

### Patient Information

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_  
Last First MI

Male  Female  Married  Single  Child

Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Drivers License #: \_\_\_\_\_ (Please provide copy of your license to our office if you financially responsible for your account)

Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ Ext: \_\_\_\_\_

**We would also like to receive your cell phone # and e-mail address to send friendly reminders of your dental appointments.**

Cell Phone #: \_\_\_\_\_  
 E - Mail Address: \_\_\_\_\_

Mailing Address: \_\_\_\_\_  
Street Apartment #  
City State Zip Code

### Health Information

Date of Last Dental Visit (if known): \_\_\_\_\_ Reason for this visit: \_\_\_\_\_

**Have you ever had any of the following? Please check those that apply:**

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> AIDS  | <input type="checkbox"/> Glaucoma                                     | <input type="checkbox"/> Pacemaker                             | <input type="checkbox"/> Penicillin Allergy                          |
| <input type="checkbox"/> Anemia  | <input type="checkbox"/> Growths                                      | <input type="checkbox"/> Pregnant? If so...<br>Due date: _____ | <input type="checkbox"/> ANY OTHER allergies and/or health con       |
| <input type="checkbox"/> Arthritis                                     | <input type="checkbox"/> Hay Fever                                    | <input type="checkbox"/> Radiation Treatment                   | _____  |
| <input type="checkbox"/> Artificial Joints <small>of any kind</small>  | <input type="checkbox"/> Head Injuries                                | <input type="checkbox"/> Respiratory Problems                  | _____  |
| <input type="checkbox"/> Artificial Heart valve                        | <input type="checkbox"/> Heart Disease                                | <input type="checkbox"/> Rheumatic Fever                       | <input type="checkbox"/> ANY OTHER allergies and/or health con       |
| <input type="checkbox"/> Asthma  | <input type="checkbox"/> Heart Murmur and/or<br>Mitral Valve Prolapse | <input type="checkbox"/> Rheumatism                            | _____  |
| <input type="checkbox"/> Blood Disease                                 | <input type="checkbox"/> Hepatitis                                    | <input type="checkbox"/> Sinus Problems                        | <b>Please list <u>ALL</u> medications<br/>currently being taken.</b> |
| <input type="checkbox"/> Cancer  | <input type="checkbox"/> High Blood Pressure                          | <input type="checkbox"/> Stomach Problems                      | _____  |
| <input type="checkbox"/> Diabetes and/or<br>Family history of diabetes | <input type="checkbox"/> Jaundice                                     | <input type="checkbox"/> Stroke                                | _____  |
| <input type="checkbox"/> Dizziness                                     | <input type="checkbox"/> Kidney Disease                               | <input type="checkbox"/> Tumors                                | _____  |
| <input type="checkbox"/> Epilepsy                                      | <input type="checkbox"/> Liver Disease                                | <input type="checkbox"/> Ulcers                                | _____  |
| <input type="checkbox"/> Excessive Bleeding                            | <input type="checkbox"/> Mental Disorders                             | <input type="checkbox"/> Venereal Disease                      | _____  |
| <input type="checkbox"/> Fainting                                      | <input type="checkbox"/> Nervous Disorders                            | <input type="checkbox"/> Codeine Allergy                       | _____  |

- Have you ever had any complications following dental treatment?  Yes  No  
If yes, please explain: \_\_\_\_\_
- Have you been admitted to a hospital or needed emergency care during the past two years?  Yes  No  
If yes, please explain: \_\_\_\_\_
- Are you now under the care of a physician for **any** health/medical related issue?  Yes  No  
If yes, please explain and state name & number of physician treating condition: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### Referral Information

**Whom may we thank for referring you to our practice?**

- Current Patient (please state pt's name) \_\_\_\_\_  Internet and/or Website
- Dental Office (please state referring doctor's name) \_\_\_\_\_  Other \_\_\_\_\_

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature of patient, parent or guardian

Date

### Spouse or Responsible Party Information

The following is for:  the patient's spouse  the person responsible for payment

Name: \_\_\_\_\_  
 Male  Female  Married  Single  Child  Other \_\_\_\_\_

Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ Ext: \_\_\_\_\_ Best time to call: \_\_\_\_\_

Address: \_\_\_\_\_  
Street \_\_\_\_\_ Apartment # \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

### Employment Information

The following is for:  the patient  the person responsible for payment

Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

### Insurance Information

#### Primary

Name of Insured: \_\_\_\_\_ Is insured a patient?  Yes  No

Insured's Birth Date: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_  
Last First MI

Insured's Address: \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Insured's Employer Name: \_\_\_\_\_

Address: \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Patient's relationship to insured:  Self  Spouse  Child  Other \_\_\_\_\_

Insurance Plan Name and Address: \_\_\_\_\_  
\_\_\_\_\_

#### Secondary

Name of Insured: \_\_\_\_\_ Is insured a patient?  Yes  No

Insured's Birth Date: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_  
Last First MI

Insured's Address: \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Insured's Employer Name: \_\_\_\_\_

Address: \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Patient's relationship to insured:  Self  Spouse  Child  Other \_\_\_\_\_

Insurance Plan Name and Address: \_\_\_\_\_  
\_\_\_\_\_

### Consent for Services

I hereby consent for all services deemed necessary by Dr. David H. McCarley. I am aware the practice of dentistry is not an exact science, and no guarantees can be provided.

I give consent to Dr. McCarley and/or trained team members to take photographs of me for use in medical teaching and writing. These photographs may be published in medical books or CD ROMS or displayed on our office website at: [www.mccarleydental.com](http://www.mccarleydental.com)

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 costs 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 for in cash 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. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. We will give insurance company up to, but not exceeding, 90 days. At that time, balance is full patient responsibility.

A service charge (or late charge) of \$25.00 per month on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as 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 you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I understand that any appointment cancelled without 24 hour notice will be subject to a \$25 cancellation fee.

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: \_\_\_\_\_