MCAFEE DENTAL

Patient Registration

TODAY'S DATE__________

Patient's Name		**Birthdate**	**Age**	**Sex: M F**
Home Address	**City**	**State**	**Zip**	
Home Phone Number	***Please Circle One:*** Single, Married, Separated, Widow		**Your Soc Sec. #**	
Your Employer	**Occupation**		**Work Phone #**	

Are you a full time student? ☐Yes ☐No

If patient is minor we need: *Mother's Name & Birthdate* *Father's Name & Birthdate*

Person responsible for account **YOUR Driver's License Number**

Name of spouse (or parent if minor) **YOUR E-mail address** **YOUR cell phone #**

Spouse's (or parent's) employer **Spouse's Soc. Sec. #** **Work phone #**

EMERGENCY INFORMATION

Name, Address, & Telephone of
A relative not living with you:

How did you hear about our office?

Reason for this visit ?

DENTAL INSURANCE INFORMATION (Primary Carrier)			**If you have a dual insurance coverage, complete this for the second coverage (this office bills primary ins only)**		
Insured's name	**DOB**	**SS#**	Insured's name	DOB	SS#
Insured's employer			Insured's employer		
Insurance Co			Insurance Co		
Insurance Co Address			Insurance Co Address		
Phone #			Phone #		
Group #	**Policy #**		Group #		Local #

Is there any other medical or dental information we should know about?

Patient Signature (or Parent of Child) **Date** **Dentist's Signature**

DENTAL HISTORY

Please check any of the following that apply to you:

- -Sensitivity (hot, cold, sweet) ☐
  Where? UR LR UL LL
- -Headaches, ear aches, neck or jaw joint pain ☐
- -Mouth ulcers or cold sores ☐
- -Teeth or fillings breaking ☐
- -Grinding or clenching teeth ☐
- -Bleeding, swollen or irritated gums ☐
- -Loose, tipped or shifting teeth ☐
- -Bad breath ☐

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

- -Dentures ☐
- -Partial dentures ☐
- -Braces ☐
- -Gum treatments ☐

Please share the following dates:

- -Your last cleaning ___ / ___
- -Your last oral cancer screening ___ / ___
- -Your last complete X-Rays ___ / ___

Name of Previous Dentist ____________________

City ____________________ **State** ________

Phone Number ____________________

What is the most important thing to you about your future smile and dental health? ____________________

If you could whiten your teeth for a cost anyone could afford, would you do it? ☐

Do you smoke or use chewing tobacco? ☐

How much? For how long?

If I could change my smile, I would: ☐

- -Make my teeth whiter ☐
- -Make my teeth straighter ☐
- -Close spaces ☐
- -Replace metal fillings with tooth colored restorations ☐
- -Repair chipped teeth ☐
- -Replace missing teeth ☐
- -Replace old crowns that don't match ☐
- -Have a smile makeover ☐

On a scale of 1 – 10, with 10 being the highest rating:

-How important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

-Where would you rate your current dental health?

1 2 3 4 5 6 7 8 9 10

Why did you leave your previous dentist?

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What is the most important thing to you about your dental visit today? ____________________

MEDICAL HISTORY

Please check any of the following that apply to you:

☐ Allergies (Seasonal)
☐ Anemia
☐ Artificial Heart Valve
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Bruise Easily
☐ Cancer
☐ Chemotherapy
☐ Diabetes
☐ Dizziness/Fainting
☐ Drug Addiction
☐ Emphysema
☐ Excessive Bleeding
☐ Glaucoma
☐ Heart Conditions
☐ Heart Murmur
☐ Hepatitis A
☐ Hepatitis B
☐ Hepatitis C
☐ High Blood Pressure
☐ HIV/AIDS
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Mitral Valve Prolapse
☐ Nervousness/Depression
☐ Pacemaker
☐ Phen Fen (1 month +)
☐ Radiation (head/neck)
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Scarlet Fever
☐ Seizures
☐ Stomach Problems
☐ Stroke
☐ Thyroid Disease
☐ Tuberculosis
☐ Ulcers
☐ OTHER (please list):

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For WOMEN Only

- ❑ Birth Control Pills
- ❑ Breast-feeding
- ❑ Pregnant

1-3 mos,3-6 mos,6-9mos,

Do you have an allergy to any of the following?

☐ Aspirin
☐ Erythromycin
☐ Latex
☐ Local Anesthetic
☐ Nitrous Oxide
☐ Penicillin
☐ Codeine
☐ Other:

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What medications are you currently taking?

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Are you under a physician's care? For what?

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Family Physician ____________________ **Phone Number** ____________________

Medications: Please list below any medications you are taking, either prescription or non prescription.

Drug	Reason for taking	For office use only

*Signature____Date____________

*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 charges in medical status.

*Signature(parent or guardian)______________________________Date____________

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. We accept the following forms of payment for our services:

- Cash
- Check
- Credit Card/Debit (VISA, Master Card, Discover)
- Care Credit (which has payment plan options)

Besides these various payment agreements, We 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 indicate 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.

Your insurance percentage is 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.

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-day notice, should you need to change or cancel an appointment previously scheduled so we can offer it to another patient in need. If a shorter notice is given or you do not show for an appointment there will be a $75 charge. Thank you for your understanding and cooperation.

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______________________________