Douglas L. McClung, D.D.S.

General Dentistry

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1) Patient Information

This appointment is for ☐ **Yourself** ☐ **Dependent**

Patient Full Name _____ **Social Security #** _____

Birth Date _____ **Age** _____ ☐ **Male** ☐ **Female**

Address _____ **City**_____ **State**_____ **Zip**_____

Home Phone _____ **Work Phone** _____ **Cell Phone** _____

Email _____

Are you ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Widowed**

In the event of an emergency, who should we contact?

Name _____ **Relationship** _____

Home Phone _____ **Cell Phone** _____

Full Time Student ☐ **Yes** ☐ **No** **School Name** _____

Employer _____ **Occupation** _____

Previous Dentist _____ **Previous Dentist Phone** _____

Current Physician _____ **Current Physician Phone** _____

Whom may we thank for referring you? _____

2) Responsible Party

Who is responsible for this patient? If different than above, please fill in the following:

Full Name _____ **Social Security #** _____

Birth Date_____ **Age** _____ ☐ **Male** ☐ **Female**

Address _____ **City** _____ **State** _____ **Zip** _____

Employer _____ **Occupation** _____

Home Phone _____ **Work Phone** _____

3) Insurance Information

Dental Insurance Coverage **Yes** ☐ **No** ☐

Insured's Name _____

Relationship _____

Insured's Social Security # _____

Birthdate _____

Insured's Employer _____

Insurance Group # _____

Insurance Policy # _____

Insurance Company Name _____

Insurance Co Phone _____

4) Dental History

Why have you come to the dentist today? _____

Do you require antibiotics before dental treatment? ..... **Yes**____ **No**____

If yes, please explain _____

Are you currently in pain? ..... **Yes**____ **No** ___

Do your gums ever bleed? ..... **Yes**____ **No**____

Have you ever had difficulties associated with any previous dental work?..... **Yes**____ **No**____

If yes, please explain _____

Do you or have you ever experienced pain in your jaw joint (TMJ / TMD)?..... **Yes**____ **No**____

Have your tonsils or adenoids been removed? ..... **Yes**____ **No**____

Do you floss on a regular basis?..... **Yes**____ **No**____

5) Medical History

Do you consider yourself in good medical condition?..... Yes ____ No_____

Are you taking any medications? ..... Yes____ No____

Please list ALL medications and supplements below. If you need more space, you may write on the back of this page.

_____

_____

_____

_____

Are you allergic to any medications? ..... Yes___ No____

If so, please list here. _____

(WOMEN) Are you currently pregnant? ..... Yes____ No____

If so, how may weeks? _____

(WOMEN) Are you nursing? ..... Yes____ No____

(WOMEN) Are you taking birth control? ..... Yes____ No____

Are you allergic to aspirin? ..... Yes____ No____

Are you allergic to Codeine? ..... Yes____ No____

Are you allergic to dental anesthetics? ..... Yes____ No____

Are you allergic to Erythromycin? ..... Yes____ No____

Are you allergic to latex or rubber products? ..... Yes____ No____

Are you allergic to metals? ..... Yes____ No____

Are you allergic to Penicillin? ..... Yes____ No____

Are you allergic to Tetracycline? ..... Yes____ No____

Have you ever had any of the following medical problems?

Abnormal bleeding..... Yes____ No____
Alcohol/Drug Abuse..... Yes____ No____
Anemia..... Yes____ No____
Arthritis..... Yes____ No____
Artificial Joints..... Yes____ No____
Require PreMedication..... Yes____ No____
Asthma..... Yes____ No____
Cancer..... Yes____ No____
Diabetes..... Yes____ No____
Difficulty Breathing..... Yes____ No____
Emphysema..... Yes____ No____
Epilepsy..... Yes____ No____
Fainting Spells..... Yes____ No____
Frequent Headaches..... Yes____ No____
Glaucoma..... Yes____ No____
Hay Fever..... Yes____ No____
Heart Attack..... Yes____ No____
Heart Murmur..... Yes____ No____
Heart Surgery..... Yes____ No____

Hemophilia..... Yes____ No____
Hepatitis..... Yes____ No____
Herpes/Fever Blisters..... Yes ____ No____
High Blood Pressure..... Yes____ No____
HIV/AIDS..... Yes____ No____
Kidney problems..... Yes____ No____
Liver Problems..... Yes____ No____
Low Blood Pressure..... Yes____ No____
Pacemaker..... Yes____ No____
Rheumatic Fever..... Yes____ No____
Seizures..... Yes____ No____
Shingles..... Yes____ No____
Sickle Cell Disease..... Yes____ No____
Sinus Problems..... Yes____ No____
Stroke..... Yes____ No____
Thyroid Problems..... Yes____ No____
Tuberculosis..... Yes____ No____
Ulcers..... Yes____ No____
Venereal Disease..... Yes____ No____

6) ACKNOWLEDGEMENT & AUTHORIZATION

I certify that I have read and understand the above. I acknowledge that my questions have been answered truthfully and to the best of my knowledge. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

SIGNATURE:_____ DATE:_____

Our Office Policies

PAYMENT FOR SERVICES

The payment for our services is the patient's responsibility. Our policy requires payment for services at the time the service is rendered. We do not accept temporary checks or cash advance checks from credit cards. A $35.00 fee will be assessed on all returned checks.

REGARDING INSURANCE

If you choose not to provide us with your Social Security number, our office will not accept assignment from your insurance company. In that case, you must pay in full for all services. By providing your insurance information, you are giving us permission to file claims to your insurance company. It is important to recognize that your insurance policy is an agreement between you and your insurance company. Our office is NOT responsible for determining or confirming your insurance benefits, nor are we responsible for the accuracy of information we relay to you that was obtained from your insurance company. We are only the messengers. If you doubt the accuracy of the information, you must contact your insurance company directly and obtain written documentation from your insurance contrary to benefits we obtained. You are responsible for knowing your own insurance coverage and whether your claim goes to medical or dental insurance, as well as the difference between in-network and out-of-network benefits. Verification of insurance benefits is not a guarantee of payment by your insurance company. Your insurance company makes final determination of your financial responsibility at the time they process your claim. If insurance fails to process your claim within 90 days, the balance becomes the patient's responsibility and is due immediately thereafter. In the event of an overpayment by you on your account, a refund will be sent to you within 30 business days, as long as there is no outstanding balance on your account or family account.

IN CASE OF DIVORCED PARENTS, the parent bringing the child to the initial visit will be deemed responsible for payment. Our contact will only be with the parent bringing the child to the consultation. It is the parents' responsibility to communicate with each other regarding treatment and fees. Please do not ask us to communicate with the other parent. Our office will not become involved in custody disputes over which parent is the responsible billing party.

Who can we discuss your treatment and financial/insurance information with?

_____ Relationship to patient_____

_____ Relationship to patient_____

I have read the above and agree to all policies above. I understand that I am responsible for all office charges. I also understand that once payment has been received from my insurance company, any balance remaining on my account will be due immediately. I authorize the release of any information necessary to process insurance claims and request payment of benefits to the provider of services.

_____

Name of responsible party (Please print)

Relation to Patient_____

Signature of Responsible Party_____ Date_____

Patient name if different than the responsible party (please print)

_____

Thank you for choosing our office for your dental needs. We look forward to serving you in obtaining your optimal dental health.

Dr. Douglas L. McClung and Staff