

**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 □ Dry Mouth

□ Bleeding gums □ Fingernail biting

□ Blisters on lips or mouth □ Food collection between the teeth

□ Burning sensation on tongue □ Foreign object

□ Chew on one side of mouth □ Grinding teeth

□ Cigarette, pipe or cigar smoking □ Gums swollen or tender

□ Clicking or popping jaw □ Jaw pain or tiredness

□ Lip or cheek biting □ Loose teeth or broken fillings

□Mouth breathing □ Mouth pain, brushing

□ Orthodontic treatment □ Pain around ear

□ Periodontal treatment □ Sensitivity to cold

□ Sensitivity to heat □ Sensitivity to sweets

□ Sensitivity when biting □Sores or growth in your mouth

How often do you floss? 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 □ Anemia □ Thyroid Problems

□ Arthritis, Rheumatism □ Artificial Heart Valves □ Tonsillitis

□ Asthma □ Back Problems □ Tuberculosis

□ Bleeding abnormally, with extractions or surgery □ Blood Disease □ Tumor/ growth on head or neck

□ Cancer □ Chemical Dependency □ Ulcer

□ Chemotherapy □ Circulatory Problems □ Venereal Disease

□ Congenital Heart Lesions □ Cortisone Treatments □ Weight Loss, unexplained

□ Cough, persistent or bloody □ Diabetes □ Sinus Trouble

□ Emphysema □ Epilepsy □ Skin Rash

□ Fainting or dizziness □ Glaucoma □ Special Diet

□ Headaches □ Heart Murmur □ Stroke

□ Heart Problems □ Hepatitis Type □ Swollen Neck Glands

□ Herpes □ High Blood Pressure □ Swollen Feet or Ankles

□ Jaundice □ Jaw Pain

□ Kidney Disease □ Liver Disease

□ Low Blood Pressure □ Mitral Valve Prolapse

□ Nervous Problems □ Pacemaker/Defibrillator

□ Psychiatric Care □ Radiation Treatment

□ Respiratory Disease □ Rheumatic Fever

□ Scarlet Fever □ Shortness of Breath

**MEDICATIONS**

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

Rx: for

Rx: for

Rx: for

Rx: for

Rx: for

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 □ Other

□ Latex

**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 □ Emergency situation

□ Communication barriers □ Other

**CONSENT FOR SERVI CES**

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.

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: