#### PATIENT INFORMATION FOR PATIENTS UNDER 18 YEARS OF AGE

Date

A B C

Patient’s name

Last First Middle

Address

Street City Zip

Nickname Birthdate Social Security # School Sports/Hobbies Parent or guardian name Whom may we thank for referring you to our office?

#### RESPONSIBLE PARTY INFORMATION

Name

Last First Middle

Residence

Street City Zip

Mailing Address

Street City Zip

How long at this address?\_ Home phone Work phone Cell/other phone Email address Previous Address (If less than 3 years) Social Security # Birthdate Relationship to Patient Employer Occupation No. years employed Spouse’s Name Relationship to Patient Employer Occupation No. years employed Social Security # Birthdate Work Phone

#### DENTAL INSURANCE INFORMATION

Insured’s Name Insured’s Social Security #

Insurance Company Group No. Local No.

Insurance Co. Address Phone No.

Do you have dual coverage? Yes

No

If yes:

Insured’s Name Insured’s Social Security #

Insurance Company Group No. Local No.

Insurance Co. Address Phone No.

#### EMERGENCY INFORMATION

Name of nearest relative not living with you

Complete address

Street City Zip

Phone

I understand that, where appropriate, credit bureau reports may be obtained.

Parent Signature

Updates (date & initial)

# Medical History

Physician Office Phone # Date of Last Exam

1. Are you under medical treatment now? - - - - - - - - - - - - - - - - - - - - - - -
2. Have you ever been hospitalized or had major surgery? If yes, please list/date
3. Are you taking any medications (prescription or OTC)? If yes, please list
4. Have you ever taken Fosamax, Boniva, Actonel or any medications containing bisphosphonates? - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - -
5. Do you use any tobacco products? - - - - - - - - - - - - - - - - - - - - - - - - - - -
6. Do you use controlled substances? - - - - - - - - - - - - - - - - - - - - - - - - - - -
7. Do you have or have you had any of the following?

Yes No

Yes No

## □ □

□ □

□ □

□ □

□ □

□ □

1. Are you allergic to or have you had any bad reactions to:

Local Anesthetics (e.g. Novocaine) - - - - - - - Sulfa - - - - - - - - - - - - - - - - - - - - - - - - - - - - -

Penicillin or any other Antibiotic - - - - - - - - - Aspirin - - - - - - - - - - - - - - - - - - - - - - - - - - - -

Codeine - - - - - - - - - - - - - - - - - - - - - - - - - - -

Iodine - - - - - - - - - - - - - - - - - - - - - - - - - - - -

Metals (e.g. nickel, mercury, etc.) - - - - - - - - Sedatives - - - - - - - - - - - - - - - - - - - - - - - - - -

Latex Rubber - - - - - - - - - - - - - - - - - - - - - - -

Other:

1. *Women Only:*

 *a) Are you pregnant or think you may be pregnant?*

 *b) Are you nursing? - - - - - - - - - - - - - - - - - - - - - - -*

 *c) Are you taking oral contraceptives? - - - - - - - - -*

Yes No

## □ □

□ □

□ □

□ □

□ □

□ □

□ □

□ □

□ □

□ □

□ □

□ □

□ □

Acid Reflux/GERD - - - - - - - - - - □ □

AIDS/HIV - - - - - - - - - - - - - - - - □ □

Anemia - - - - - - - - - - - - - - - - - □ □

Anxiety - - - - - - - - - - - - - - - - - □ □

Arthritis - - - - - - - - - - - - - - - - - □ □

Asthma - - - - - - - - - - - - - - - - - □ □

Cancer - - - - - - - - - - - - - - - - - - □ □

Cardiac Pacemaker - - - - - - - - - □ □

Chemotherapy - - - - - - - - - - - - □ □

Chest Pain - - - - - - - - - - - - - - - □ □

Depression - - - - - - - - - - - - - - - □ □

Diabetes - - - - - - - - - - - - - - - - □ □

Emphysema/COPD - - - - - - - - - □ □

Frequently Tired - - - - - - - - - - - □ □

Glaucoma - - - - - - - - - - - - - - - - □ □

# Dental History

Heart Attack - - - - - - - - - - - - - - -

Heart Disease - - - - - - - - - - - - - -

Hepatitis/Liver Disease - - - - - - -

High Blood Pressure - - - - - - - - -

Joint Replacement or Implant - -

Kidney Disease - - - - - - - - - - - - -

Leukemia - - - - - - - - - - - - - - - - -

Low Blood Pressure - - - - - - - - -

Migraines - - - - - - - - - - - - - - - - -

Mitral Valve Prolapse - - - - - - - -

Osteoporosis - - - - - - - - - - - - - -

Radiation Therapy - - - - - - - - - - -

Yes No

## □ □

□ □

□ □

□ □

□ □

□ □

□ □

□ □

□ □

□ □

□ □

□ □

Radiation Therapy - - - - - - - - - - - - - -

Rheumatic Fever - - - - - - - - - - - - - - -

Seasonal Allergies - - - - - - - - - - - - - -

Seizures/Epilepsy - - - - - - - - - - - - - -

Sexually Transmitted Disease - - - - -

Sinus Problems - - - - - - - - - - - - - - - -

Stomach Problems/Ulcer - - - - - - - - -

Stroke - - - - - - - - - - - - - - - - - - - - - -

Swollen Ankles - - - - - - - - - - - - - - - -

Thyroid Problems - - - - - - - - - - - - - -

Tuberculosis - - - - - - - - - - - - - - - - -

Other:

Yes No

## □ □

□ □

□ □

□ □

□ □

□ □

□ □

□ □

□ □

□ □

□ □

□ □

Name of Last Dentist City Date of Last Exam

* 1. Do you feel pain in any of your teeth? - - - - - - - - - - - - - - - -
	2. Are your teeth sensitive to hot or cold? - - - - - - - - - - - - - - -
	3. Are your teeth sensitive to sweet or sour things? - - - - - - - -
	4. Do your gums bleed when brushing or flossing? - - - - - - - -
	5. Do you have any sores or lumps in or near your mouth? - -
	6. Have you had any head, neck or jaw injuries? - - - - - - - - - -
	7. Have you ever experienced any of the following problems in your jaw?

Clicking- - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - -

Pain with Opening/Closing - - - - - - - - - - - - - - - - - - -

Difficulty opening or closing - - - - - - - - - - - - - - - - - -

Difficulty chewing - - - - - - - - - - - - - - - - - - - - - - - - -

Yes No

## □ □

□ □

□ □

□ □

□ □

□ □

□ □

□ □

□ □

□ □

* 1. Have you ever been treated for periodontal disease? - - - - - -
	2. Do you have frequent headaches? - - - - - - - - - - - - - - - - - - - -
	3. Do you clench or grind your teeth? - - - - - - - - - - - - - - - - - - -
	4. Do you bite your lips or cheeks frequently? - - - - - - - - - - - - -
	5. Have you ever had any difficult extractions? - - - - - - - - - - - -
	6. Have you ever had prolonged bleeding after an extraction? -
	7. Have you had any orthodontic treatment (braces)? - - - - - - -
	8. Do you wear dentures or partials? - - - - - - - - - - - - - - - - - - - - If yes, date made
	9. Is there anything you would like to change about your teeth or smile? - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - -

Yes No

## □ □

□ □

□ □

□ □

□ □

□ □

□ □

□ □

□ □

**Authorization and Release**

*I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing*

*incorrect information can be dangerous to my health. I authorize Dr. McDade/Quality Dentistry to release any information including the diagnosis and the records of any*

*treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance*

*company to pay directly to Dr. McDade/Quality Dentistry insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual*

*bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.*

X Date: Signature of Patient (or Responsible Party)

 Relationship to Patient:\_ Printed Name

## “NO SHOW” POLICY

It is the policy of this office that, if you are unable to keep your scheduled appointment, you are required to call the office to cancel and/or reschedule your appointment at least 48 hours prior to the scheduled appointment. Appointment reminder calls, texts and emails are a courtesy only, patients/guardians are responsible for remembering scheduled appointments.

We understand that emergencies are out of everyone’s control. Therefore, you will not be charged for a missed appointment due to an emergency. However, you are required to contact us in the event you are unable to keep your scheduled appointment due to an emergency.

In the event you do not call to cancel and/or reschedule your appointment 48 hours prior to the appointment time, you will be considered a “No-Show” and will be financially responsible with a charge of $100.00 per hour for the missed appointment.

After three (3) “No-Show” appointments you will be dismissed from our practice by certified letter.

Your signature below is acknowledgment that you have read and understand the above policy.

Patient/Guardian Signature:

Patient’s Printed Name:

Date: Relationship to Patient: \_

Diagnosis & Treatment Policy

With my knowledge and consent I hereby authorize the doctor or designated staff to take x- rays, study models, photographs or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of:

Name of Patient: ’s dental needs.

Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance where required to provide proper care.

I consent to the use of appropriate medication and therapy as deemed necessary. I fully understand that using agents embodies a certain risk.

Lastly, I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that financial arrangements should be made for all services.

Your signature below is acknowledgment that you have read and understand the above policy.

Patient/Guardian Signature:

Date: Relationship to Patient:

**MICHAEL E. MCDADE, D.D.S.**

**Michael McDade. D.D.S., PLLC 1710 Lafayette Street**

**Steilacoom. WA 98388**

**Acknowledgment of Receipt of Notice of Privacy Practices**

I acknowledge that I have received a copy of the Notice of Privacy Practices for the offices of Michael E. McDade, '·The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services or in the performance of office's health care operations. The Notice of Privacy Practices a.lso describes my rights and the responsibilities and duties of this office with respect to my protected health informatiqn. The Notice of Privacy Practices is also posted in the facility.

ichael E . McDade · reserves the right to change the privacy practices that are described in the Notice of Privacy Practi'ces. If pq'{acy practices change, I will be offered a copy of the revised Notice of Privacy Practices at the time of my first i it a r tt)e revisions become effective. I may also obtain a revised Notice of Privacy Practices by requesting that one

be...mal-iM to.. me.

-

..



|  |
| --- |
| ' ... .. **ADDITIONAL DISCLOSURE AUTHORITY**.. . ... In addition to the allowable disclosures described in the Notice of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below. |
| ANY MEMBER OF MY IMMEDIATE FAMILY | DYES | 0NO |
| SPOUSE ONLY | DYES | 0NO |
| OTHER *(PLEASE SPECIFY)* | DYES | 0NO |

**Name of Patient** or Personal Representative **Signature of Patient** or Personal Representative

, , "·.

Date Description of Personal Representative's Authority

**OFFICE USE ONLY BELOW THIS LINE**

PROVIDED PRIOR TO

TREATMENT? DATE PROVIDED:

.. ...,.:

'.

REASON FOR DENIAL: 0NEEDED MORE TIME TO REVIEW NOTICE OF PRIVACY PRACTICES.

0WANTED TO CONSULT WITH ANOTHER PERSON, BEFORE SIGNING.

DUNABLE TO SIGN. DREASON NOT GIVEN. DOTHER (EXPLAIN):