Patient Information, Medical & Dental History

Welcome! So that we may provide you with the best possible care, please complete both sides of this medical/dental history form. All information is completely confidential.

PATIENT INFORMATION

Name_____ { } Male { } Female Today's Date_____
First MI Last

How do you wish to be addressed by our staff?_____ Date of Birth____/____/____

Whom may we thank for referring you?_____

SSN #_____ Email Address_____

Mailing Address_____ City_____ State_____ Zip_____

Home #_____ Cell #_____ Work #_____

Physician's Name_____ Phone #_____

Do you prefer appointment reminders by: { } Email { } Phone { } Text { } All forms/No preference

Do you prefer to receive calls from our office at: { } Home { } Cell { } Work { } All forms/No preference

Are you: { } Minor { } Married { } Single { } Divorced { } Widowed { } Separated

Employer_____ Occupation_____

Spouse's Name_____ Spouse's Date of Birth____/____/____
First MI Last

Spouse's Employer_____ Spouse's Occupation_____

Spouse's Work #_____ Is the patient a full time student? { } No { } Yes

If yes, name of the school_____

RESPONSIBLE PARTY (only if different than patient)

Name_____ Date of Birth____/____/____
First MI Last

Mailing Address_____ City_____ State_____ Zip_____

Home #_____ Cell #_____ Work #_____

SSN #_____ Relationship_____

INSURANCE INFORMATION

Medical Insurance

Subscriber's Name_____ Date of Birth____/____/____

SSN#_____ Relationship to Patient_____

Insurance Company_____ Policy #_____ Group#_____

All information is completely confidential.

Supplemental Insurance (Dental)

Subscriber's Name_____ Relationship to Patient_____

Mailing Address_____ City_____ State_____ Zip_____

Date of Birth____/____/____ SSN#_____ Employer_____

Insurance Company_____ Group#_____ Effective Date____/____/____

Do you have additional Dental Insurance? { } Yes { } No If yes, please complete the following:

Subscriber's Name_____ Relationship to Patient_____

Mailing Address_____ City_____ State_____ Zip_____

Date of Birth____/____/____ SSN#_____ Employer_____

Insurance Company_____ Group#_____ Effective Date____/____/____

DENTAL HISTORY – *Please fill out the following to the best of your ability*

What is the reason for your visit today? _____

Previous Dentist's Name _____ Telephone _____

Date of last dental visit _____ Last dental cleaning _____ Last X-Rays _____

How often do you have dental examinations? _____ How often do you brush? _____

Have you ever used topical fluoride?_____ How often do you floss? _____

What other dental aids do you use? (Toothpick, etc.) _____

Do you have any dental problems now? _____

Are any of your teeth sensitive to:

Hot or cold?	Y / N
Sweets?	Y / N
Biting or chewing?	Y / N
Have you noticed any bad odors or tastes?	Y / N
Do you frequently get cold sores or blisters?	Y / N
Do your gums hurt or bleed?	Y / N
Have your parents experienced gum disease or tooth loss?	Y / N
Have you noticed loose teeth or change in your bite?	Y / N
Does food tend to become caught in your teeth?	Y / N

If yes, where? _____

Do you:

Clench or grind your teeth?	Y / N
Bite your lips or cheeks regularly?	Y / N
Hold foreign objects with your teeth?	Y / N
Mouth breathe?	Y / N
Have tired jaws, especially in the morning?	Y / N
Snore or have any sleep disorders?	Y / N
Smoke/chew tobacco or other tobacco products?	Y / N

Have you ever had:

Orthodontic treatment?	Y / N
Oral surgery?	Y / N
Periodontal treatment?	Y / N
Your teeth ground or bite adjusted?	Y / N
A bite plate or mouth guard?	Y / N
A serious injury to the mouth or head?	Y / N

If yes, explain _____

Have you experienced:

Clicking or popping of the jaw?	Y / N
Pain? (ear, side of face, joint)	Y / N
Difficulty opening or closing the mouth?	Y / N
Difficulty chewing on either side?	Y / N
Headaches, neck aches, shoulder aches?	Y / N
Sore muscles (neck, shoulders)?	Y / N
Are you satisfied with your teeth's appearance?	Y / N
Would you like to keep your teeth all of your life?	Y / N
Do you feel nervous about having dental treatment?	Y / N

If so, biggest concern? _____

(see other side)

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have or had, or medication that you may be taking, could have an important interrelationship with the treatment you will receive. Thank you for answering the following questions. All information is completely confidential.

