DENTAL REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

E-mail _____

City _____

State _____ Zip _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School _____

Occupation _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

2 DENTAL INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

_____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ 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(ies) 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 Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

3 PHONE NUMBERS

Phone (_____) _____ Work (_____) _____ Ext _____ Cell (_____) _____

Spouse's Work (_____) _____ Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____ Relationship _____

Home Phone (_____) _____ Work Phone (_____) _____

4 DENTAL HISTORY

Reason for today's visit _____

_____

Former Dentist _____

City/State _____

Date of last dental visit _____

Date of last dental X-rays _____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Bad breath	☐ Yes	☐ No
Bleeding gums	☐ Yes	☐ No
Blisters on lips or mouth	☐ Yes	☐ No
Burning sensation on tongue	☐ Yes	☐ No
Chew on one side of mouth	☐ Yes	☐ No
Cigarette, pipe, or cigar smoking	☐ Yes	☐ No
Clicking or popping jaw	☐ Yes	☐ No
Dry mouth	☐ Yes	☐ No
Fingernail biting	☐ Yes	☐ No
Food collection between the teeth	☐ Yes	☐ No
Foreign objects	☐ Yes	☐ No
Grinding teeth	☐ Yes	☐ No
Gums swollen or tender	☐ Yes	☐ No
Jaw pain or tiredness	☐ Yes	☐ No
Lip or cheek biting	☐ Yes	☐ No
Loose teeth or broken fillings	☐ Yes	☐ No
Mouth breathing	☐ Yes	☐ No
Mouth pain, brushing	☐ Yes	☐ No
Orthodontic treatment	☐ Yes	☐ No
Pain around ear	☐ Yes	☐ No
Periodontal treatment	☐ Yes	☐ No
Sensitivity to cold	☐ Yes	☐ No
Sensitivity to heat	☐ Yes	☐ No
Sensitivity to sweets	☐ Yes	☐ No
Sensitivity when biting	☐ Yes	☐ No
Sores or growths in your mouth	☐ Yes	☐ No

How often do you floss? _____

How often do you brush? _____

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5 HEALTH HISTORY

Physician's Name _____ Date of last visit_____

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva. ☐ Yes ☐ No

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 (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Respiratory Disease	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Fainting or dizziness	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Arthritis, Rheumatism	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Artificial Heart Valves	☐ Yes ☐ No	Headaches	☐ Yes ☐ No	Shortness of Breath	☐ Yes ☐ No
Artificial Joints	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Heart Problems	☐ Yes ☐ No	Skin Rash	☐ Yes ☐ No
Back Problems	☐ Yes ☐ No	Hepatitis Type _____	☐ Yes ☐ No	Special Diet	☐ Yes ☐ No
Bleeding abnormally, with extractions or surgery	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
		High Blood Pressure	☐ Yes ☐ No	Swollen Feet or Ankles	☐ Yes ☐ No
Blood Disease	☐ Yes ☐ No	Jaundice	☐ Yes ☐ No	Swollen Neck Glands	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Jaw Pain	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Chemical Dependency	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Chemotherapy	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Circulatory Problems	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No	Tumor or growth on head or neck	☐ Yes ☐ No
Congenital Heart Lesions	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No		
Cortisone Treatments	☐ Yes ☐ No	Nervous Problems	☐ Yes ☐ No	Ulcer	☐ Yes ☐ No
Cough, persistent or bloody	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No	Weight Loss, unexplained	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No	Radiation Treatment	☐ Yes ☐ No		
Do you wear contact lenses?	☐ Yes ☐ No				

Women:

Are you pregnant? ☐ Yes ☐ No Due date_____ Are you nursing? ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ No

MEDICATIONS

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

_____

_____

Pharmacy Name _____

Phone (_____) _____

ALLERGIES

☐ Aspirin ☐ Local Anesthetic

☐ Barbiturates (Sleeping pills) ☐ Penicillin

☐ Codeine ☐ Sulfa

☐ Iodine ☐ Other _____

☐ Latex _____

6 UPDATES (To be filled in at future appointments)

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? _____

Are you taking any new medications?_____ If so, what? _____

Patient's Signature_____ Date_____

Doctor's Signature_____ Date_____

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? _____

Are you taking any new medications?_____ If so, what? _____

Patient's Signature_____ Date_____

Doctor's Signature_____ Date_____

Harvest Dental

The Office of Kathleen E. McDonald, DMD

Cancellation Policy

Although we know that unforeseen events and circumstances arise from time to time, it is important for patients to honor their appointments so that your hygienist, doctor, and our staff allow appropriate time to serve each and every one of our patients in a timely manner. If you are unable to make your appointment, we request a minimum **48 hour** cancellation notice.

