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: Cell Phone:			Work 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? ☐ YES ☐ 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**

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

ALLERGIES

Are you allergic to any of the following? ☐**None**

☐ Aspirin	☐ Codeine	☐ Iodine	☐ Latex	☐ Local anesthetic	☐ Penicillin	☐ Sulfa	☐ Other

Please list any other allergies you have: ____

FAMILY HISTORY

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

☐ Cancer	☐ Diabetes	☐ Heart problems	☐ Periodontal disease	☐ None

MEDICATIONS

Are you currently taking any of the following medications? ☐**None**

☐ Aspirin	☐ Antibiotics	☐ Anticoagulants (blood thinners)
☐ Antidepressants or tranquilizers	☐ Cortisone or other steroids	☐ High blood pressure medicine
☐ Insulin or other diabetes drug	☐ Nitroglycerin	☐ Osteoporosis medicine (increase bone density)

Please list all daily medications here including dosage:

____
____
____

PATIENT MEDICAL/DENTAL HISTORY FORM

SOCIAL HISTORY

Do you drink ALCOHOL?

☐ Yes, less than 5 drinks/week	☐ Yes, 5-10 drinks/week	☐ Yes, more than 10 drinks/week	☐ No

Do you use TOBACCO in any form?

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

☐ Regular (twice a year)	☐ Intermittent (about once a year)	☐ 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**

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

Are you DISSATISFIED with any of the following? ☐**None**

☐ Position of teeth	☐ Color of teeth	☐ Shape of teeth	☐ Size of teeth	☐ Spaces/missing teeth	☐ Other

Are your teeth SENSITIVE to any of the following? ☐**None**

☐ Cold	☐ Biting	☐ Heat	☐ Pressure	☐ Sweets	☐ 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.

ADDITIONAL DISCLOSURE AUTHORIZATION		
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.)		
Spouse Only	☐ **YES**	☐ **NO**
OR		
Any member of my immediate family: (Spouse, Children, Children's Spouses)	☐ **YES**	☐ **NO**
Any member of my extended family: (Parents, Grandchildren)	☐ **YES**	☐ **NO**
Other: ____	☐ **YES**	☐ **NO**
PLEASE SIGN BELOW		
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				
Provided Prior to Treatment?	☐ **YES**	☐ **NO**	**Date Statement Provided: ____________**	
Reason for not obtaining patient signature	☐	**Needed more time to review Statement**	☐	**Wanted to consult another person before signing**
	☐	**Physically unable to sign**	☐	**No reason offered**
	☐	**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 these photos **will not** be used for social media, printed materials, or our website without signed authorization for use of this information.

I further understand that if the photographs, slides, and/or videos are posted anywhere or in any publication, my name and other personal 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**