NAME: _____ TODAY'S DATE: _____
BIRTHDATE: _____ SPOUSE'S NAME: _____
NUMBER OF CHILDREN: _____ THEIR AGES: _____

MEDICAL HISTORY

DO YOU HAVE OR HAVE YOU EVER BEEN TREATED FOR THE FOLLOWING: (CIRCLE)

HEART DISEASE	PROSTHETIC VALVE	EPILEPSY
KIDNEY DISEASE	ASTHMA	VENEREAL DISEASE
LIVER DISEASE	CANCER	TUBERCULOSIS
HIGH BLOOD PRESSURE	HIV	PROSTHETIC JOINTS
DIABETES	ANEMIA	SURGERY:_____
BLOOD DISORDER	SUBSTANCE ABUSE	_____
RHEUMATIC FEVER	THYROID	OTHER:
HEART MURMUR	FAINTING	
ULCER	HEPATITIS	

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING: (CIRCLE)

PENICILLIN	NOVACAINE	MOTRIN
CODEIENE	ASPIRIN	OTHER:_____
ERYTHROMYCIN	PERCODAN/PERCOSET	

ARE YOU TAKING ANY MEDICATIONS NOW?_____

IF SO, WHAT?_____

ARE YOU AWARE OF A NEED FOR ANTIBIOTIC PRE-MEDICATION?_____

HAVE YOU EVER BEEN TREATED WITH RADIATION (CANCER)?_____

DO YOU SMOKE? _____ HOW MUCH?_____ per day

DO YOU GET FREQUENT HEADACHES? YES NO

ARE YOU A SLOW HEALER?_____

DO YOU HAVE SINUS PROBLEMS? _____ HAY FEVER?_____

FOR WOMEN: 1) ARE YOU PREGNANT?_____ HOW FAR?_____

2) ARE YOU TAKING BIRTH CONTROL PILLS? _____

PLEASE INITIAL HERE:_____

DENTAL HISTORY

DATE OF LAST DENTAL EXAM? _____

WHAT CONCERNS YOU MOST ABOUT YOUR TEETH? _____

_____

HOW OFTEN DO YOU HAVE YOUR TEETH CLEANED?_____

HOW OFTEN DO YOU BRUSH? _____ FLOSS?_____

HAVE YOU EVER HAD GUM TREATMENTS? _____ WHAT KIND? _____

ARE YOU HIGH STRUNG? _____ a DENTAL PHOBIC? _____

DO YOU HAVE ANY MISSING TEETH? _____ HAVE THEY BEEN REPLACED? _____

IF NOT, WHY? _____

DO YOU HAVE PAIN IN ANY PART OF YOUR MOUTH? _____

IF SO, WHERE? _____

WHAT CAUSES THE PAIN? _____ HOT—COLD—SWEETS—OTHER _____

DOES FOOD TRAP BETWEEN YOUR TEETH? _____ WHERE? WHEN? _____

ARE YOU AWARE OF CLENCHING YOUR TEETH AS A HABIT? _____

DO YOU BREAK FILLINGS? _____ HOW OFTEN? _____

DO YOU WAKE UP FEELING THAT YOUR JAW IS FATIGUED AND/OR THE MUSCLES OF YOUR FACE ARE TIRED? _____ HEADACHES WHEN YOU WAKE UP? _____

ARE YOU COMPLETELY HAPPY WITH YOUR *SMILE?* _____ YOUR TEETH? _____

IF NOT, WHAT BOTHERS YOU? _____

_____

WOULD YOU BE INTERESTED IN LEARNING ABOUT HOW WE COULD ENHANCE YOUR SMILE? _____

DO YOU WANT TO KEEP YOUR TEETH AS LONG AS POSSIBLE? _____

IF NOT, WHY? _____

DO YOU FEEL DENTURES ARE INEVITABLE? _____ IF SO, WHY? _____

SIGNATURE: _____ DATE: _____
Patient / Parent or Guardian

FOR OFFICE USE ONLY (MEDICAL UPDATES)

PATIENT REGISTRATION

1. NAME: Mr./ Mrs./Ms./ Miss :_____

2. NICKNAME/ PREFERENCE:_____ (S) (M) (W) (D)

3. ADDRESS:_____

   CITY: _____ STATE: _____ ZIP: _____

4. ***HOME** PHONE*: _____***CELL** PHONE*: _____

6. EMPLOYER:_____***WORK** PHONE*:_____

7. E-MAIL :_____

8. SSN or Insurance Id# : _____ BIRTHDATE:_____

9. Ask patient for Driver License, Student Id (Get photo copy of ID)

10. WHOM MAY WE THANK FOR REFERRING YOU?

    _____

GUARANTOR INFORMATION

THE GUARANTOR IS THE PERSON RESPONSIBLE FOR YOUR BILL, NOT YOUR INSURANCE COMPANY.

