MULCAHY
Dental Associates

PATIENT INFORMATION

Patient Name: _____

Address: _____

City:_____ State: _____ Zip: _____

DOB: _____ SS: _____

Phone Number: _____ home mobile work (circle one)

Phone Number: _____ home mobile work (circle one)

Email: _____

How did you hear about us? _____

IN CASE OF EMERGENCY, CONTACT:

Name: _____ Relationship: _____

Phone: _____

DENTAL INSURANCE (if applicable)

Subscriber Name: _____ Relationship to patient _____

Subscriber birthdate: _____ Subscriber ID# or SS#: _____

Insurance Company: _____ Group or Plan #: _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with the listed Insurance Company and assign directly to Mulcahy Dental Associates all insurance benefits if any, otherwise payable to me for services rendered, I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above named-dentist may use my health care information and may disclose such information to the above-named insurance Company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____

Signature of Parent/Guardian Date

_____ _____

Printed name of Parent/Guardian Relationship to Patient

DENTAL HISTORY

Reason for today's visit: _____

Previous Dentist: _____ City/State_____

Date of last dental visit: _____ Date of last dental x-rays: _____

Please check all that apply:

□ Bad Breath
□ Bleeding gums
□ Blisters on lips or mouth
□ Burning sensation on tongue
□ Chew on one side of mouth
□ Cigarette, pipe or cigar smoking
□ Clicking or popping jaw
□ Lip or cheek biting
□Mouth breathing
□ Orthodontic treatment
□ Periodontal treatment
□ Sensitivity to heat
□ Sensitivity when biting
How often do you floss? _____

□ Dry Mouth
□ Fingernail biting
□ Food collection between the teeth
□ Foreign object
□ Grinding teeth
□ Gums swollen or tender
□ Jaw pain or tiredness
□ Loose teeth or broken fillings
□ Mouth pain, brushing
□ Pain around ear
□ Sensitivity to cold
□ Sensitivity to sweets
□Sores or growth in your mouth
How often do you brush? _____

HEALTH HISTORY

Physician's Name: _____ Phone #: _____ Date of last visit:_____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of Phentermine), Pondimin (fenfluranine) and Redux (dexfenfluramine). □ Yes □ No

Please check all that apply:

□ AIDS/HIV
□ Artificial Heart Valves
□ Back Problems
□ Blood Disease
□ Chemical Dependency
□ Cortisone Treatments
□ Emphysema
□ Glaucoma
□ Heart Problems
□ High Blood Pressure
□ Joint Replacement
□ Low Blood Pressure
□ Pacemaker/Defibrillator
□ Respiratory Disease
□ Shortness of Breath
□ Special Diet
□ Swollen Neck Glands
□ Tumor/ growth on head or neck
□ Weight Loss, unexplained

□ Anemia
□ Asthma
□ Bleeding abnormally, with extractions or surgery
□ Cancer
□ Circulatory Problems
□ Cough, persistent or bloody
□ Epilepsy
□ Headaches
□ Hepatitis Type _____
□ Jaundice
□ Kidney Disease
□ Mitral Valve Prolapse
□ Psychiatric Care
□ Rheumatic Fever
□ Sinus Trouble
□ Stroke
□ Swollen Feet or Ankles
□ Venereal Disease

□ Arthritis, Rheumatism
□ Thyroid Problems
□ Tonsillitis
□ Chemotherapy
□ Congenital Heart Lesions
□ Diabetes
□ Fainting or dizziness
□ Heart Murmur
□ Herpes
□ Jaw Pain□ Thyroid Problems
□ Liver Disease
□ Nervous Problems
□ Radiation Treatment
□ Scarlet Fever
□ Skin Rash
□ Shortness of Breath
□ Tuberculosis
□ Ulcer

MEDICATIONS

List any medication you are currently taking and the correlating diagnosis:

Rx: _____ for _____

Rx: _____ for _____

Rx: _____ for _____

Rx: _____ for _____

Rx: _____ for _____

Pharmacy Name: _____

City/State: _____ Phone#: _____

ALLERGIES

□ Aspirin □ Local Anesthetic □ Barbiturates (Sleeping pills) □ Penicillin □ Codeine □ Sulfa
□ Iodine □ Latex □ Other _____

CONSENT FOR SERVICES

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the cost incurred in their care and financial responsibility on their part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in full at the time services are performed. Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. We will not rebill insurances, call to question insurance decisions on payment, or wait more than 45 days for payment. Please contact your insurance company if you feel they did not apply the proper coverage. This dental office cannot render services on the assumption that our charges will be paid by an insurance company. A service charge of 1 1/2 % per month (18% per yr) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination. In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and U further agree to pay all cost and reasonable attorney fees if suit be instituted hereunder.

24 Hour Cancellation & "No Show" Fee Policy - Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, Mulcahy Dental Associates reserves the right to charge a fee of $25.00 for all missed appointments ("no shows") and appointments which, absent a compelling reason, are not cancelled with a 24-hour advance notice. "No Show" fees will be billed to the patient. This fee is not covered by insurance, and must be paid prior to your next appointment. Multiple "no shows" in any 12 month period may result in termination from our practice. Thank you for your understanding and cooperation as we strive to best serve the needs of all our patients.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.
I have read the above conditions of treatment and payment and agree to their content.

Signature: _____ Date: _____

Relationship to Patient: _____

MULCAHY
Dental Associates

ACKNOWLEDGEMENT
OF
PRIVACY PRACTICES

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that his information can and will be used to:

- □ Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly.
- □ Obtain payment from third-party payers for my health care services.
- □ Conduct normal health care operations such as quality assessment and improvement activities.

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact the office to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree than you are bound to abide by such restrictions.

Patient Name (printed): _____ Date: _____

Signature: _____ Relationship to Patient: _____

Dependents family members also covered by this acknowledgement:

_____

Individual authorized to receive my private information including but not limited to treatment, health care, financial and personal: _____

_____

_____

For Office Use Only:

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:

□ The patient refused to sign
□ Communication barriers
□ Emergency situation
□ Other