McMurray Family Dental

2001 Waterdam Plaza Drive

Suite 203

McMurray, PA. 15317

Name:_____ Date:_____

Street Address:_____

City:_____ State:_____ Zip Code:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Best time to contact you?_____ Preferred phone?__ cell ____home____work

Date Of Birth:_____ Marital Status:_____ Social Security Number:_____

Emergency Contact Name:_____ Phone Number:_____

Pharmacy/Location:_____

Email:_____

Name of subscriber/Date of Birth:_____

Employer name of subscriber/insured:_____

Dental Insurance company:_____

ID number:_____ Group Number:_____

Name of secondary subscriber/insured:_____

Employer name of secondary subscriber/insured:_____

Secondary Insurance company:_____

ID Number:_____ Group Number:_____

Are you in good health? Yes____ No_____ Please explain:_____

_____

Please name ALL medications and supplements:_____

_____

_____

_____

_____

_____

_____

_____

_____

How did you find our practice? _____

Drug Allergies? _____ Latex Allergy?_____

Food or environmental allergies? _____

Have you ever had or have now:

Y	N		Y	N	
		ABNORMAL BLOOD PRESSURE			HEART MURMUR
		ANEMIA			HEPATITIS, TYPE:
		ANXIETY			HIV/AIDS
		ARTHRITIS			JAUNDICE
		ASTHMA			JOINT REPLACEMENT-OF?
		CANCER			KIDNEY DISEASE
		CELIAC DISEASE			LIVER DISEASE
		CHEMOTHERAPY			PACEMAKER
		CHEST PAINS			CURRENTLY PREGNANT
		CORONARY BLOCKAGE			PROLONGED BLEEDING OF MINOR CUT
		DIABETES-TYPE?			RADIATION
		DIFFICULTY BREATHING WHILE LAYING DOWN			RAPID WEIGHT LOSS AND GAIN
		DOCTOR LIMITS YOUR ACTIVITIES			RHEUMATIC FEVER
		EMPHYSEMA			SCARLET FEVER
		EPILEPSY			SINUS PROBLEMS
		FAINTING			STROKE
		FREQUENT NOSEBLEEDS			THYROID DISEASE
		FREQUENT OR BURNING URINATION			ULCERS
		GERD, STOMACH ULCERS			OTHER
		HAYFEVER			
		HEART ATTACK			