If you are your own guarantor, please answer "SELF". If patient is under 18 years of age, please provide information of parent or legal guardian.

11. GUARANTOR'S NAME: Mr./Mrs./Ms./ Miss_____

12. GUARANTOR'S ADDRESS: _____

13. GUARANTOR'S **HOME** PHONE NUMBER: ( ) _____

14. GUARANTOR'S **WORK** PHONE NUMBER: ( ) _____ EXT._____

15. GUARANTOR'S EMPLOYER:_____ GRP#:_____

16. INSURANCE COMPANY:_____

17. GUARANTOR'S SOCIAL SECURITY NUMBER: _____

18. GUARANTOR'S BIRTHDATE: _____

Patient and/or Guardian is responsible for providing accurate-current Insurance Information

NOTICE OF PRIVACY PRACTICES – PATIENT ACKNOWLEDGEMENT

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information. I understand this practice reserves the right to change the terms of its Notice of Privacy Prractices, and to make changes regarding all protected health information resident at, or controlled by, this practice. I understand I can obtain this practice's current Notice of Privacy Practices on request.

Signature: _____Date:_____

Relationship to Patient: _____

ABOUT FINANCIAL OBLIGATIONS AND DENTAL INSURANCE

YOU MUST READ AND UNDERSTAND THE FOLLOWING---DON'T JUST SIGN YOUR NAME!

We are committed to providing you with the best possible and most comprehensive dental care. If you have dental insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve this, we need your assistance and cooperation in understanding our payment policy.

Payment for services is due at the time services are rendered unless a payment arrangement has been approved *in advance* by our team. We accept cash, checks, Mastercard or Visa. We will be happy to file your insurance claim for you. Just identify your employer, their group number and the name of your insurer and their mailing address. *The insurance company should send the reimbursement check directly to you.*

We will gladly discuss your proposed treatment and answer any questions relating to your dental insurance. You must realize, however, that:

1. Your insurance is a contract between you, your employer and the insurance company. *We are not a party to that contract*. Therefore, regardless of insurance status or coverage, you are responsible for the entire fee of all services rendered (We are a participating provider for Delta Dental Premier)

2. Our fees are generally considered to fall within the acceptable range by most insurance companies, and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage (such as 50% or 80%) of "U.C.R." "U.C.R." is defined as "Usual, Customary and Reasonable" fees for "an area". Thus, our fees are considered usual and reasonable for this area. Please note: ***U.C.R. is never consistent for all insurance companies. We can not guarantee that your company does not subscribe to an inferior or outdated U.C.R. schedule.***

The above statement does not apply to companies, who reimburse based on an arbitrary "schedule" of fees, which bears no relationship to the current standard of and cost of care in this area.

3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services or materials that they will not cover based on their individual profit motive. These services are outlined in your insurance policy booklet.

Returned checks and balances older than **60** days are subject to additional collection fees and interest charges of **1.5 %** per month (the same as most credit cards) Charges may also be made for broken appointments and appointments cancelled without the courtesy of **48** hours notice.

We must emphasize that as dental care professionals, our relationship is with you, not your insurance company. We are the direct advocate for your dental health.. If you have any questions regarding the above information, please do not hesitate to ask. We are here to help you.

I UNDERSTAND AND AGREE THAT I AM ULTIMATELY RESPONSIBLE FOR THE BALANCE OF MY ACCOUNT FOR ANY PROFESSIONAL SERVICES RENDERED---***REGARDLESS OF MY INSURANCE STATUS.***

I hereby give permission to McKeever Dental Care to use my name and photographs/videos of me for advertising, exposition displays, trade and any other lawful purposes.

I HAVE READ ALL THE ABOVE INFORMATION ON BOTH SIDES OF THIS FORM AND HAVE COMPLETED THE ABOVE ANSWERS. I HEREBY CERTIFY THAT THE INFORMATION WHICH I HAVE PROVIDED IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I AGREE TO NOTIFY THIS OFFICE OF ANY CHANGES IN HEALTH STATUS OR THE PREVIOUSLY RENDERED INFORMATION.

SIGNATURE: _____ **DATE:** _____

Mckeever Dental Care

HIPAA RELEASE FORM

Name_____ D.O.B_____

Release of information

Medical / Dental / General information

I authorize the release of my information to:

Name: _____Relationship:_____

Name: _____Relationship:_____

Name: _____Relationship:_____

Patients Signature: _____

Date:_____