

Knowing your health history helps us plan for better dental health. Please let us know if you have any questions about this form or need any assistance.

Health History

Name of Physician _____ Physician's Phone _____

Please circle your response to the following questions

YES NO Are you currently under the care of a physician? If so, please explain:

-
- YES NO Have you ever taken antibiotics before dental treatment?
YES NO Are you taking a blood thinning medication?
YES NO Do you take cortisone or steroid medications?
YES NO Are you taking medicines for osteoporosis (i.e. Fosamax, Actonel, etc)

Are you allergic to any of the following?

Penicillin	Codeine	Aspirin	Sulfites/Wine
Acrylic	Metals	Latex	Local Anesthetics

Other Allergies: _____

Please mark the following health conditions as they apply to you:

- | | | |
|---|--|---|
| <input type="checkbox"/> Aids/HIV | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Excessive bleeding | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Fainting | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Food Allergies | <input type="checkbox"/> Rapid Weight +/- |
| <input type="checkbox"/> Arthritis/Rheumatic | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Respiratory Disorder |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Heart Disorders | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Back/Neck Surgery | <input type="checkbox"/> Headaches | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Blood Disorder | <input type="checkbox"/> Herpes | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Canker Sores | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Surgical Implant |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> TMJ |
| <input type="checkbox"/> Cold Sores | <input type="checkbox"/> MS | <input type="checkbox"/> Tobacco Habit |
| <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> MVP | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Nervous Disease | <input type="checkbox"/> Tumors |
| | | <input type="checkbox"/> Ulcers |
| | | <input type="checkbox"/> Venereal Disease |

Pregnant? (Women only) _____ Due date: _____ Are you currently nursing? _____

Have you ever had any serious illness or operation not listed above? Y N If yes, please explain:

McAfee Dental

Financial Agreement

At **McAfee Dental**, our team is dedicated to making your treatment as comfortable and affordable as possible. We believe nothing should stand between you and the smile you want and deserve. Our team is committed to finding affordable payment options that fit you and your lifestyle.

McAfee Dental accepts the following forms of payment for our services:

- Cash
- Check
- Credit Card (VISA, Master Card, Discover)
- Debit Card
- Third Party Payment Plans

Besides these various payment agreements, you can also plan treatment to help it fit into your budget. If you have questions about any of these options, feel free to ask. We believe in being open and up front about our fees, treatment options, and payment arrangements.

Insurance Assignment: We understand the value of insurance benefits and we will assist you in obtaining your maximum allowance.

As a courtesy, we will process your claim and ESTIMATE your co-payment amounts based on the insurance breakdown quoted to us. Although we may estimate your insurance benefits, knowledge of benefits as well as benefit amounts, limitations, exclusions, waiting periods, etc. is entirely your responsibility. Receiving our services indicated your acceptance of responsibility to pay regardless of our estimate. Your insurance policy is a contract between you, your employer and the insurance company. We are not a party to that contract. Our relationship is with you and not your insurance company.

Co-payments are due at the time of service. The final payment made by the insurance company may be different from the original estimate; any overpayment will be refunded or credited to your account, and any underpayment will be billed directly to you.

McAfee Dental

Office Appointment Agreement

We, at McAfee Dental, value our patients' time, and therefore do everything possible to see our patients at their scheduled appointment times.

We will make every effort to accommodate you and your scheduling needs. For that reason, we ask that you give us at least two business-days notice, should you need to change or cancel an appointment you had previously asked us to reserve. This courtesy allows us to practice more efficiently by allowing another patient to have that appointment time. It also allows us to keep our fees as low as possible.

Dental appointments are in high demand, and if you reschedule in a timely manner it will allow us to give another patient the opportunity to have access to timely dental care. If a shorter notice is given, and your reserved time goes unused, you may be charged for the value of the time lost to the practice, usually the fee for the scheduled procedure that you missed.

It is our goal to provide the highest quality dental care possible to our patients in a comfortable and convenient fashion. Thank you for your understanding and your cooperation.

McAfee Dental

NOTICE OF PRIVACY PRACTICE

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

THIS PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect ___/___/___, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For information about our privacy practices, or for additional copies of the Notice, please contact us using the information list at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example :

TREATMENT: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

PAYMENT: We may use and disclose your health information to obtain payment for services we provide to you.

HEALTHCARE OPERATIONS: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, renewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

YOUR AUTHORIZATION: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

TO YOUR FAMILY AND FRIENDS: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

PERSON INVOLVED IN CARE: We may use or disclose health information to notify, or assist in the notification of (including identify or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstance, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your care or inferences of your best interest in allowing a person to pick up filled prescription, medical supplies, x-rays, or other similar forms of health information.

MARKETING HEALTH-RELATED SERVICES: We will not use health information for marketing communications without your written authorization.

REQUIRED BY LAW: We may use or disclose your health information when we are required to do so by law.

ABUSE OR NEGLECT: We may use or disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert threat to your or safety or the health or safety of others.

NATIONAL SECURITY: We may disclose to military authorizes health information of Armed Forces personnel under certain circumstance. We may disclose to authorize federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

APPOINTMENT REMINDERS: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters)

PATIENT RIGHTS

ACCESS: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provided copies in format other than photocopies we will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time, You may also request access by sending us a letter to the address at the end of the Notice, If you request copies, we will charge you \$0___ for each page, \$___ per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full of our fee structure.

DISCLOSURE ACCOUNTING: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional request.

RESTRICTION: You have the right to receive a list of instances in which we or our business associates disclosed your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

ALTERNATIVE COMMUNICATION: You have the right to request that we communicate with you about your health information by alternative means or alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

AMENDMENT: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

ELECTRONIC NOTICE: If you receive this Notice on our website or by electronic mail (e-mail), you are entitled to receive

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or has questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you made by alternative means or at alternative locations, you may complain to using the contact information listed at the end of this Notice. You also may submit a written complaint to the U, S, and Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: _____

McAfee Dental

Please initial the following spaces and sign below to ensure the best quality
service possible

I understand, and agree to the conditions outlined in the following
documents:

___ **Financial Agreement.**

___ **Appointment Policy.**

___ **Notice of Privacy Practices**

I consent to the use and disclosure of my health information to carry out treatment, payment activities, and health care operations as set forth in our Privacy Practices Notice. I understand that I have a right to revoke consent at any time by giving a written notice.

Patient/ParentSignature _____ Date _____