



**McDonald Family Dentistry  
Patient Information**

Today's Date:   /  /  

Patient's Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Social Security #: \_\_\_\_\_

By what name do you prefer to be addressed: \_\_\_\_\_ E-mail: \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Patient's Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Marital Status: Married      Single      Divorced      Widowed

Whom may we thank for referring you to our office? \_\_\_\_\_

<b>If Patient is a Minor:</b>		
Father's Name: _____	Social Security #: _____	Home Phone: _____
Father's Address: _____		
Mother's Name: _____	Social Security #: _____	Home Phone: _____
Mother's Address: _____		

Party Responsible for account: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address (if different from above): \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

**Dental Insurance**

**Primary Insurance**

Insured's Name \_\_\_\_\_ Relationship \_\_\_\_\_

Birthdate \_\_\_\_\_ Social Security# \_\_\_\_\_

Employer \_\_\_\_\_ Date Employed \_\_\_\_\_ Ins. Co. Phone # \_\_\_\_\_

Insurance Co. \_\_\_\_\_ Group # \_\_\_\_\_

Ins. Co. Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_

**Additional Insurance**

Insured's Name \_\_\_\_\_ Relationship \_\_\_\_\_

Birthdate \_\_\_\_\_ Social Security# \_\_\_\_\_

Employer \_\_\_\_\_ Date Employed \_\_\_\_\_ Ins. Co. Phone # \_\_\_\_\_

Insurance Co. \_\_\_\_\_ Group # \_\_\_\_\_

Ins. Co. Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_

# Medical History

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Physician Name: \_\_\_\_\_

Physician Telephone: \_\_\_\_\_

**Please circle Yes or No and check boxes that apply**

**Do you have, or have you had heart or cardiovascular problems?**

Yes No

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Previous Premedication prior to dental procedures | <input type="checkbox"/> Mitral Valve Prolapse  | <input type="checkbox"/> Congenital Heart Defect |
| <input type="checkbox"/> Heart Murmur                                      | <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Heart Attack            |
| <input type="checkbox"/> Rheumatic Fever/ Rheumatic Heart Disease          | <input type="checkbox"/> Pacemaker              | <input type="checkbox"/> Chest Pain              |
| <input type="checkbox"/> Heart Surgery/ Angioplasty                        | <input type="checkbox"/> Stroke                 | <input type="checkbox"/> Circulatory problems    |
| <input type="checkbox"/> High or Low Blood Pressure                        | <input type="checkbox"/> Irregular Heart Beat   | <input type="checkbox"/> Other _____             |

**Do you have, or have you had lung or breathing problems?**

Yes No

- Asthma,  Sinusitis,  Seasonal Allergies,  Bronchitis,  Tuberculosis,  Emphysema,  Other \_\_\_\_\_

**Do you have, or have you had skeletal or joint problems?**

Yes No

- Artificial joints,  Arthritis,  Jaw joint pain,  Back pain,  Other \_\_\_\_\_

**Do you have, or have you had blood problems?**

Yes No

- Anemia,  Prolonged bleeding,  Bruise easily,  Hemophilia,  Blood Thinners,  
 Sickle Cell disease,  Leukemia,  Other \_\_\_\_\_

**Do you have, or have you had stomach or intestinal problems?**

Yes No

- Ulcer,  Acid reflux,  Other \_\_\_\_\_

**Do you have, or have you had endocrine problems?**

Yes No

- Diabetes,  Thyroid problems,  Steroid or Prednisone treatments,  Other \_\_\_\_\_

**Do you have, or have you had liver or kidney problems?**

Yes No

- Hepatitis,  Yellow jaundice,  Renal failure/Dialysis,  Other \_\_\_\_\_

**Do you have, or have you had neurologic problems?**

Yes No

- Seizures,  Multiple Sclerosis,  Psychiatric Treatment,  Substance abuse,  Other \_\_\_\_\_

**Do you use tobacco in any form?**

Yes No

**Have you ever been diagnosed with cancer or a tumor?**

Yes No

Type \_\_\_\_\_ Treatment \_\_\_\_\_

**Have you been diagnosed as HIV/ AIDS positive?**

Yes No

**Women, are you or might you be pregnant or breastfeeding?**

Yes No

**Please list any other diseases, illnesses, or health problems not listed above:**

**Please list all medications that you are currently taking:** \_\_\_\_\_

**Please list all allergies to medications and food:** \_\_\_\_\_

The above information is accurate and complete to the best of my knowledge. I will not hold Dr. McDonald or any member of his staff accountable for errors or omissions that I may have made in completing this form. I also consent to examination and treatment in this office.

