McKinney Smiles

PATIENT INFORMATION

So that we may give you the best care, please complete the patient information, medical history, and dental history. If you have any questions regarding these forms, we will be glad to help.

Referred by:_____

Patient Name (Mr. Mrs. Miss. Ms. Dr.):_____

Birth Date:_____ Age:_____ Sex:_____ Marital Status:_____

If Married, Spouse's Name:_____

Address:_____
Number Street City/State Zip Code

Home/Cell Phone:_____ Business Phone:_____

Social Security Number:_____ Employer:_____

Email:_____

Person Responsible for Payment (If Other Than Above)

Name:_____ Relationship to Patient:_____

Address:_____
Number Street City/State Zip Code

Home/Cell Phone:_____ Business Phone:_____

Social Security Number:_____ Employer:_____

Email:_____

CONSENT FOR TREATMENT

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluation and administering claims for insurance benefits.

I authorize release of any information my (or my child's) health care, advice and treatment to another dentist.

I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.

I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services I understand I am financially responsible for payments in full of all accounts over sixty days. By signing this statement, I revoke all previous agreements to the Contrary and agree to be responsible for payment of services not paid, in whole or in part by my dental care payor.

I attest to the accuracy of the information on this page.

Signature:_____ Date:_____
(Patient/Guardian)

McKinney Smiles

Medical History

Patient Name:_____ Date of Birth _____

Physicians Name:_____ Physician's Phone:_____

1. Are you seeing any specialists?.....Yes No

If yes, specialist's name and reason:_____

2. Have you been a patient in the hospital during the past five years? .....Yes No

If yes, for what? _____

_____

3. Are you taking any medication, drugs or pills now? .....Yes No

If yes, please list name and dosage:_____

_____

4. Are you aware of having an allergic (or adverse reaction) to any medication or substance?.....Yes No

If yes, please list:_____

5. Indicate which of the following you have, had or have at present.

- □ Heart Surgery/Disease/Attack
- □ Chest Pain
- □ Congenital Heart Disease
- □ Heart Murmur
- □ High Blood Pressure
- □ Mitral Valve Prolapse
- □ Artificial Heart Valve
- □ Heart Pace Maker
- □ Rheumatic Fever
- □ Arthritis/Rheumatism
- □ Cortisone Medicine
- □ Swollen Ankles
- □ Stroke
- □ Diet (Special/Restricted)
- □ Artificial Joints (Hip/Knee/Etc)
- □ Kidney Trouble
- □ Ulcers
- □ Diabetes
- □ Thyroid Problems
- □ Glaucoma
- □ Contact Lenses
- □ Emphysema
- □ Chronic Cough
- □ Tuberculosis
- □ Asthma
- □ Hay Fever
- □ Latex Sensitivity
- □ Allergies or Hives
- □ Sinus Trouble
- □ Radiation Therapy
- □ Chemotherapy
- □ Tumors
- □ Hepatitis A/Infectious B/Serum
- □ Venereal Disease
- □ A.I.D.S.
- □ H.I.V. Positive
- □ Cold Sores/Fever Blisters
- □ Blood Transfusions
- □ Hemophilia
- □ Sickle Cell Disease
- □ Bruise Easily
- □ Liver Disease
- □ Yellow Jaundice
- □ Neurological Disorders
- □ Epilepsy or Seizures
- □ Nervous/Anxious
- □ Fainting or Dizzy Spells
- □ Psychiatric/Psychological

6. Do you have or have you had any disease, condition or problem not listed.....Yes No

If yes, please list:_____

7. Woman: Are you, Pregnant? Yes No If yes,_____months Nursing? Yes No Taking Birth Control Pills? Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient/Guardian Signature:_____ Date:_____

McKinney Smiles

HIPAA Acknowledge and Confidential Communication Agreement

Name of Patient: _____

I acknowledge that a copy of the current notice is posted in the reception area, and that I can request a copy of any amended Notice of Privacy Practices at each appointment.

Signed: _____ Date: _____

Print Name: _____ Phone: _____

If not signed by the patient, please indicate relationship:

___ Parent or guardian of minor patient

___ Guardian or conservator of an incompetent patient

___ Beneficiary of personal representative of deceased patient

List the family members or other persons, if any, with whom we may discuss your dental treatment and/or your diagnosis or in case of emergency:

Name: _____ Phone: _____

Name: _____ Phone: _____

List the email address where we may send your private health information to:

_____

Print the phone numbers where you want to receive calls about appointments, billing and insurance inquiries, or dental care questions: _____

May we send text messages to this number? Yes____ No____

May we leave a message or voice mail at this number? Yes____ No____

I understand that this agreement remains in effect until revoked by me in writing. I also understand and consent to McKinney Smiles sharing proceeds with associate and group dentists within McKinney Smiles as part of their arrangement in bringing me excellent dental care.

I also understand that there will be a $50.00 fee incurred on my account for any and all missed appointments without a prior 24 hour notice given.

Signature: _____ Date: _____

Print Name: _____