

**Patient Information**

Patient Name: \_\_\_\_\_

Last

First

MI

Preferred Name

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email: \_\_\_\_\_ Gender: \_\_\_\_\_ SS#: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Employer: \_\_\_\_\_

**Whom may we thank for referring you to our practice?**

Website  Google  Facebook  Doctor's Office  Other \_\_\_\_\_

**Responsible Party:**  Same as above

Responsible Party Name: \_\_\_\_\_

Last

First

MI

Preferred Name

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email: \_\_\_\_\_ Gender: \_\_\_\_\_ SS#: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

**Dental History:**

What is your immediate concern? \_\_\_\_\_

Please answer YES or NO to the following:

**Personal History:**

Are you fearful of dental treatment?  Yes  No

Have you had an unfavorable dental experience?  Yes  No

Have you ever had complications from past dental treatment?  Yes  No

Have you ever had trouble getting numb or had reactions to local anesthetic?  Yes  No

Did you ever have braces, orthodontic treatment or had your bite adjusted?  Yes  No

**Gums and Bone:**

- Do your gums bleed or are they painful when brushing or flossing?  Yes  No
- Have you ever been treated for gum disease or been told you have lost bone around your teeth?  Yes  No
- Is there anyone with a history of periodontal disease in your family?  Yes  No
- Have you experienced a burning sensation in your mouth?  Yes  No

**Tooth Structure:**

- Have you had any cavities within the past three years?  Yes  No
- Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing food?  Yes  No
- Are your teeth sensitive to hot, cold, biting, sweets or brushing?  Yes  No
- Do you frequently get food caught between any teeth?  Yes  No

**Bite and Jaw Joint:**

- Do you have any problems with your jaw joint? (pain, sounds, limited opening, locking, popping)  Yes  No
- Do you avoid or have difficulty chewing gum, carrots, nuts or other hard foods?  Yes  No
- Have your teeth changed in the last 5 years, become shorter, thinner or worn?  Yes  No
- Are your teeth crowding or developing spaces?  Yes  No
- Do you have more than one bite and have to squeeze to make your teeth fit together?  Yes  No
- Do you chew ice, bite your nails, use your teeth to hold objects or have any other oral habits?  Yes  No
- Do you clench your teeth in the day time or make them sore?  Yes  No
- Do you have any problems with sleep or wake up with an awareness of your teeth?  Yes  No
- Do you wear or have you ever worn a mouth appliance?  Yes  No

**Smile Characteristics:**

- Is there anything about the appearance of your teeth that you would like to change?  Yes  No
- Have you ever whitened (bleached) your teeth?  Yes  No
- Have you ever felt uncomfortable or self-conscious about the appearance of your teeth?  Yes  No
- Have you ever been disappointed with the appearance of previous dental work?  Yes  No

**Medical History:**

- Have you been under the care of a physician in the past 2 years?  No  Yes If yes, why? \_\_\_\_\_
-

# Graham McCabe

## FAMILY DENTISTRY

Are you now or have you taken any prescription drugs during the past year?     No     Yes    If yes, please list \_\_\_\_\_

Do you use tobacco products? \_\_\_\_\_

Have you ever been told you need antibiotics prior to dental treatment? \_\_\_\_\_

Are you allergic or sensitive to any medication? \_\_\_\_\_

Please indicate which of the following you have had, or have at the present for any of the following:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> *Pre-med          | <input type="checkbox"/> Epi Sensitive       | <input type="checkbox"/> Lidocaine Allergy    |
| <input type="checkbox"/> Acid Reflux       | <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> Liver Disease        |
| <input type="checkbox"/> Allergies         | <input type="checkbox"/> Excessive Bleeding  | <input type="checkbox"/> Mental Disorders     |
| <input type="checkbox"/> Anemia            | <input type="checkbox"/> Fainting            | <input type="checkbox"/> Nervous Disorders    |
| <input type="checkbox"/> Arthritis         | <input type="checkbox"/> Glaucoma            | <input type="checkbox"/> Pacemaker            |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Head Injuries       | <input type="checkbox"/> Parkinson Disease    |
| <input type="checkbox"/> Aspirin           | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Penicillin Allergy   |
| <input type="checkbox"/> Asthma            | <input type="checkbox"/> Heart Murmur        | <input type="checkbox"/> Pregnancy            |
| <input type="checkbox"/> Blood Disease     | <input type="checkbox"/> Hepatitis; A, B, C  | <input type="checkbox"/> Radiation Treatment  |
| <input type="checkbox"/> Blood Thinners    | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Respiratory Problems |
| <input type="checkbox"/> Cancer            | <input type="checkbox"/> High Cholesterol    | <input type="checkbox"/> Rheumatism           |
| <input type="checkbox"/> Chemotherapy      | <input type="checkbox"/> Hip Replacement     | <input type="checkbox"/> Sinus Problems       |
| <input type="checkbox"/> Codeine Allergy   | <input type="checkbox"/> HIV                 | <input type="checkbox"/> Stomach Problems     |
| <input type="checkbox"/> Defibrillator     | <input type="checkbox"/> HPV                 | <input type="checkbox"/> Stroke               |
| <input type="checkbox"/> Diabetes Type I   | <input type="checkbox"/> Kidney Disease      | <input type="checkbox"/> Tuberculosis         |
| <input type="checkbox"/> Diabetes Type II  | <input type="checkbox"/> Knee Replacement    | <input type="checkbox"/> Ulcers               |
| <input type="checkbox"/> Dizziness         | <input type="checkbox"/> Latex Sensitive     | <input type="checkbox"/> Under Active Thyroid |

