Graham McCabe
FAMILY DENTISTRY

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

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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
In the past were you seen more frequently than 6 months for your dental cleaning?	[ ] 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? _____

_____

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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:

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

Patient's Name: _____

Signature: _____ Date: _____

If not the patient, relationship to the patient: _____

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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: _____

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Financial Policy

We are committed to providing you the nest possible care. Our office is in the Assurant Alliance Group, which includes the following plans: Aetna, Ameritas, Assurant, BC&BS, Sunlife, United Concordia and United Healthcare. The above must be in the Alliance Group for us to be in-network. We are also in-network with Delta Dental as a Premier Delta dentist only. We are not in-network with more insurance plans due to the limitations they attach to treatment, regardless of the doctors' diagnosis. Our commitment is with you, our patient, not to any insurance company.

We offer several options regarding financial arrangements for treatment.

- 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 if paid by cash or check only. (Applicable for private pay patients only.)
- 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.

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

Print Name: _____

If not the patient relationship to the patient: _____

Signature: _____ Date: _____

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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) <u>NOT</u> be used in association with Graham Family Dentistry

Print Name: _____

If not the patient relationship to the patient: _____

Signature: _____ Date: _____