McDonald Family Dentistry
Patient Information

Today's Date:__/__/__

Patient's Name:_____ Birthdate:_____Social Security #:_____

By what name do you prefer to be addressed:_____E-mail:_____

Home Address: _____City:_____Zip:_____

Home Phone:_____Work Phone:_____Cell Phone: _____

Patient's Employer:_____Occupation:_____

Marital Status: Married Single Divorced Widowed

Whom may we thank for referring you to our office?_____

If Patient is a Minor:
Father's Name:_____Social Security #:_____Home Phone: _____

Father's Address: _____

Mother's Name:_____Social Security #:_____Home Phone: _____

Mother's Address:_____

Party Responsible for account:_____Relationship:_____

Address (if different from above):_____

Emergency Contact:_____Relationship:_____Phone:_____

Dental Insurance

Primary Insurance
Insured's Name _____ Relationship_____

Birthdate _____ Social Security# _____

Employer _____Date Employed _____ Ins. Co. Phone # _____

Insurance Co. _____ Group # _____

Ins. Co. Address _____ City _____ State ___ Zip _____

Additional Insurance
Insured's Name _____ Relationship_____

Birthdate _____ Social Security# _____

Employer _____Date Employed _____ Ins. Co. Phone # _____

Insurance Co. _____ Group # _____

Ins. Co. Address _____ City _____ State ___ Zip _____

Medical History

Name: _____ Date of Birth: _____

Physician Name: _____ Physician Telephone: _____

Please circle Yes or No and check boxes that apply

Do you have, or have you had heart or cardiovascular problems? Yes No

☐ Previous Premedication prior to dental procedures ☐ Mitral Valve Prolapse ☐ Congenital Heart Defect
☐ Heart Murmur ☐ Artificial Heart Valve ☐ Heart Attack
☐ Rheumatic Fever/ Rheumatic Heart Disease ☐ Pacemaker ☐ Chest Pain
☐ Heart Surgery/ Angioplasty ☐ Stroke ☐ Circulatory problems
☐ High or Low Blood Pressure ☐ Irregular Heart Beat ☐ Other _____

Do you have, or have you had lung or breathing problems? Yes No

☐ Asthma, ☐ Sinusitis, ☐ Seasonal Allergies, ☐ Bronchitis, ☐ Tuberculosis, ☐ Emphysema, ☐ Other _____

Do you have, or have you had skeletal or joint problems? Yes No

☐ Artificial joints, ☐ Arthritis, ☐ Jaw joint pain, ☐ Back pain, ☐ Other _____

Do you have, or have you had blood problems? Yes No

☐ Anemia, ☐ Prolonged bleeding, ☐ Bruise easily, ☐ Hemophilia, ☐ Blood Thinners,
☐ Sickle Cell disease, ☐ Leukemia, ☐ Other _____

Do you have, or have you had stomach or intestinal problems? Yes No

☐ Ulcer, ☐ Acid reflux, ☐ Other _____

Do you have, or have you had endocrine problems? Yes No

☐ Diabetes, ☐ Thyroid problems, ☐ Steroid or Prednisone treatments, ☐ Other _____

Do you have, or have you had liver or kidney problems? Yes No

☐ Hepatitis, ☐ Yellow jaundice, ☐ Renal failure/Dialysis, ☐ Other _____

Do you have, or have you had neurologic problems? Yes No

☐ Seizures, ☐ Multiple Sclerosis, ☐ Psychiatric Treatment, ☐ Substance abuse, ☐ Other _____

Do you use tobacco in any form? Yes No

Have you ever been diagnosed with cancer or a tumor? Yes No

Type _____ Treatment _____

Have you been diagnosed as HIV/ AIDS positive? Yes No

Women, are you or might you be pregnant or breastfeeding? Yes No

Please list any other diseases, illnesses, or health problems not listed above:

_____

Please list all medications that you are currently taking: _____

_____

_____

Please list all allergies to medications and food: _____

The above information is accurate and complete to the best of my knowledge. I will not hold Dr. McDonald or any member of his staff accountable for errors or omissions that I may have made in completing this form. I also consent to examination and treatment in this office.

Date: _____ Patient's Signature (parent or guardian if minor): _____

Reviewed (patient initials): ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Date: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

DENTAL HISTORY

Patient Name: _____ Date: _____

GENERAL INFORMATION

Approximate date of last dental visit: _____ Approximate date of last x-rays taken: _____

How often do you brush your teeth? _____ Floss your teeth? _____

Are there any areas of dental health or dentistry that you have questions about? Please circle:

Whitening Bonding/Veneers Crowns/Caps Braces Other: _____

Are you experiencing any pain in your teeth, gums, or jaws? Yes No
Please explain: _____

WHAT CAN WE DO TO MAKE YOU FEEL MORE COMFORTABLE?

