Lisa McDonald, DMD
& Associates

Complete Health and Wellness for All

Welcome to our Practice!

PATIENT HEALTH RECORD

Date: _____

Dr. Mr. Mrs. Ms. _____ I prefer to be addressed as: _____

(Last) (First) (Initial)

Address: _____

(Street) (City) (State) (Zip code)

Home Phone: _____ Business Phone: _____

Cell Phone: _____ E-Mail address: _____

Date of Birth: _____ Sex: M F Married: _____ Single: _____ Other: _____

Employer: _____ Social Security #: _____ Spouse's Name: _____

Emergency Contact – Name: _____ Phone Number: _____

Whom may we thank for referring you to us: _____

MEDICAL HEALTH

What is your general state of health? Excellent _____ Good _____ Fair _____ Poor _____

Name/Address/Phone # of Physician: _____

Have you been under a physician's care during the last two years? _____

Have you been treated in a hospital in the past three years? _____

Have you had major surgery? _____

History with general or IV anesthesia? _____ If female: Are you pregnant or nursing? _____

Do you or have you had any of the following? *Blood Pressure (office to take)* _____

	Past	*Present*	*None*		*Past*	*Present*	*None*		*Past*	*Present*	*None*
Epilepsy or Seizures	[ ]	[ ]	[ ]	Kidney Problems	[ ]	[ ]	[ ]	Cancer	[ ]	[ ]	[ ]
Fainting or Dizziness	[ ]	[ ]	[ ]	Bruise/Bleeds easily	[ ]	[ ]	[ ]	Chemotherapy	[ ]	[ ]	[ ]
Stroke	[ ]	[ ]	[ ]	Heart Problems	[ ]	[ ]	[ ]	Radiation Therapy	[ ]	[ ]	[ ]
Persistent Cough	[ ]	[ ]	[ ]	Chest Pain/Angina	[ ]	[ ]	[ ]	Thyroid Disease	[ ]	[ ]	[ ]
Emphysema/Bronchitis	[ ]	[ ]	[ ]	Osteoporosis/Penia	[ ]	[ ]	[ ]	AIDS/HIV+	[ ]	[ ]	[ ]
Tuberculosis/PPD+	[ ]	[ ]	[ ]	Rheumatic Fever	[ ]	[ ]	[ ]	Arthritis	[ ]	[ ]	[ ]
Asthma	[ ]	[ ]	[ ]	Heart Murmur	[ ]	[ ]	[ ]	Fibromyalgia	[ ]	[ ]	[ ]
Sinus Problems	[ ]	[ ]	[ ]	Mitral Valve Prolapse	[ ]	[ ]	[ ]	High Blood Pressure	[ ]	[ ]	[ ]
Anemia/Sickle Cell	[ ]	[ ]	[ ]	Congenital Heart Lesions	[ ]	[ ]	[ ]	Gastric Reflux	[ ]	[ ]	[ ]
Hepatitis A, B, C	[ ]	[ ]	[ ]	Heart Surgery	[ ]	[ ]	[ ]	Heartburn	[ ]	[ ]	[ ]
Liver Disease	[ ]	[ ]	[ ]	Artificial Heart Valves	[ ]	[ ]	[ ]	Snoring	[ ]	[ ]	[ ]
Pneumonia	[ ]	[ ]	[ ]	Pacemaker	[ ]	[ ]	[ ]	Sleep Apnea	[ ]	[ ]	[ ]
Nervousness/Anxious	[ ]	[ ]	[ ]	Dry Mouth	[ ]	[ ]	[ ]	Daytime Sleepiness	[ ]	[ ]	[ ]
Irregular Heart Beat	[ ]	[ ]	[ ]	Latex Allergy	[ ]	[ ]	[ ]	Diabetes	[ ]	[ ]	[ ]
Blood Thinners	[ ]	[ ]	[ ]	Artificial Joints	[ ]	[ ]	[ ]	Herpes	[ ]	[ ]	[ ]

Do you have any condition, disease or problem not previously listed? _____

Please list all the medications you are taking, including over the counter drugs and herbs.

Medications:	Dosage/Day	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Vitamins & Supplements	Yes	No
If yes, do you take daily:		
Multivitamin	Yes	No
Fish Oil (Omega 3)	Yes	No
Joint Support	Yes	No
Other:		
_____		
_____		
_____		

Are you allergic to: [ ] Penicillin [ ] Codeine [ ] Local Anesthetics [ ] Other_____
Do you take medicine for osteoporosis? Yes No

Do you currently smoke or have a history of smoking? _____

Are you interested in treatment for the following:

snoring/sleep apnea _____

straightening your teeth _____

Whitening your teeth _____

HIPAA CONSENT

By signing this form, you consent to our use and disclosure of your protected health information which may include emailing documents to specialists to carry out treatment, payment activities and health care operations. It also confirms that you have read and been offered a copy of our Notice of Privacy Practices.