MEDICAL HISTORY *– Please fill out the following to the best of your ability*

Are you under a physician's care now?	Yes	No	If yes, please list the information on the following page.
Have you ever been hospitalized or had a major operation?	Yes	No	If yes, please list the information on the following page.
Have you ever had a serious head or neck injury?	Yes	No	If yes, please list the information on the following page.
Are you currently taking a blood thinner?	Yes	No	If yes, please list the information on the following page.
Have you ever taken Fosamax, Boniva, Actonel?	Yes	No	If yes, please explain:_____
Do you take, or have you taken, Phen-Fen or Redux?	Yes	No	If yes, please list the information on the following page.
Are you on a special diet?	Yes	No	If yes, please explain:_____
Do you use tobacco or smoke?	Yes	No	If yes, how often:_____
Do you consume alcoholic beverages?	Yes	No	If yes, how often:_____
Do you use recreational drugs?	Yes	No	If yes, please explain:_____
Do you use controlled substances?	Yes	No	If yes, please explain:_____
Do you need to **pre-medicate**?	Yes	No	If yes, please explain:_____

Women: Are you Pregnant/Trying? { } Yes { } No **Taking Oral Contraceptives?** { } Yes { } No **Nursing?** { } Yes { } No

Are you allergic to any of the following? { } Penicillin { } Latex { } Codeine { } Aspirin { } Acrylic { } Metal
{ } Local Anesthetics { } Other_____ If yes, please explain_____

Do you currently have, or have you had, any of the following?

AIDS/HIV Positive	Yes	No	Intestinal Disease	Yes	No	Difficulty Swallowing?	Yes	No
Alzheimer's Disease	Yes	No	Irregular Heartbeat	Yes	No	Dizziness	Yes	No
Anaphylaxis	Yes	No	Kidney Problems	Yes	No	Do you wear removable teeth?	Yes	No
Anemia	Yes	No	Leukemia	Yes	No	Dry Mouth	Yes	No
Angina	Yes	No	Liver Disease	Yes	No	Dysphagia	Yes	No
Arthritis/Gout	Yes	No	Low Blood Pressure	Yes	No	Ear Pain	Yes	No
Artificial Heart Valve	Yes	No	Lung Disease	Yes	No	Eating Disorders	Yes	No
Artificial Joint	Yes	No	Mitral Valve Prolapse	Yes	No	Excessive Stress	Yes	No
Asthma	Yes	No	Pain in Jaw Joints	Yes	No	Fibromyalgia	Yes	No
Blood Disease	Yes	No	Parathyroid Disease	Yes	No	Frequent Urination	Yes	No
Blood Transfusion	Yes	No	Psychiatric Care	Yes	No	GERD	Yes	No
Breathing Problem	Yes	No	Radiation Treatments	Yes	No	Gout	Yes	No
Bruise Easily	Yes	No	Recent Weight Loss	Yes	No	High Cholesterol	Yes	No
Cancer	Yes	No	Renal Dialysis	Yes	No	Hormonal Change	Yes	No
Chemotherapy	Yes	No	Rheumatic Fever	Yes	No	Joint Pain	Yes	No
Chest Pains	Yes	No	Rheumatism	Yes	No	Knee/Hip Replacement	Yes	No
Cold Sores	Yes	No	Scarlet Fever	Yes	No	Memory Loss	Yes	No
Congenital Heart Disorder	Yes	No	Shingles	Yes	No	Memory Problems	Yes	No
Convulsions	Yes	No	Sickle Cell Disease	Yes	No	Multiple Sclerosis (MS)	Yes	No
Cortisone Medicine	Yes	No	Sinus Trouble	Yes	No	Muscle Weakness	Yes	No
Diabetes	Yes	No	Spina Bifida	Yes	No	Nocturia	Yes	No
Drug Addiction	Yes	No	Stroke	Yes	No	Nose Bleeding	Yes	No
Easily Winded	Yes	No	Swelling of Limbs	Yes	No	Pulmonary Embolism	Yes	No
Emphysema	Yes	No	Thyroid Disease	Yes	No	Recent Trauma or Injury	Yes	No
Epilepsy	Yes	No	Tonsillitis	Yes	No	Seizures	Yes	No
Excessive Bleeding	Yes	No	Tuberculosis	Yes	No	Soft or Special Diet	Yes	No
Excessive Thirst	Yes	No	Tumors or Growths	Yes	No	Sulfa Allergy?	Yes	No
Fainting/Dizzy Spells	Yes	No	Ulcers	Yes	No	Tachycardia	Yes	No
Frequent Cough	Yes	No	Venereal Disease	Yes	No	Tingling/Numbness	Yes	No
Frequent Diarrhea	Yes	No	Yellow Jaundice	Yes	No	Tinnitus (Ringing in Ear)	Yes	No
Frequent Headaches	Yes	No				Tremor	Yes	No
Genital Herpes	Yes	No	**Also, please answer the following...**			Trigeminal Neuralgia	Yes	No
Glaucoma	Yes	No				Wisdom Teeth Extraction?	Yes	No
Hay Fever	Yes	No	Current Weight: _____ lbs.					
Heart Attack/Failure	Yes	No	Height: _____ ft. _____ in.			Obstructive Sleep Apnea	Yes	No
Heart Murmur	Yes	No				Do you use a CPAP?	Yes	No
Heart Pace Maker	Yes	No	Acid Reflux	Yes	No	If yes, how often_____		
Heart Trouble/Disease	Yes	No	ADD/ADHD	Yes	No	Do you snore?	Yes	No
Hemophilia	Yes	No	Anxiety	Yes	No	Daytime Sleepiness	Yes	No
Hepatitis A	Yes	No	Back Pain	Yes	No	Fatigue/Tired	Yes	No
Hepatitis B or C	Yes	No	Bronchitis	Yes	No	Morning Headaches	Yes	No
Herpes	Yes	No	Change in Hearing	Yes	No	Nasal Obstruction	Yes	No
High Blood Pressure	Yes	No	Change in Vision	Yes	No			
Hives or Rash	Yes	No	Congestion	Yes	No			
Hypoglycemia	Yes	No	Depression	Yes	No			

