



**NEW PATIENT REGISTRATION FORM**  
(PLEASE PRINT)

PATIENT INFORMATION					
Full Legal Name (First) (Middle) (Last)				Preferred Name (Nickname)	
Address		Apt. No.	City	State	Zip
E-mail		Home Phone:		Work Phone	
		Cell Phone:			
Social Security No.		Sex	Marital Status	Date of Birth	
Employer Name		Employer City		Employer State	
Whom may we thank for referring you?					
Permitted Contact Method(s) (circle all that apply) home phone cell phone work phone mail e-mail				Ok to leave message on answering machine/voicemail?	
				<input type="checkbox"/> YES <input type="checkbox"/> NO	
SPOUSE'S INFORMATION					
Full Legal Name (First) (Middle) (Last)				Home Phone	
Occupation		Employer name		Work phone	Cell Phone
INSURANCE INFORMATION					
Primary Insurance Company Name		Group No.		ID/Certificate No.	
Policy Holder's Name/Parent's Name (if patient a child)		Policy Holder's DOB		Policy Holder's Social Security No.	
Secondary Insurance Company Name		Group No.		ID/Certificate No.	
Policy Holder's Name		Policy Holder's DOB		Policy Holder's Social Security No.	
EMERGENCY INFORMATION					
Person to Notify in Case of Emergency		Relationship	Home Phone	Cell Phone	
INFORMATION FOR THE PATIENT					
1. Patients who carry standard health insurance should remember that professional services are rendered and charged to the patient and not to the insurance company. All patients with standard health care insurance are expected to make payment as services are rendered, regardless of pending insurance, litigation, etc. 2. Patients with contract health plans should present their insurance ID card to the receptionist after completing this form. Some contract health plans (HMOs, PPOs, IPAs, etc) require a copayment at the time of service. Most contract health plans require that the claim be submitted by our office.					
Signature of Patient or Responsible Party			Date		



**PATIENT MEDICAL/DENTAL HISTORY FORM**

**NAME:** \_\_\_\_\_

**DOB:** \_\_\_\_\_

**TODAY'S DATE:** \_\_\_\_\_

- Is your general health good?  Yes  No
- Has there been a CHANGE IN YOUR HEALTH within the last THREE YEARS?  Yes  No
- Have you been HOSPITALIZED or had a SERIOUS ILLNESS within the last THREE YEARS?  Yes  No
- Are you being TREATED BY A PHYSICIAN NOW?  Yes  No

If yes, include NAME OF PHYSICIAN and REASON FOR TREATMENT:

\_\_\_\_\_

**ILLNESSES AND TREATMENTS**

Do you have, or have you ever had, the following:  None

<input type="checkbox"/> Adrenal disease	<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Anemia/blood disorders	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Artificial joint/heart valve
<input type="checkbox"/> Asthma	<input type="checkbox"/> Blood transfusion	<input type="checkbox"/> Bleeding disorder	<input type="checkbox"/> Cancer/tumors	<input type="checkbox"/> Chemotherapy
<input type="checkbox"/> Congenital heart defect	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Emotional condition	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Hayfever/sinus trouble
<input type="checkbox"/> Heart attack or angina	<input type="checkbox"/> Heart murmur	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Herpes/cold sores	<input type="checkbox"/> High blood pressure
<input type="checkbox"/> HIV positive/AIDS	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Migraine/frequent headaches	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Radiation treatments
<input type="checkbox"/> Rheumatic fever/heart disease	<input type="checkbox"/> Stomach problems	<input type="checkbox"/> Thyroid disorder	<input type="checkbox"/> Tuberculosis	

**ALLERGIES**

Are you allergic to any of the following?  None

<input type="checkbox"/> Aspirin	<input type="checkbox"/> Codeine	<input type="checkbox"/> Iodine	<input type="checkbox"/> Latex	<input type="checkbox"/> Local anesthetic	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Sulfa	<input type="checkbox"/> Other
----------------------------------	----------------------------------	---------------------------------	--------------------------------	---	-------------------------------------	--------------------------------	--------------------------------

Please list any other allergies you have: \_\_\_\_\_

**FAMILY HISTORY**

Do you have family members that have been diagnosed with the following:

<input type="checkbox"/> Cancer	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart problems	<input type="checkbox"/> Periodontal disease	<input type="checkbox"/> None
---------------------------------	-----------------------------------	---	--	-------------------------------