Would you like a personal walkman to listen to CDs?	Yes	No
Will you need blankets to help with the temperature?	Yes	No
Will you need a pillow to support your neck?	Yes	No
Would you prefer sunglasses to wear during your appointment?	Yes	No

Any preferences of yours we have not asked? _____

WHAT ARE YOUR FEELINGS ABOUT YOUR:

FRONT TEETH

Are you happy with their color?	Yes	No
Are you happy with their length?	Yes	No
Are they crooked?	Yes	No
Are you happy with their overall appearance?	Yes	No

Is there anything about your front teeth that you would change? _____

BACK TEETH

Are they sensitive to hot or cold foods?	Yes	No
Do they trap food when you eat?	Yes	No

Is there anything about your back teeth that you would change? _____

GUMS

Do they ever bleed?	Yes	No
Are they sensitive?	Yes	No
Do you have bad breath?	Yes	No

Is there anything about your gums that you would change? _____

MISSING TEETH

Do you have any missing teeth?	Yes	No
Are you wearing a replacement?	Yes	No
Is your denture or partial comfortable?	Yes	No

Is there anything about them that you would change? _____

McDonald Family Dentistry
Patient Financial Policy

Our office wants all of our patients to be able to comfortably afford dental care. We proudly offer the following financial policy so that our patients can have the opportunity to decide which payment option best suits your needs.

Insurance:
We are committed to providing you with the best possible dental care. If you have dental insurance, we will help you receive your maximum benefits and we are pleased to file a claim for you at no charge. Most dental insurance plans do not cover 100% of your cost of treatment. Because of this, **you will be asked to pay your deductible and your co-payment for the charges on the day the service is rendered.** We will estimate as closely as possibly your coverage, but we can make no guarantee of any estimated coverage. Because the insurance policy is an agreement between you and your insurance company, the ultimate responsibility for all charges lies with you. If after 60 days the insurance company has not paid on the claim, you will be responsible for the total balance including finance charges (1.5% per month). *Please be sure to follow-up with your insurance company to ensure payment of claims submitted.*

Payment Options:

1. **Cash or Check** is gladly accepted. No post-dated checks are accepted.
2. **Credit Card**: Our office also accepts MasterCard or Visa.
3. **Outside Financing:** Financial services through Care Credit or Citi Health Card Services for low or no interest financing to support you in having optimal treatment when necessary. These companies will ask you to do a brief application and will verify your credit history prior to extending credit.

*Payment not made for services after a reasonable period of time will be forwarded to a collection agency or attorney and formal action to collect the debt will be initiated. You will be responsible for any attorney's fees and/or collection charges incurred.

** A $25 charge will be incurred for any checks returned for non-sufficient funds.

Thank you for reviewing our financial policies. We make every effort to explain in advance of treatment your costs to you so that we can avoid misunderstandings and focus on your dental health. If you have any questions, please ask. We are here to serve you.

By signing below, I understand and agree to the terms stated above. I have also received a copy of this agreement for my records.

Signed _____ Date _____

Patient Acknowledgment of Receipt of Privacy Practices Notice

Please Print

I, _____, hereby acknowledge that I have reviewed and received a copy of this office's *Notice of Privacy Practices* explaining:

- How this office will use and disclose my protected health information.
- My privacy rights with regard to my protected health information.
- This office's obligations concerning the use and disclosure of my protected health information.

I understand that the *Notice of Privacy Practices* may be revised from time to time and that I am entitled to receive a copy of any revised *Notice of Privacy Practices* upon request.

I also understand that if I have any questions or complaints, I may contact:

McDonald Family Dentistry
2400 128th Street
Urbandale, Iowa 50323
info@mcdonaldfamilydentistry.com

You may also contact the Secretary of the U.S. Department of Health and Human Services with any concerns regarding our privacy and security policies and procedures. Please contact our office for information on how to contact the U.S. Department of Health and Human Services.

Patient or Personal Representative

Signature: _____ Date: ___/___/___

Name: _____
Please Print

Relationship to Patient: _____

For Office Use Only

We made a good-faith effort to obtain an acknowledgment of _____'s receipt of our Notice of Privacy Practices. In spite of these efforts, our office has been unable to obtain a signed acknowledgment of receipt for the following reasons (check all that apply):

☐ Patient refused to sign (date of refusal) ___/___/___.

☐ Communications barriers prohibited obtaining an acknowledgment.

☐ An emergency situation prevented us from obtaining an acknowledgment.

☐ Other _____

Attempt was made by: _____ Date: ___/___/___