(see other side)

All information is completely confidential.

List any medications you are currently taking:

	Medication	Reason
1.		
2.		
3.		
4.		
5.		
6.		

List any major surgeries or hospitalizations you have had:

	Date	Surgery
1.		
2.		
3.		
4.		
5.		
6.		

NOTE: If you have a current list, the front desk may make a copy of this for your records

List and detail any medical condition or history not listed above:

Primary Physician's Name_____ Phone #_____

Are you under the care of other physicians? If so, please list:

Physician	Phone #	Reason

GENERAL CONSENT TO DISGNOSE AND TREAT

The undersigned hereby authorizes McMahon Family Dental to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the undersigned patient's dental condition and needs. I authorize McMahon Family Dental to perform any and all forms of treatment, medication, and therapy that may be necessary and further consent that McMahon Family Dental chooses to employ such assistance as deemed necessary. I understand that the use of local anesthetics agents embodies certain risk and consent to their use as deemed appropriate by McMahon Family Dental. To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect or incomplete information can be dangerous to my/the patient's health. **It is my responsibility to inform the dental office of any change in medical health or status.**

CONSENT (ADULT)

Name of Patient_____ Signature of Patient_____ Date_____

CONSENT (FOR A MINOR)

Name of Parent/Guardian_____ Signature of Parent/Guardian_____ Date_____

(see other side)

Notice of Privacy Practices & HIPAA Consent

Patient Privacy is important to our practice. We are required by law to maintain privacy of Protected Health Information (PHI) and to provide individuals with notice of our legal duties and privacy practices with respect to PHI.

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you (the patient). The Notice contains a Patient Rights section describing your rights under the law (this may be requested at the front desk). You have the right to review our full Notice before signing Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.
You have the right to request that we restrict protected health information about you that is used or disclosed for treatment, payment or healthcare operations.
By signing this form, you consent to our use and disclosure of protected health information about your treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Policy.
- The patient has the right to restrict the use of their information.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon execution of this Consent. No insurance can be billed on the patient's behalf without this signed HIPAA consent form, therefore payment in full is required at the time services are rendered.

Information SHARING: Please list any individuals we can share your personal information with other than healthcare providers.

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

_____ _____

This HIPAA Consent/Sharing was signed by (Signature) *Today's Date*

_____

Relationship to Patient (if other than patient)

(see other side)

Financial Consent & Office Guidelines

McMahon Family Dental is committed to providing all patients with exceptional service and quality care. Please review our financial consent and office guidelines then sign/date below. Thank you.

Financial Obligation & Payment Guidelines

All patients: I understand that any responsibility for payment of services provided in this office for myself and my dependent(s) is mine, due and payable at the time services are rendered regardless of whether I have medical or dental insurance. I am responsible for all fees for services rendered. I am responsible for all fees necessary to collect my account. Any quoted fees will be honored for a period of 3 months. I am aware that any balance carried past 90 days will be subject to interest at 7%, simple interest, and to a 5% rebilling fee at each statement period thereafter, as well as being sent to collections.

