PATIENT INFORMATION

Date: _____

Name: _____ ☐ Male ☐ Female *I prefer to be called*: _____
Mr. Mrs. Ms. Dr.

☐Single ☐Married ☐Divorced ☐Widowed ☐Separated Birth Date: ___/___/___ Age: _____ SS#: _____

Home Address: _____ Home Phone: _____
Street City State Zip

Email Address: _____ Cell Phone: _____ Work Phone _____

Employer: _____ Occupation: _____How long there? _____

When and how is the best time to reach you? ☐ Morning ☐Afternoon ☐Anytime ☐Home ☐Cell ☐Work ☐Email

If a full time student, name of school: _____

Spouse's Name: _____ Daytime phone: ____ _____ Birth Date: ____/____/____

Employer: _____ Work Phone: _____

Whom may we thank for referring you? ☐Family or Friend _____

☐Website ☐Internet Search (Google, etc) ☐Mailer ☐School/Work ☐Other _____

PERSON RESPONSIBLE FOR ACCOUNT

If you have dental insurance under someone else, please provide this information for the policy holder.

Name: _____ Relationship to Patient: _____

Address: _____
Street City State Zip

Home Phone: _____ Cell Phone: _____ Work Phone: _____

SS#: _____ Birth Date: _____ Email: _____

Employer: _____ Address: _____
Street City State Zip

INSURANCE INFORMATION – Please provide insurance card to Front Office

**Your name, address, phone number, email address, SSN and any other information you provide are held in strict confidence. We do not sell or share your information with anyone else.

For Office Use Only:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

DENTAL HISTORY

Please check any of the following problems that apply to you.

- ❑ Sensitivity (hot, cold, sweet)
- ❑ Tooth pain or discomfort when chewing
- ❑ Headaches, earaches, neck pain
- ❑ Jaw joint pain
- ❑ Teeth or fillings breaking
- ❑ Grinding or clenching teeth
- ❑ Bleeding, swollen or irritated gums
- ❑ Loose, tipped or shifting teeth
- ❑ Bad breath or bad taste in your mouth

Do you have or have you had any of the following?

- ❑ Dentures/Partials
- ❑ Oral Surgery _____
- ❑ Braces
- ❑ Periodontal (gum) treatments
- ❑ Serious Head/Neck Injury _____
  _____

Please share the following dates:

Your last cleaning: _____/_____
Your last oral cancer screening: ____/____
Your last complete x-rays: ____/____

Name of Previous Dentist:

_____

City: _____

State: _____ Zip: _____

Phone Number: _____

Why did you leave your previous dentist?

_____

Have you ever had an upsetting dental experience? _____

If you could whiten your teeth for a cost anyone could afford, would you do it?

_____

Do you smoke or use chewing tobacco?_____
If yes, how much? How long?

_____

If you could change your smile, you would:

- ❑ Make them brighter
- ❑ Make them straighter
- ❑ Close spaces
- ❑ Replace black metal fillings with natural, tooth-colored fillings
- ❑ Repair chipped teeth
- ❑ Replace missing teeth
- ❑ Replace old crowns that don't match
- ❑ Have a smile makeover

On a scale of 1-10, with 10 the highest rating:

How important is your dental health to you?
1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health?
1 2 3 4 5 6 7 8 9 10

How important is it for you to keep your teeth healthy for your lifetime?
1 2 3 4 5 6 7 8 9 10

Is there anything standing in the way of getting the smile that you want? (fear, finances)?_____

What is the most important thing to you about your visit today?

_____

_____

Do I have your permission to tell you everything I see? _____

Is there anything else you would like for me to know about you? _____

MEDICAL HISTORY

Patient Name: _____

Physician's Name: _____ Phone Number _____

1. Have you had any major medical care within the past two years? Yes No
   Describe: _____
2. Have you taken any prescription medication during the past two years? *(use back if more room is needed)* Yes No
   Name of drug(s), dosage and reason for taking: _____
3. Have you ever taken prescription drugs for weight loss (diet pills) Yes No
   If yes, did you take any of the following (circle all that apply): Fen-Phen Pondimen Redux Other
   If yes to any of the drugs listed, did you have a medical exam for heart issues? Yes No
4. Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva, other? Yes No
5. Are you aware of having an allergic (or adverse) reaction to any substance or medication? Yes No
   If yes, please specify: _____
6. Have you been a patient in the hospital during the past five years? Yes No
7. Have you had or have sleep apnea? Yes No

Indicate which of the following you have had or have at present. ***Circle "yes" or "no" to each item.***

Heart Surgery/Disease/Attack	Yes	No	Ulcers	Yes	No	Hepatitis A B C (circle)	Yes	No
Chest Pain	Yes	No	Diabetes	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disease	Yes	No	Thyroid Problems	Yes	No	AIDS/HIV Positive	Yes	No
Heart Murmur	Yes	No	Glaucoma	Yes	No	Cold Sores/Fever Blisters	Yes	No
High/Low Blood Pressure	Yes	No	Contact Lenses	Yes	No	Blood Transfusion	Yes	No
Mitral Valve Prolapse	Yes	No	Emphysema	Yes	No	Hemophilia	Yes	No
Artificial Heart Valve/Pacemaker	Yes	No	Chronic Cough	Yes	No	Sickle Cell Disease	Yes	No
Rheumatic Fever	Yes	No	Tuberculosis	Yes	No	Bruise Easily	Yes	No
Arthritis/Rheumatism	Yes	No	Asthma	Yes	No	Liver Disease/Yellow Jaundice	Yes	No
Cortisone Medicine	Yes	No	Hay Fever/Allergy/Hives	Yes	No	Neurological Disorders	Yes	No
Swollen Ankles	Yes	No	Latex Sensitivity	Yes	No	Epilepsy or Seizures	Yes	No
Stroke	Yes	No	Sinus Trouble	Yes	No	Fainting or Dizzy Spells	Yes	No
Diet (Special/Restricted)	Yes	No	Radiation Therapy	Yes	No	Nervous/Anxious	Yes	No
Artificial Joints (hip, knee, etc)	Yes	No	Chemotherapy	Yes	No	Psychiatric/Psychological Care	Yes	No
Kidney Trouble	Yes	No	Tumors	Yes	No	Headaches (migraines, tension)	Yes	No

