PATIENT YEARLY INFORMATION UPDATE

It is important that we have accurate information. Please fill out medical history, medications, address, phone number, and insurance

PATIENT NAME: _____ DATE: _____

DATE OF BIRTH: _____

PERSONAL INFORMATION

ADDRESS: _____ CITY: _____ STATE: _____

ZIP: _____ HOME PHONE: _____ CELL PHONE: _____

Email address: _____

INSURANCE

DENTAL INSURANCE COMPANY: _____

Subscriber Name: _____ Date of Birth: _____

Member ID: _____ Group number: _____

MEDICAL

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING

MEDICATIONS: _____

_____

_____

PRIMARY PHYSICIAN: _____ PHONE: _____

MEDICAL HEALTH HISTORY

PLEASE CHECK ALL THAT APPLY

[ ] Chest Pain?
[ ] Heart murmur?
[ ] Rheumatic fever?
[ ] Abnormal bleeding?
[ ] Hay fever?
[ ] Taking allergy medication?
[ ] Weight gain or loss?
[ ] Kidney or bladder problems?
[ ] Joint replacement? Date_____
[ ] Frequent or severe headaches?
[ ] Cancer/Tumor?
[ ] Herpes or other STD?
[ ] History of head injury?
[ ] Tuberculosis/respiratory disease?
[ ] History of alcohol or drug abuse?

[ ] Shortness of breath?
[ ] Artificial heart valve?
[ ] Pacemaker?
[ ] Blood disease (anemia)?
[ ] Sinus problems?
[ ] Asthma?
[ ] Special Diet?
[ ] Arthritis?
[ ] Seizures or epilepsy?
[ ] Thyroid problems?
[ ] Diabetes?
[ ] HIV-positive/AIDS?
[ ] Epilepsy?

[ ] Blood pressure problem?
[ ] Heart Condition?
[ ] Easy bruising?
[ ] Had blood transfusion?
[ ] Skin rashes?
[ ] Ulcers?
[ ] Constipation/ Diarrhea?
[ ] Back or neck pain?
[ ] Stroke(s)?
[ ] Coughing/swollen glands?
[ ] Hepatitis or liver trouble?
[ ] Glaucoma?
[ ] Smoker?
(If yes, how often?)_____

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

_____

_____

DO YOU REQUIRE PRE-MEDICATION PRIOR TO DENTAL TREATMENT? YES / NO

IF YES- MEDICATION NAME/DOSE: _____

ALLERGIES: (CHECK ALL THAT APPLY)

[ ] ANESTHETICS
[ ] METALS
[ ] MEDICATIONS: (PLEASE LIST)
[ ] LATEX

_____

_____

PATIENT SIGNATURE: _____ Date: _____

DENTIST 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 do not 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):_____

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 (Signature) Date

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 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: _____