Date: \_\_\_\_\_ Patient's Signature (parent or guardian if minor): \_\_\_\_\_

Reviewed (patient initials): \_\_\_\_\_

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

## DENTAL HISTORY

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

### GENERAL INFORMATION

Approximate date of last dental visit: \_\_\_\_\_ Approximate date of last x-rays taken: \_\_\_\_\_

How often do you brush your teeth? \_\_\_\_\_ Floss your teeth? \_\_\_\_\_

Are there any areas of dental health or dentistry that you have questions about? Please circle:

Whitening      Bonding/Veneers      Crowns/Caps      Braces      Other: \_\_\_\_\_

Are you experiencing any pain in your teeth, gums, or jaws?      Yes      No

Please explain: \_\_\_\_\_

### WHAT CAN WE DO TO MAKE YOU FEEL MORE COMFORTABLE?

Would you like a personal walkman to listen to CDs?      Yes      No

Will you need blankets to help with the temperature?      Yes      No

Will you need a pillow to support your neck?      Yes      No

Would you prefer sunglasses to wear during your appointment?      Yes      No

Any preferences of yours we have not asked? \_\_\_\_\_

### WHAT ARE YOUR FEELINGS ABOUT YOUR:

#### FRONT TEETH

Are you happy with their color?      Yes      No

Are you happy with their length?      Yes      No

Are they crooked?      Yes      No

Are you happy with their overall appearance?      Yes      No

Is there anything about your front teeth that you would change? \_\_\_\_\_

#### BACK TEETH

Are they sensitive to hot or cold foods?      Yes      No

Do they trap food when you eat?      Yes      No

Is there anything about your back teeth that you would change? \_\_\_\_\_

#### GUMS

Do they ever bleed?      Yes      No

Are they sensitive?      Yes      No

Do you have bad breath?      Yes      No

Is there anything about your gums that you would change? \_\_\_\_\_

#### MISSING TEETH

Do you have any missing teeth?      Yes      No

Are you wearing a replacement?      Yes      No

Is your denture or partial comfortable?      Yes      No

Is there anything about them that you would change? \_\_\_\_\_



## McDonald Family Dentistry Patient Financial Policy

Our office wants all of our patients to be able to comfortably afford dental care. We proudly offer the following financial policy so that our patients can have the opportunity to decide which payment option best suits your needs.

### Insurance:

We are committed to providing you with the best possible dental care. If you have dental insurance, we will help you receive your maximum benefits and we are pleased to file a claim for you at no charge. Most dental insurance plans do not cover 100% of your cost of treatment. Because of this, **you will be asked to pay your deductible and your co-payment for the charges on the day the service is rendered.** We will estimate as closely as possible your coverage, but we can make no guarantee of any estimated coverage. Because the insurance policy is an agreement between you and your insurance company, the ultimate responsibility for all charges lies with you. If after 60 days the insurance company has not paid on the claim, you will be responsible for the total balance including finance charges (1.5% per month). *Please be sure to follow-up with your insurance company to ensure payment of claims submitted.*

### Payment Options:

1. **Cash or Check** is gladly accepted. No post-dated checks are accepted.
2. **Credit Card:** Our office also accepts MasterCard or Visa.
3. **Outside Financing:** Financial services through Care Credit or Citi Health Card Services for low or no interest financing to support you in having optimal treatment when necessary. These companies will ask you to do a brief application and will verify your credit history prior to extending credit.

\*Payment not made for services after a reasonable period of time will be forwarded to a collection agency or attorney and formal action to collect the debt will be initiated. You will be responsible for any attorney's fees and/or collection charges incurred.

\*\* A \$25 charge will be incurred for any checks returned for non-sufficient funds.

Thank you for reviewing our financial policies. We make every effort to explain in advance of treatment your costs to you so that we can avoid misunderstandings and focus on your dental health. If you have any questions, please ask. We are here to serve you.

By signing below, I understand and agree to the terms stated above. I have also received a copy of this agreement for my records.

Signed \_\_\_\_\_ Date \_\_\_\_\_

# Patient Acknowledgment of Receipt of Privacy Practices Notice


Please Print

I, \_\_\_\_\_, hereby acknowledge that I have reviewed and received a copy of this office's *Notice of Privacy Practices* explaining:

- How this office will use and disclose my protected health information.
- My privacy rights with regard to my protected health information.
- This office's obligations concerning the use and disclosure of my protected health information.

I understand that the *Notice of Privacy Practices* may be revised from time to time and that I am entitled to receive a copy of any revised *Notice of Privacy Practices* upon request.

I also understand that if I have any questions or complaints, I may contact:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  McDonald Family Dentistry  
2400 128<sup>th</sup> Street  
Urbandale, Iowa 50323  
info@mcdonaldfamilydentistry.com \_\_\_\_\_  
\_\_\_\_\_

You may also contact the Secretary of the U.S. Department of Health and Human Services with any concerns regarding our privacy and security policies and procedures. Please contact our office for information on how to contact the U.S. Department of Health and Human Services.

## Patient or Personal Representative

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Name: \_\_\_\_\_  
Please Print

Relationship to Patient: \_\_\_\_\_

### For Office Use Only

We made a good-faith effort to obtain an acknowledgment of \_\_\_\_\_'s receipt of our *Notice of Privacy Practices*. In spite of these efforts, our office has been unable to obtain a signed acknowledgment of receipt for the following reasons (check all that apply):

- Patient refused to sign (date of refusal) \_\_\_\_/\_\_\_\_/\_\_\_\_.
- Communications barriers prohibited obtaining an acknowledgment.
- An emergency situation prevented us from obtaining an acknowledgment.
- Other \_\_\_\_\_

Attempt was made by: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_