Do you have any diseases, conditions, or problems not previously listed? \_\_\_\_\_

Have you recently used illegal drugs?     No     Yes    If yes, please list \_\_\_\_\_

I understand that records are stored electronically and that an electronic copy shall be considered an original.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**Acknowledgement of Receipt of Notice of Privacy Practices**

The privacy of your protected health information is important to us. We have provided you with a copy of our Notice of Privacy Practices. It describes how your health information will be handled in various situations. We ask that you sign this form to acknowledge you received a copy of our Notice of Privacy Practices.

I have received Graham Family Dentistry Privacy Notice.

Print Name: \_\_\_\_\_

If not the patient relationship to the patient: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**2018 Financial Policy**

We are committed to providing you the best possible care available. Our office is an in-network provider for the following insurance plans: Delta Dental Premier, Assurant, Cigna Discount Plan, Aetna and United Concordia through the Assurant Alliance Group. We are not in-network with more insurance plans due to the limitations they attach to treatment, regardless of the diagnosis. Our commitment is to you, our patient, not to any insurance company.

**We offer several options regarding financial arrangements for treatment.  
Check the option you feel would work best for you.**

- As a special service to you, we offer a **5% cash courtesy** if you pay for your entire **treatment plan in full**, on day service is rendered. (Not applicable for Delta Dental or United Concordia patients)
- Payment by appointment (this option lets you spread out payment according to treatment plan)
- Payments made in full by Visa, Mastercard, Discover and American Express
- For any **payment arrangements longer than 3 months**, we offer a healthcare financing program, which when you are accepted, will allow extended small monthly payments for the treatment received. **(Care Credit)**
- Payment of **estimated** patient portion and **filing Dental Insurance**
  - We will file an insurance claim on your behalf as a courtesy to you, however you must supply all necessary information needed for filing.
  - Any deductible as well as estimated portion your insurance does not cover are to be paid on the date of treatment rendered.
  - It is the patient's responsibility to know the details of the insurance coverage including pay tables, waiting periods, deductibles, yearly maximums, services not covered etc.
  - If your insurance company has not paid their liability in 60 days, then the balance becomes the patient's liability.
  - Your insurance policy is a contract between you and your insurance company and the financial responsibility for your treatment is yours whether your insurance pays or not.
- Finance charges of 1.5% per month will be applied to balances over 90 days old.

**I understand that it is the policy of this office to require at least 24 hours advance notice for any cancellation or scheduling changes. Failure to do so will result in a fee of \$50.00.**

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

If not the patient relationship to the patient and print name: \_\_\_\_\_



**Photo/Video Release Form**

I, \_\_\_\_\_(please print), grant permission to Graham Family Dentistry right to take photographs and/or video images taken of me, or members of my family, for the purpose of publication, promotion, advertising, or social media, in any manner. I hereby release Graham Family Dentistry and its legal representatives for all claims and liability relating to said images or video.

Over the age of 18

The legal guardian of the following

If legal guardian of patient(s), please list name(s) here: Name(s):

\_\_\_\_\_

***I request that my photo(s) or video(s) NOT be used in association with Graham Family Dentistry***

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

If not the patient relationship to the patient: \_\_\_\_\_



**Credit Card on File**

**"CONFIDENTIAL Authorization Form"**

[ ] I allow that Graham Family Dentistry keep my credit card on file. Please fill out the form below.

[ ] I request that Graham Family Dentistry **NOT** keep my credit card on file.

Patient Name: \_\_\_\_\_

Cardholder Name: \_\_\_\_\_

Card Type:  VISA     MASTERCARD     AMERICAN EXPRESS     DISCOVER

Card Number: \_\_\_\_\_

Expiration Date: \_\_\_\_\_ CVV Code: \_\_\_\_\_

Name as it Appears on Card: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

The dental practice of Graham Family Dentistry is authorized to keep my signature on file and to issue a credit and/or charge memo to my credit card account for any outstanding balance. After insurance payment and/or correspondence have been received and applied to my account, any balance will be directly applied to the credit card on file.

Authorized: \_\_\_\_\_ Date: \_\_\_\_\_