7. Have you been told that you should take a pre-medication before dental appointments? Yes No
   If yes, why: _____ Which medication do you take ?_____
8. Do you have, or have you had, any disease, condition or problem not listed above? Yes No
   If yes, please list: _____
9. **Women** – Are you pregnant or think you could be pregnant? Yes No _____ months Are you nursing? Yes No
   Do you use prescription birth control? Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider (or agency), who may release such information to you. I will notify the doctor of any changes in my health or medication.

Patient/Guardian Signature: _____ Date: _____

For Office Use - History Review / Medical Alerts

Dentist Signature: _____ Date: _____

CONSENT FOR TREATMENT AND OFFICE AGREEMENTS

I hereby authorize the doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my or my dependant's dental needs.

Upon such diagnosis, I authorize the doctor and/or a designated staff to perform all recommended treatment mutually agreed upon by me as required in providing proper care.

I consent to the use of any anesthetics, sedatives and other medication deemed necessary for my dental care. I fully understand that using anesthetic agents embodies certain risks.

Dentistry is a commitment for both the patient and the dental team. The following are a few guidelines, which will clarify and strengthen this commitment:

Consultation: I regularly consult with colleagues to make sure that I am doing the best work possible. When I discuss any patient under those circumstances, I withhold any identifying information to insurance confidentiality.

Appointments/Reservation Changes: By scheduling an appointment, you reserve a specific time with our office. If you need to reschedule your reserved time, we ask that you give us notice of at least 2 BUSINESS DAYS. Giving adequate notice results in avoiding a cancellation fee of $55.00 ***per hour*** for the time reserved for you.

Business Hours/Phone Contact: Our normal business hours are Monday–Thursday from 8:00 am–5:00 pm. During normal business hours, you are welcome to contact us by phone at **(707) 579-9993** or after hours at Dr. McCormick's home at **(707) 829-3907**.

FINANCIAL ACKNOWLEDGEMENT

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patient for the costs incurred for their care. Financial responsibility on the part of each patient will be determined as accurately as possible before treatment is started.

All emergency dental services or any dental services performed without previous financial arrangements must be paid for 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 they are personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms and assist in making follow-up calls to the insurance companies should the need arise. Payment by the insurance company will be made directly to the patient. If, at any time, a payment is sent to the dental office, a prompt refund will be made to the patient by the dental office for any credit accrued. The dental office will not render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1.5% per month (18% per annum) on any unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangement are satisfied.

Following examination, diagnosis and consultation, you will be presented with a definite treatment plan as well as any alternatives and their costs. This is not a contract, as either party may change it. Unless additional work, or changes, becomes necessary, the work will be completed as specified and for the fee quoted, provided that treatment is started within six months of the date of presentation.

In consideration of the professional services rendered to me, or at my request, by the doctor, I agree to pay therefore that reasonable value of said service to said doctor, or his assignee, at the time said services are rendered or per any financial agreement I have made with the dentist or his assignee. I further agree that the reasonable value of said services shall be billed, unless objected to by me, in writing, within the time for payment thereof. 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 I further agree to pay all costs and reasonable attorney fees if suit were instituted hereunder.

I grant my permission to the doctor, or his 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 of Patient, Parent or Guardian	Date	Relationship to Patient
_____	_____	_____
Signature of Guarantor of Payment/Responsible Party	Date	Relationship to Patient

Andrew T, McCormick, DDS
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Santa Rosa, CA 95403
(707) 579-9993 / www.docmac.com

NOTICE OF PRIVACY PRACTICES SUMMARY (HIPAA)

This summary discloses how Healthcare information about you may be used by our office. *A full notice of your privacy rights is available upon request.*

Treatment, Payment, Operations. We may use health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive.

Uses and Disclosures for Appointment Reminders. We may use and disclose your Healthcare information to contact you as a reminder that you have an appointment at the office. If you request that such communications be made confidentially, please contact our office in writing. We will accommodate all reasonable requests.

Authorization for Use and Disclosure. We will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so.

Public health, research, health and safety, government, works compensation. We may disclose your information for public health activities, research, health and safety, governmental function, and in order to comply with workers compensation laws and regulations.

Rights. You have a right to inspect and copy information used to make decisions about your care, to request an amendment of the information, to an accounting of disclosures, to request communication with you by alternate means, to request restrictions on the information we use, and to revoke your authorization for release of information.

Complaints. You may complain to our Office Manager at (707) 579-9993 or to the Department of Health and Human resources if you believe your privacy rights have been violated. You will not be retaliated against for filing a complaint.

Organization duties. We must maintain the privacy of protected health information, provide you with notice of our legal duties and privacy practice with respect to your health information, abide by the terms of the notice, notify you if we are unable to agree to the requested restriction on how your information is used or disclosed, accommodate reasonable requests you may make to communicate with health information by alternative means or by alternative locations, and obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted under law.

Questions. If you have any questions, please contact our Office Manager at (707) 579-9993.

I acknowledge that I have received/been offered the full Privacy Notice.

Name of Patient: _____
*Parent or Guardian:*_____

Signature:_____Date:_____

For Office Use:
O Patient refused to sign.
O Patient unable to sign.
O Other: