacemaker? | Y | N | Easy bruising? | Y | N |
| Abnormal bleeding? | Y | N | Blood disease (anemia)? | Y | N | Had blood transfusion? | Y | N |
| Hay fever? | Y | N | Sinus problems? | Y | N | Skin rashes? | Y | N |
| Taking allergy medication? | Y | N | Asthma? | Y | N | Ulcers? | Y | N |
| Weight gain or loss? | Y | N | Special Diet? | Y | N | Constipation/ Diarrhea? | Y | N |
| Kidney or bladder problems? | Y | N | Arthritis? | Y | N | Back or neck pain? | Y | N |
| Joint replacement? | Y | N | Seizures or epilepsy? | Y | N | Stroke(s)? | Y | N |
| Frequent or severe headaches? | Y | N | Thyroid problems? | Y | N | Coughing/swollen glands? | Y | N |
| Cancer/Tumor? | Y | N | Diabetes? | Y | N | Hepatitis or liver trouble? | Y | N |
| Herpes or other STD? | Y | N | HIV-positive/AIDS? | Y | N | Glaucoma? | Y | N |
| History of head injury? | Y | N | Pregnant? | Y | N | Smoker? | Y | N |
| Tuberculosis/respiratory disease? | Y | N | | | | (If yes, how much?)_____ | | |

**Have you been told to Premedicate for dental treatment Y N**

**Do you have any disease, condition, or problem not listed above that you feel we should know about?**

_____

**Patient Name:**_____ **Date:** _____

**Please check any of the following that you are allergic to or had an adverse reaction**

- Local Anesthetics ("Novocain")
  - Sulfa Drugs
  - Aspirin
  - Acetaminophen, Demerol, or pain medication
  - Reaction to metals
  - Codeine
  - Penicillin
  - Other antibiotics
  - Barbiturates, sedatives, or sleeping pills
  - Latex or rubber dam

If yes, please supply name of medications:

_____

_____

_____

_____

Please list any allergies not listed:

_____

_____

_____

**During the past twelve months have you taken any of the following? (Please Circle Yes or No)**

| | | | | | |
|---|---|---|---|---|---|
| Antibiotics or sulfa drugs | Y | N | Anticoagulants (e.g. Coumadin) | Y | N |
| High blood pressure medicine | Y | N | Insulin, Orinase, etc. | Y | N |
| Aspirin | Y | N | Digitalis or drugs for heart trouble | Y | N |
| Nitroglycerin | Y | N | Cortisone (steroids) | Y | N |
| Natural remedies | Y | N | Nonprescription drugs/supplement | Y | N |
| Are you taking contraceptives? | Y | N | Are you pregnant? | Y | N |

**List all medications you are currently taking:**

_____

_____

_____

_____

_____

_____

Patient/Parent Signature: _____ Date: _____

Doctor Signature: _____

## MISSED APPOINTMENT POLICY

We have reserved this time especially for you. Therefore, we require confirmation of this appointment 48 hours in advance. If confirmation is not received, you may forfeit this appointment. Please feel free to contact our office after hours via voicemail, email or through our website if you are not able to call during regular business hours. We also request at least 48 hour notice in order to cancel or reschedule your appointment. This will enable us to offer your canceled time to another patient.

If you cancel less than 48 hours before or fail to come to your scheduled appointment, you will be charged a $50, per scheduled hour. A missed appointment fee will be applied and a deposit may be required to reschedule. A third missed appointment may also result in dismissal from our practice.

Our office staff will also attempt to reach you to confirm this appointment through text, email, and by phone as a courtesy, but responsibility of managing your appointment is ultimately your responsibility.

## APPOINTMENT POLICY

A non-refundable deposit may be required for any appointments that are over 1 hour. This deposit amount will be applied toward your treatment copay for that particular visit. Any cancellation less than 5 business days will deem the deposit non-refundable and not applicable toward any treatment.

We understand there are times when 5 business days' notice is not possible. Emergency cancellations or missed appointments will be evaluated on an individual basis.

Patient Name: (Printed) _____

Patient/Parent Signature: _____ Date: _____

# Authorization and Consent to Send Unencrypted Patient Information by Email and Other Electronic Means

Until I tell you in writing to stop, I authorize McCartney Dental to transmit patient information relating to my treatment, health, or payment by email or other electronic means, without encryption or special security precautions, to me or someone I designate, or to other healthcare providers, dental plans, and others involved in my treatment, payment for my treatment, or McCartney Dental's dental care operations The patient information that may be emailed may include my x-rays, health history, diagnosis, treatment, and payment record.

I understand that:

- I do not have to sign this form
- My treatment, payment, enrollment and eligibility for benefits will not be affected by my decision about signing this form.
- If I don't sign this form, McCartney Dental may use other ways to send my information, such as U.S. Mail, or may ask me to send my information to third parties myself.
- There is some risk that emails and other electronic messages may be improperly acquired by hackers or received by unintended recipients. If that happens, the information may be redisclosed and no longer protected by privacy law.
- McCartney Dental does not email such sensitive personal information as social security number, credit card number, mental health diagnosis, genetic information, alcohol/substance abuse, or positive HIV status unless the patient insists.

I can tell you in writing to stop emailing my patient information at any time, but to do so, this will not stop affect emails that McCartney Dental already sent before receiving my written instructions to stop.

Patient name (please print):_____

Patient/Parent Signature: _____Date:_____

# EXAMINATION CONSENT FORM

Comprehensive Examination: As the standard of care for this practice, a new patient appointment will consist of the following: a current panoramic radiograph with four bitewing radiographs OR a full mouth series of x-rays; comprehensive examination; full mouth periodontal evaluation. In addition, other diagnostic tests may be necessary, including but not limited to, intra-oral pictures and additional radiographs. I authorize Dr. Jonathan McCartney to perform any procedures or tests necessary to make a complete diagnosis of my dental needs.

X-rays and Photos: Modern dental x-ray equipment is extremely low-dose radiation. Diagnostic x-rays provide the dentist valuable information about your teeth and supporting bone that cannot be evaluated otherwise. Without these x-rays we cannot do a complete examination of the entire mouth and jaw.

If you would like to use x-rays from another dental office, they must be less than 2 years old, in our office the day of your examination and of diagnostic quality. Our preferred method of transfer is by email but if printed, they must be on photo paper and will be up to Dr. McCartney to determine quality. If films are not in office by appointment or of diagnostic quality we will need to retake films, which may not be covered by your dental plan, or reschedule your appointment.

I have been made aware of the office policy at McCartney regarding the comprehensive examination and x-rays any questions have been answered to my satisfaction.

_____

Patient (Printed) Date

_____

Patient/Parent (Signature) Date

# HIPAA FORM

## Keeping Your Personal Health Information Private

Home/daytime contact phone number: _____

May we leave a message with other residents? _____ Yes _____ No

May we leave a message on your home answering/voicemail? _____ Yes _____ No

**To whom may we talk to about your medical treatment?**

1. Name _____ Relationship _____

Home Phone No. _____ Cell No. _____

Other Phone No. _____

2. Name _____ Relationship _____

Home Phone No. _____ Cell No. _____

Other Phone No. _____

If any of the above information changes, it is the Patient/Parent/Legal Guardian's responsibility to contact our office.

I acknowledge that I was offered a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so choose) and understood the Notice.

**Printed Name:** _____

**Patient/Parent/Legal Guardian Signature** _____

# Financial Agreement

Our goal is to provide the highest quality of dental care possible and to have clear communication of our financial policy.

ALL ACCOUNTS ARE DUE AND PAYABLE AT TIME OF SERVICE unless prior arrangements have been made. If a procedure requires multiple appointments, payment is required, in full, at the first appointment. Treatment plans given are an ESTIMATE and not a guarantee of payment by your insurance company.

Payment options.

Cash, Check, Master Card, Visa, Discover, American Express, Care Credit

Patients with insurance: We participate with a number of dental plans that we will contact to verify eligibility and benefits, and we encourage you to call to obtain benefit information as well. Your insurance policy is a contract between you and your insurance company; we are not a party to that contract. We will submit claims to your insurance as a courtesy but regardless of benefits or coverage, you are responsible for any amount unpaid by your insurance. The PATIENT is responsible for the ESTIMATED non-covered portion, procedures and/or deductibles at the time of service. If the insurance company does not pay after 60 days, or underpays, we will bill you directly for the full balance.

Patients who PREPAY for treatment with a credit/debit card and request a refund, will be responsible for the finance charges incurred of refund amount.

I agree that should my account become delinquent, I will be responsible for all collection costs, including but not limited to the outstanding balance, attorney's fees, court costs, and collection agency fees.

Parents accompanying their children are financially responsible for payment at time of service.

Missed Appointments: We request at least 48 hour notice of cancellation, as a courtesy to the doctor, staff and other patients.

There is a $30.00 processing charge for non-sufficient funds or returned checks.

Financially Responsible Party: (Print Name): _____

Responsible Party Signature_____ Date_____