Signature _____ **Date**_____

I give authorization to share my health information with the following individual(s):

1. _____
2. _____
3. _____

To the best of my knowledge, all of the preceding is correct. If I ever have a change in my health, medication, or medical condition, I will inform the dentist at my next appointment. I authorize release of any information to my insurance company and/or other healthcare providers involved in my treatment.

Signature _____ **Date** _____

Doctor Signature _____ **Date** _____

Children and Adolescents

Sleep, Breathing & Habit Questionnaire

Patient's Name: _____ Age: _____ Date: _____

Please indicate if your child experiences or has experienced any of the symptoms below by using this scale to measure the severity of these symptoms.

0 - No Occurrence 1 - Occurs Rarely 2 - Occurs 2 to 4 times per week 3 - Occurs 5 to 7 times per week

1. _____ Snoring
2. _____ Interrupted snoring where breathing stops
3. _____ Labored, difficult or loud breathing at night
4. _____ Gasping for air while sleeping
5. _____ Mouth breathes while sleeping
6. _____ Mouth breathes during the day
7. _____ Restless sleep
8. _____ Grinds teeth while sleeping
9. _____ Talks in sleep
10. _____ Excessive sweating while sleeping
11. _____ Wakes up at night
12. _____ Wets the bed (currently)
13. _____ History of bedwetting
14. _____ Feels sleepy and/or irritable during the day
15. _____ Headaches
16. _____ Frequent throat infections
17. _____ Seasonal allergies
18. _____ Ear infections or history of ear infections
19. _____ Short attention span
20. _____ Trouble Focusing
21. _____ Difficulty listening/often interupts
22. _____ Hyperactive
23. _____ ADD/ADHD
24. _____ Sensory issues
25. _____ Struggles in math at school
26. _____ Struggles in reading at school
27. _____ Speech issues *
28. _____ Avoidance behavior towards food or or certain types of food

*Speech Questionnaire - to be filled out only if #27 was indicated above

Please check all that apply to your child

_____ Is it difficult to understand your child's speech?

_____ Difficult to understand over the phone?

_____ Nasal speech?

_____ Hoarseness?

_____ Others have difficulty understanding speech?

_____ Gets frustrated when people can't understand speech?

_____ Speech sounds abnormal?

_____ Sometimes omits consonants?

_____ Uses M, N, NG instead of P, V, S, Z sounds?

_____ Liquids and/or solids get into nasal area when eating or drinking?

Lisa McDonald, DMD
& Associates

Complete Health and Wellness for All

PAYMENT AND COLLECTION POLICY

The following financial policies have been enacted to enable us to continue to provide the highest quality of dental care to our patients. We value our relationship with our patients and will be happy to assist you regarding our policies and charges.

- If you have dental insurance, we will file claims as a courtesy for our patients. We do not have a contract with your insurance company, only you do. Most plans pay between 30 – 50% of the average dental treatment fee. The percentage paid is usually determined by how much you or your employer has set up with the insurance company. Insurance companies set their own fee schedules and each company uses a different set of fees. We have no control over how your insurance pays its claims or the amount they pay. We can only aid you in estimating your portion of the treatment cost; we at no time guarantee what your insurance will or will not do with each claim. **You will be responsible for your estimated fees and deductible at the time of service, as well as any balance that may remain after your insurance payments are received.**
- If we have knowledge that your insurance company sends payments to you rather than our dental office, you will be required to pay for the entire treatment at the time of services.
- If your insurance company has not paid your account within 90 days, you are responsible for the balance of your account.
- If you do not have dental insurance, full payment is required at the time of service.
- We accept payment in the form of cash, check, debit card, Visa, MasterCard and Discover or our financial partner, Care Credit.
- **A $25.00 fee will be applied for all NSF/returned/stopped payment checks.**
- If your account is referred to a collection agency, you will be responsible for all fees incurred.

Please feel free to ask any questions you may have regarding our insurance or payment policies. We are happy to help you in any way we can regarding the processing of your insurance claims. Please sign below stating that you understand and accept our payment policy.

Signature: _____ Date: _____

Lisa McDonald, DMD
& Associates

Complete Health and Wellness for All

BROKEN DENTAL APPOINTMENT POLICY

It is our policy to reserve time for your appointments in order to give you the best treatment possible. We honor and value your time, and we expect that you will do the same for us. If for any reason you need to reschedule an appointment please call us **48 hours before your reserved time** so that we can give that time to someone who is waiting. Otherwise, as a matter of mutual respect, we trust that you will set other things aside and be here as agreed.

We hate to, but **we do charge for missed or broken dental appointments**. If you miss an appointment, you will be expected to pay a **Broken Appointment Charge of $75** before coming in for a rescheduled appointment. If you miss a subsequent appointment, we will ask you to pay for your next appointment in advance.

We understand that some people have unpredictable schedules, but there is usually some way – such as same day or last minute scheduling – to accommodate almost anyone who really wants to take care of their health.

Our goal is to improve your health and well-being through quality dental care. Aiming for this, we can certainly make our schedules work together.

Signature:_____ Date: _____

Lisa McDonald, DMD
& Associates
Complete Health and Wellness for All

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____ (PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ _____ Date: _____