Patient Information

Who may we thank for referring you? □ Another Patient _____ □ Dental Office

□ Yellow Pages □ Newspaper □ School □ Work □ Other _____

Preferred Pharmacy: _____ **Pharmacy Phone:** _____

Patient Name: _____ _____

First Name Middle Initial Last Name Preferred Name

Gender: □ Female □ Male **Family Status:** □ Married □ Single □ Divorced □ Child □ Widowed

Address: _____

Home Phone: _____ **Cellular Phone:** _____

Birth Date: _____ **Soc. Sec#** _____ **Email:** _____

Work Phone: _____ **Occupation:** _____

Employer Name: _____ **Address:** _____

Next of Kin: _____ **Contact #** _____

Responsible Party Information if not same as Patient

Responsible Party: □ Patient □ Other _____

Responsible Party Name: _____ _____

(If different than patient) First Name Middle Initial Last Name Preferred Name

Gender: □ Female □ Male **Family Status:** □ Married □ Single □ Divorced □ Child □ Widowed

Address: _____

Home Phone: _____ **Work Phone:** _____ **Ext:** _____

Birth Date: _____ **Soc. Sec#** _____ **Email:** _____

Employer Name _____ **Occupation:** _____

Insurance Information

Is Insured the: □ Patient □ Responsible Party □ Other _____ **Group #** _____

Name of Insured: _____ _____

First Name Middle Initial Last Name **Employee Insurance ID #**

Gender: M F **Birth Date:** _____ **Soc. Sec#** _____ **Home Phone:** _____

Home Address: _____

Employer Name: _____ **Emp. Phone:** _____

Insurance Co. Name: _____ **Phone:** _____

Ins. Co. Address: _____

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 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 the services are performed.

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 patient 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 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 60 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 six months from the date of the patient 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 her assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home, via cell phone, or at my work to discuss matters related to this form. I have read the above conditions of treatment and agree to their content.

X_____ **Date:** _____ **Relationship to Patient:**_____

Signature of patient, parent or guardian

Additional Medications Information

The medications listed below can potentially cause serious complications if mixed with some medications used in the dental office. Please read and answer carefully

Actonel ____ Yes ____ No Boniva ____ Yes ____ No Fosamax of Alendronate Sodium as Generic ____ Yes ____ No

Viagra ____ Yes ____ No Cialis ____ Yes ____ No Levitra ____ Yes ____ No

Have you had Reclast or Zometa by IV in the last year? _____ Have you ever had a **MRSA** staph infection? _____

Please list all Medications that you take:

_____

_____

_____

May we contact your pharmacy for your medication list or additional information regarding the medications you are taking?

____ Yes ____ No If yes, please list pharmacy name and phone number: _____

Patient Signature: _____ Date: _____

Financial Policy Information

We do accept Cash, Check, Visa, MasterCard, Discover and American Express

We also offer Third Party Financing with CareCredit; please ask for assistance or apply online at www.carecredit.com

Payment is due at the time of service unless other arrangements have been made.

A service charge of 1 1/2% per month of unpaid balances will be charged on all accounts exceeding 60 days.

Please note:

For larger, more comprehensive treatment plans of $1,000 or more, we ask for a deposit of $500 prior to scheduling the first treatment appointment.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment. **However, if we do not receive payment from your insurance carrier within 60 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.*

A fee of $100 is charged for patients who miss or cancel more than two times in a calendar year without 48-hour notice.

Dr. Leanne L. McDonald charges $30 for returned checks.

Consent for Services

I understand that the fees listed for this dental care can only be extended for a period of six months from the date of examination. In consideration of 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 the assignee, at the time said services are rendered. I further agree that the said services shall be billed unless objected to by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any condition hereunder shall constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

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

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

Patient or Guardian Signature _____ Date _____

Leanne McDonald, DMD

MEDICAL HISTORY

Patient Name: _____ Date of Birth: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

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: _____
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please complete our Additional Medications Information form
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____
Are you on a special diet? ◯ Yes ◯ No _____
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you

Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics

☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pace Maker ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No	Yellow Jaundice ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No	

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

Comments: _____

_____

_____

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

GENERAL PHOTO RELEASE

I hereby grant to: Dr. Leanne McDonald and to any of their assigns, the absolute and irrevocable right and permission, with respect to the photographs taken of me, or in which I may be included with others; to use, re-use, and/or publish the same in whole or in part, individually, or in conjunction with other photographs, without limitation or perpetuity. These photographs shall be used specifically and exclusively for the purpose of dental education and or patient education.

I hereby release and discharge: Dr. Leanne McDonald and assigns, from any and all claims and demands arising out of or in connection with the use of the photographs, including any and all claims for libel.

Signed at _____ this day of _____, 20___.

_____
Legal Signature

_____
Name (please print)

_____
Full Address

I, the undersigned, hereby state that I am the (mother, father or guardian)_____ of the above named individual and do hereby consent and give permission to this agreement.

_____
Legal Signature

_____
Date

_____
Name (please print)