HAVE YOU BEEN FULLY VACCINATED FOR COVID-19? ____ YES ____ NO

SIGNATURE:_____

REASON FOR VISIT:_____

WHEN WAS YOUR LAST DENTAL EXAM?_____

HAVE YOU HAD ANY SERIOUS PROBLEMS WITH PAST DENTAL TREATMENT? IF SO PLEASE EXPLAIN:_____

DO YOU FLOSS YOUR TEETH? _____Y _____N HOW OFTEN?_____

DO YOU BRUSH YOUR TEETH? ___2 OR MORE TIMES A DAY ____MORNING ONLY ___BEDTIME ONLY ___LESS OFTEN

IS YOUR TOOTHBRUSH? __SOFT __MEDIUM ___HARD ___POWER BRUSH ___NOT SURE

DO YOUR GUMS BLEED? ___WHEN BRUSHING ___WHEN FLOSSING ___SOMETIMES ____NEVER

DO YOU AVOID BRUSHING, FLOSSING, OR CHEWING IN ANY PART OF YOUR MOUTH? IF YES, PLEASE EXPLAIN:_____

DO YOUR GUMS FEEL TENDER OR SWOLLEN? _____YES _____NO

ARE YOU OR YOUR SPOUSE AWARE OF YOU CLENCHING YOUR JAWS OR GRINDING YOUR TEETH? ___YES __NO

DO YOU HAVE NECK OR SHOULDER PAIN? ___YES ____NO

DO YOU WEAR DENTURES? ____YES ____NO PARTIALS? ___YES ___NO

DO YOU GAG EASILY? ____YES ____NO

DO YOU SMOKE? ___YES ___NO PLEASE CIRCLE: CIGARETTES CIGARS PIPE

DO YOU USE (PLEASE CIRCLE): SNUFF CHEW SMOKELESS TOBACCO VAPE

HAVE YOU HEARD ABOUT THE CONNECTION BETWEEN SMOKING AND PERIODONTAL (GUM) DISEASE? __YES __NO

ARE YOU FAMILIAR WITH THE LINK BETWEEN PERIODONTAL DISEASE AND MAJOR HEALTH PROBLEMS? __YES ___NO

IS THERE ANYTHING WITH YOUR SMILE THAT YOU WOULD LIKE TO CHANGE?_____

WHO CAN WE THANK FOR REFERRING YOU? HOW DID YOU FIND OUR OFFICE?_____

DO YOU NEED TO TALK PRIVATELY WITH THE DOCTOR BEFORE TREATMENT BEGINS TODAY? ___YES ___NO

PLEASE ADD ANYTHING YOU FEEL IS IMOPORTANT:_____

_____

TO THE BEST OF MY KNOWLEDGE, ALL THE PRECEEDING ANSWERS AND INFORMATION PROVIDED ARE TRUE AND CORRECT. IF I EVER HAVE ANY CHANGES IN MY HEALTH OR PERSONAL INFORMATION, I WILL INFORM THE DOCTOR AT MY NEXT APPOINTMENT.

_____ _____

SIGNATURE OF PATIENT, PARENT OR GUARDIAN DATE

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation if HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods, or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete, or modify any of these provisions to better serve the needs of both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____ date_____ do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

CONSENT FOR SERVICES AND FINANCIAL POLICY

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.

GENERAL:

Thank you for choosing our practice as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy, which we require you to read and sign prior to treatment. All patients must complete our information and insurance form before seeing the doctor.

WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, AMERICAN EXPRESS, DISCOVER, AND CARE CREDIT.

DENTAL INSURANCE:

Our office will gladly work with you to help get the maximum benefit available to you. Most dental insurance plans do NOT cover 100% of your cost of treatment. Therefore, you will be expected to pay your deductible and your ESTIMATED co-payment or co-insurance on the day services are rendered. We will gladly file your insurance claim. Many variables exist from carrier to carrier (IE deductibles, annual maximums, allowable fee limitations, non-covered procedures and other restrictions), therefore, we cannot guarantee any estimated charges. Because your insurance is an agreement between **YOU** and the insurance company, ultimately you are responsible for all charges. Please know that we will do everything possible to see that you receive the full benefits from your insurance company. If for some reason your insurance company has not paid their estimated portion within 90 days from the start of treatment, you are responsible for payment in full at that time. Treatment could be altered if your dental needs change. The patient will be notified of any change(s) in treatment. After a statement of accounts has been sent and a balance is left on the account after 90 days, the account will be sent over to collections for payment.

REGARDING INSURANCE PLANS WHERE WE ARE A PARTICIPATING PROVIDER

All **ESTIMATED** portions and deductibles are due prior to treatment. In the event **YOUR** insurance coverage changes to a plan where we are a non-participating provider, refer to above paragraph. You are responsible for advising this office if you have a change in your insurance coverage prior to your appointment.

USUAL AND CUSTOMARY RATES:

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

ADULT PATIENTS:

Adult patients are responsible for full payment at time of service.

MINOR PATIENTS:

The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to be approved by Visa/Mastercard, American Express, Discover, care credit, or payment by cash or check at time of service has been verified.

MISSED APPOINTMENTS:

We respectfully ask that you give us a minimum of 48 hours notice to cancel or reschedule your appointment. Please help us serve you better by keeping scheduled appointments.

AUTHORIZATION AND RELEASE: I authorize the dentist to release any information including diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or healthcare practitioners. I authorize and request my insurance company to pay directly to the dentist (if my insurance will allow it) or dental group insurance benefits otherwise payable to me. I understand that my insurance carrier my pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

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 agree to have any photos taken of me to be used for education, training, or marketing.

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: _____

McMurray Family Dental

2001 Waterdam Plaza Drive Suite 203

McMurray, PA. 15317

Medical Information Release Form

HIPAA Release Form

Name: _____ Date of Birth: _____

Release of Information

___ I authorize the release of information including diagnosis, records, examination rendered to me and claims information. This information may be released to:

___ Spouse: _____

___ Child(ren): _____

___ Other: _____

___ Information is not to be released to anyone.

Messages

Please call ___ home phone ___ work phone ___ cell phone

If unable to reach me:

___ you may leave a detailed message

___ please leave a message asking me to return your call

___ other: _____

The best time to reach me is: (day)_____ between (time) _____

Signature: _____ Date: _____