Therefore, our cancellation policy is that, upon first cancellation in less than **48 hours** of your scheduled time, we will inform you of our cancellation policy and the fee will be waived if you **reschedule** your appointment. If your first cancellation is **24 hours or less** of your scheduled time, **we will assess the $50 cancellation fee**. After your first cancellation, **any cancellations made less than 48 hours before your scheduled appointment time will be assessed a fee of $50.00.**

If you need to cancel an appointment for an unseen reason, call 48 hours in advance and talk directly to our staff.

Leaving a message or "voicemail" will be considered a canceled appointment so please contact one of our staff directly and no fees will be charged.

Our goal and mission is to work in partnership with each one of our patients and dedicate our time to do just that!

I have read and understand the Appointment Cancellation Policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

I, _____ (print name), have received a copy of the Appointment Cancellation Policy.

Signature : _____ *Date:* _____

2244 S. Ave A. Suite B · Yuma, AZ 85364 · Phone(928)783-8481· Fax (928)343-0055

www.dentistinyuma.com

Harvest Dental

The Office of Kathleen E. McDonald, DMD

You May Refuse to Sign This Acknowledgment

I have received a copy of this office's Notice of Privacy Practices.

Print Name: _____

Signature: _____

Date: _____

Name of individual(s) we can share your medical information with:

_____

May we contact your medical physician(s) regarding your health information, such as HIV related information, genetic information, alcohol and/or substance abuse and mental health records? Yes: __ or No: __

Signature: _____ Date: _____

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- O Individual refused to sign
- O Communication barriers prohibited obtaining acknowledgment
- O An emergency situation prevented us from obtaining acknowledgment
- O Other (please specify)

Harvest Dental
The Office of Kathleen E McDonald, DMD

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 the 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 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. As a courtesy, this office will help prepare the patient's insurance forms and assists in making collections from insurance companies and will credit any such collections to the patient's account. Furthermore, I understand that if the claim is not paid on the initial submission Harvest Dental will resubmit my insurance claim only ONE additional time. After the initial submission and resubmission if the claim remains unpaid, further communication and negotiation with the insurance company becomes the patient's sole responsibility. Moreover, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. Thus, if the insurance company denies the dental claim for any reason, the patients, or guardian will be responsible for the full dental fee. I hereby authorize Harvest Dental to release any information regarding my claim for dental benefits. I understand all copayments and deductibles are due at time of scheduling. I understand that the fee estimate listed for this dental care only is extended for a period of six months from the date of the patient's examination.In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable services value of said services to said Doctor, or her assignee, at the time services are rendered, or within five (5) days of the billing if credit shall be extended. I further agree that the value of said services shall be billed unless objected to me, by me, in writing, within the time for payments thereof. I further agree that a waiver of any breach of any type or condition hereunder shall not constitute a waiver of any further term or condition and I fully agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

A service charge of 1 ½ %per month (18%) per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial agreements are satisfied. I understand that Harvest Dental will allow the insurance company 90 days to finalize payment on a dental claim . If there is an outstanding account balance remaining 90 days following the date of service, I understand that the full dental fee is now the patient's responsibility regardless of insurance claim status. After 120 days from the date of service, I understand that the account will be referred to an outside collection agency, and the undersigned also agrees to pay additional 40% collection fees, costs, and interest charged by the collection agent.

Our office accepts cash, personal checks, American Express, Discover Card, Mastercard and Visa as payment. For those who need extended payment plans, our office participates with CareCredit. For all minor children brought to this office for treatment, we consider both parents finally responsible for all costs incurred in treating your child regardless which parent brings the child to this office. In the case of divorce, both parents will be held responsible until the account is paid. 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. When the office schedules an appointment for you, we are reserving our doctor's and or hygienist's time for you. With this in mind, **I agree to give 48 hours notice when canceling or rescheduling appointments; if I fail to do this, I understand there will be a $50.00 charge.**

I have read and understand the above Consent for Service and agree to its content for myself and my family.

Signature : _____

Date : _____