**MEDICATIONS**

Are you currently taking any of the following medications?  None

<input type="checkbox"/> Aspirin	<input type="checkbox"/> Antibiotics	<input type="checkbox"/> Anticoagulants (blood thinners)
<input type="checkbox"/> Antidepressants or tranquilizers	<input type="checkbox"/> Cortisone or other steroids	<input type="checkbox"/> High blood pressure medicine
<input type="checkbox"/> Insulin or other diabetes drug	<input type="checkbox"/> Nitroglycerin	<input type="checkbox"/> Osteoporosis medicine (increase bone density)

Please list all daily medications here including dosage:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



## PATIENT MEDICAL/DENTAL HISTORY FORM

### SOCIAL HISTORY

Do you drink ALCOHOL?

<input type="checkbox"/> Yes, less than 5 drinks/week	<input type="checkbox"/> Yes, 5-10 drinks/week	<input type="checkbox"/> Yes, more than 10 drinks/week	<input type="checkbox"/> No
---	--	--	-----------------------------

Do you use TOBACCO in any form?

<input type="checkbox"/> Yes	<input type="checkbox"/> Yes, but I am interested in quitting	<input type="checkbox"/> No, but I used to	<input type="checkbox"/> No
If YES to prior question, please answer the following:			
HOW LONG have you used TOBACCO?			
<input type="checkbox"/> Less than 5 years		<input type="checkbox"/> 5 or more years	
HOW FREQUENTLY do you use TOBACCO?			
<input type="checkbox"/> Less than one (1) pack/day or equivalent		<input type="checkbox"/> One (1) pack/day or equivalent	
		<input type="checkbox"/> More than one (1) pack/day or equivalent	

### WOMEN ONLY

Are you, or could you be, pregnant or nursing?

Yes  No

Are you currently taking hormones or contraceptives?

Yes  No

### DENTAL HISTORY

What is the name of your previous dentist? \_\_\_\_\_

Approximate date of last dental cleaning? \_\_\_\_\_

Are you IN PAIN NOW?

Yes  No

How frequent has your dental care been?

<input type="checkbox"/> Regular (twice a year)	<input type="checkbox"/> Intermittent (about once a year)	<input type="checkbox"/> Infrequent (less than once a year)
---	---	---

Do you feel apprehensive about visiting the dentist?

Yes  No

Have you had a full set of x-rays taken in the past 5 years?

Yes  No  Unsure

Have you had bitewing x-rays taken in the past year?

Yes  No  Unsure

Have you had problems with prior dental treatment?

Yes  No

Have you EVER EXPERIENCED any of the following?  None

<input type="checkbox"/> Bad breath	<input type="checkbox"/> Bad/metallic taste in mouth	<input type="checkbox"/> Bleeding gums	<input type="checkbox"/> Broken fillings
<input type="checkbox"/> Clicking or popping of jaw	<input type="checkbox"/> Drifting teeth	<input type="checkbox"/> Food packing between teeth	<input type="checkbox"/> Grinding teeth
<input type="checkbox"/> High or rough fillings	<input type="checkbox"/> Loose teeth	<input type="checkbox"/> Orthodontic treatment	<input type="checkbox"/> Pain or soreness in gums
<input type="checkbox"/> Periodontal treatment	<input type="checkbox"/> Pus around the teeth	<input type="checkbox"/> Receding gums	<input type="checkbox"/> Swelling of gums

Are you DISSATISFIED with any of the following?  None

<input type="checkbox"/> Position of teeth	<input type="checkbox"/> Color of teeth	<input type="checkbox"/> Shape of teeth	<input type="checkbox"/> Size of teeth	<input type="checkbox"/> Spaces/missing teeth	<input type="checkbox"/> Other
--	---	---	--	---	--------------------------------

Are your teeth SENSITIVE to any of the following?  None

<input type="checkbox"/> Cold	<input type="checkbox"/> Biting	<input type="checkbox"/> Heat	<input type="checkbox"/> Pressure	<input type="checkbox"/> Sweets	<input type="checkbox"/> Tooth brushing
-------------------------------	---------------------------------	-------------------------------	-----------------------------------	---------------------------------	---

Have you ever had an INJURY to your FACE, NECK, or JAWS?

Yes  No

Do you suffer from PAIN in the FACE, NECK, or JAWS?

Yes  No

Do you notice a lack of saliva (dry mouth)?