Patients with medical or dental benefits: I authorize McMahon Family Dental and their staff to submit claims and provide my insurance company with information required for a claim, to assign benefits payable to them, and to handle any necessary claim appeal(s) on my behalf. I understand that insurance billing is a courtesy to me by McMahon Family Dental, and that I have ultimate responsibility for insurance claims, billing and payment of all charges regardless of insurance payment or reimbursement. **I understand that it is MY RESPONSIBILITY to know my specific plan/policy coverage.** I understand that if a pre-treatment estimate has been sent to my insurance company that this is not a guarantee of payment. I understand that the estimate is based on best available information, but the final charge for which I am responsible will be based on actual treatment. I understand my dental benefits may cover more or less than is estimated, if any. I understand that McMahon Family Dental has the capability to estimate my out-of-pocket cost of treatment based on an estimate of payment from my benefits. **Therefore, I understand that payment is expected in full at the time services are rendered, based on this estimate and that the final charge for which I am responsible may change based on treatment and on insurance payment (if any).**

Patients without dental benefits: I understand I am required to pay in full at the time services are rendered.

Patients with a Quality Dental Plan (QDP) Membership: I understand that this membership plan is offered in-office only and CANNOT be used in combination with any insurance benefits. I understand that I am required to pay in full at the time services are rendered. (For more information on QDP please see the front desk staff)

Any reference in this Patient Information packet or in any literature you receive from us to "we", "us", "our", "the Practice," "McMahon Family Dental," or similar language is considered to be a reference to John F. McMahon DDS, PLC.

All balances must be paid in full within 90 days to avoid being sent to collections.

Payment Plan Options

McMahon Family Dental accepts cash, checks, and all major credit cards as forms of payment. Payment plans are offered through our financing companies Lending Club and Care Credit. We have partnered with both companies to have a variety of options for our patients. A front desk coordinator can assist with the application process in office and brochures are available upon request.

Cancellation Guideline

We respect the importance of your time and work hard to schedule appointments that accommodate the scheduling needs of all of our patients. Broken and missed appointments create an inconvenience for other patients as well as our practice. As a result, we follow the model commonly used by many other dental practices in the area. If you find that you are unable to make your reserved appointment, we require, at minimum, a 2 business days' notice prior to your reserved appointment for any changes or cancellations. You may leave a message at any time, by calling (616) 457-2710. Starting August 1, 2019, there will be a $50 fee applied to the account for each appointment missed without a 2 business days' notice. We understand that emergencies do occur and we do not wish to penalize patients for unavoidable situations; in such situations we waive the first occurrence. We record all appointments, cancellations, and no-show appointments and discourage repeated abuse of our scheduling guidelines.

If you have any questions, please do not hesitate to ask. Thank you for your cooperation and understanding as we institute these guidelines. These guidelines will enable us to better serve the needs of all patients.

I have read and understand the above guidelines. I have the right to receive a copy of these signed forms upon request.

Signature of Patient or Guardian *Today's Date*

(see other side)

Notice of Social Security Number Privacy Policy

Privacy is important to our practice. We are required by law to maintain privacy of your Social Security number ("SSN") and to provide individuals with notice of our legal duties and privacy practices with respect to your SSN.

McMahon Family Dental ("we", "our") has adopted a Social Security Privacy Policy ("Policy"). That Policy provides information about how we may use and disclose your SSN. You may request a copy of the Policy at the front desk. We may change the terms of our Policy at any time. If we change our Policy, you may obtain a revised copy by contacting our office.

By signing this form, you consent to our use and disclosure of your SSN for our treatment, payment and health care operations and that you have had an opportunity to review the Policy. These policies are in compliance with the Michigan Social Security Privacy Act (MCLA 445.81, et. seq).

_____ _____

Signature of Patient or Guardian *Today's Date*

Authorization & Consent
To Send Unencrypted Patient Information by Email and Other Electronic Means

Until I tell you in writing to stop, I authorize McMahon Family Dental to transmit patient information relating to my treatment, health, or payment by email or other electronic means, without encryption or special security precautions, to me or someone I designate, or to other health care providers, health plans and others involved in my treatment, payment for my treatment, or McMahon Family Dental's health care operations. The patient information that may be emailed may include my x-rays, health history, diagnosis, treatment, and payment records.

I understand that:

- I do not have to sign this form.
- My treatment, payment, enrollment and eligibility for benefits will not be affected by my decision about signing this form.
- If I don't sign this form, McMahon Family Dental may use other ways to send my information, such as U.S. Mail, or may ask me to send my information to third parties myself.
- There is some risk that emails and other electronic messages may be improperly acquired by hackers or received by unintended recipients. If that happens, the information may be redisclosed and no longer protected by privacy law.
- McMahon Family Dental does not email such sensitive personal information as Social Security number, credit card number, mental health diagnosis, genetic information, alcohol/substance abuse, or positive HIV status unless the patient insists.

I can tell you in writing to stop emailing my patient information at any time, but if I do so, this will not affect emails that McMahon Family Dental already sent before receiving my written instructions to stop.

Patient name (print): _____

Signature: _____ Date: _____

(see other side)