Yes  No

How often do you BRUSH? \_\_\_\_\_

How often do you FLOSS? \_\_\_\_\_

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health history and/or medications.  YES

\_\_\_\_\_  
**Signature of Patient or Responsible Party**

\_\_\_\_\_  
**Date**



## ACKNOWLEDGEMENT OF RECEIPT OF STATEMENT OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of McCauley Family and Cosmetic Dentistry. The Statement 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 health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

McCauley Family and Cosmetic Dentistry reserves the right to change the privacy practices currently described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed or otherwise transmitted to me.

<b>ADDITIONAL DISCLOSURE AUTHORIZATION</b>		
<b>In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my Protected Healthcare Information to the person(s) identified below. (I understand that the default answer is "NO." Without indicated "YES" in answer to the each individual questions, personal protected (PHI) cannot be shared with anyone unless otherwise allowed by HIPAA rules.)</b>		
Spouse Only	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<b>OR</b>		
Any member of my immediate family: (Spouse, Children, Children's Spouses)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Any member of my extended family: (Parents, Grandchildren)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Other: _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Name of Patient (Please Print): _____		
Patient's Signature: _____		
Patient's personal representative (Please Print): _____		
Personal Representative's Signature: _____		
Representative's Telephone Number: _____ Date: _____		

### OFFICE USE ONLY BELOW THIS LINE

Acknowledgement Not Obtained				
<b>Provided Prior to Treatment?</b>	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<b>Date Statement Provided:</b> _____	
<b>Reason for not obtaining patient signature</b>	<input type="checkbox"/>	Needed more time to review Statement	<input type="checkbox"/>	Wanted to consult another person before signing
	<input type="checkbox"/>	Physically unable to sign	<input type="checkbox"/>	No reason offered
	<input type="checkbox"/>	Other: _____		



## FINANCIAL POLICY

Welcome! Thank you for selecting us as your dental health care providers. Our goal is to provide you and your family with optimal dental care. We want you to feel welcome and as comfortable as possible throughout our relationship. We encourage you to ask questions and to be involved in treatment decisions. This includes understanding your treatment plan as well as our financial policy.

### **FINANCIAL AGREEMENT:**

Patients are expected to pay for our services at the time they are rendered. Our patients who have dental insurance are expected to pay the amount of their estimated co-pay and deductible at the time of service. Payments may be made using cash, check, or credit card. We also offer CareCredit, which is a financing option that is available only for healthcare finances.

It is to be noted that all removable prosthetics must be paid in full by the date of the delivery.

All emergency dental services must be paid for at the time of services rendered.

### **OPTIONAL PAYMENT TERMS:**

1. **Pre-pay Discount:** We offer a 5% courtesy discount for all services over \$500 that is paid in full prior to the commencement of services.
2. **Payment at time of service:** We accept cash, check, credit, and debit card for your convenience.
3. **CareCredit:** A patient payment program that if paid in full within the promotional period, charges 0% interest. We'd be happy to provide you with additional information regarding CareCredit.

A finance charge of 12% is added to the patient's account each month that the bill is not paid.

Checks that are returned to our office from your financial institution are subject to a \$25.00 returned check fee.

### **APPOINTMENTS:**

In order to serve you better and keep the cost of dental care down, we try to maintain an efficient appointment system. However, our cost of providing care increases greatly when people fail to keep scheduled appointments or cancel at the last minute. If you are unable to keep a scheduled appointment, please give 24 hours advance notice, to ensure that you will not be charged for the appointment.

---

**Signature of Patient or Responsible Party**

---

**Date**



## PHOTOGRAPHY RELEASE

I, \_\_\_\_\_,

hereby authorize Dr. Amanda McCauley or her assistants to take photographs, slides, and/or videos of my face, jaws, mouth, and teeth.

I understand that the photographs, slides, and/or videos will be used as a record of my care, and may be used for educational purposes in study club meetings, lectures, seminars, demonstrations, and professional publications (journals, magazines).

I understand that for marketing and educational purposes my photographs may be posted in social media forums or printed materials for patients as well.

I further understand that if the photographs, slides, and/or videos are posted anywhere or in any publication, my name and other identifying information will be kept confidential.

I do not expect compensation, financial or otherwise, for the use of these photographs.

\_\_\_\_\_  
**Signature of Patient or Responsible Party**

\_\_\_\_\_  
**Date**