



**Welcome** to our practice family! We are so excited you chose us for your dental care!

Our passion at MacDonald Dental is to *inspire you to smile*, whether that is through relieving pain, prevention of dental problems, brightening your smile, or simply building relationship with our staff. A smile is a very powerful thing, and a healthy smile is even more valuable to your overall well-being. We are eager to make you feel comfortable, informed, and appreciated.

We invite you to check out our website, [www.macdonalddental.com](http://www.macdonalddental.com) here you will find more detailed information regarding your first appointment and what to expect. Our website will allow you to meet our caring staff and learn about our comprehensive approach to dentistry.

We encourage you to contact us if you have any questions prior to your appointment. We are looking forward to meeting you as well as taking care of your dental needs!

**This packet includes:**

- Patient Registration
- Medical History
- Dental History
- Financial Policy

Please fill out the included paperwork and bring it with you to your first appointment!

# PATIENT REGISTRATION

## PATIENT INFORMATION:

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Ext: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Birthdate: \_\_\_\_\_ Email: \_\_\_\_\_  
Sex:  Male  Female  
Marital Status:  Married  Single  Divorced  Separated  Widowed  
Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Referred By:  Family/Friend: \_\_\_\_\_  Google  Facebook  
 Yellow Pages  Insurance Company  Other: \_\_\_\_\_  
Previous Dentist: \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_  
Emergency Contact Phone Number: \_\_\_\_\_  
Preferred Pharmacy: \_\_\_\_\_  
Comments: \_\_\_\_\_

## RESPONSIBLE PARTY: Patient is: Responsible Party

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_  
Relation to patient: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Ext: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Birthdate: \_\_\_\_\_ Email: \_\_\_\_\_  
Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

## PRIMARY INSURANCE INFORMATION:

Dental Insurance Company: \_\_\_\_\_  
ID Number/Member ID: \_\_\_\_\_  
Policy Holder Name: \_\_\_\_\_  
Policy Holder Birthdate: \_\_\_\_\_  
Policy Holder's SSN: \_\_\_\_\_  
Policy Holder's Employer: \_\_\_\_\_  
Policy Holder's Address: \_\_\_\_\_  
Policy Holder's Zip Code: \_\_\_\_\_

## SECONDARY INSURANCE INFORMATION:

Dental Insurance Company: \_\_\_\_\_  
ID Number/Member ID: \_\_\_\_\_  
Policy Holder Name: \_\_\_\_\_  
Policy Holder Birthdate: \_\_\_\_\_  
Policy Holder's SSN: \_\_\_\_\_  
Policy Holder's Employer: \_\_\_\_\_  
Policy Holder's Address: \_\_\_\_\_  
Policy Holder's Zip Code: \_\_\_\_\_

## In Office Signatures:

I have read and understand the Notice of Privacy Practices and Authorization (HIPPA).

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Relationship to patient: \_\_\_\_\_

I give my consent to MacDonald Dental to notify/contact me via unencrypted email or text which may include personal health information. (ex: appointment reminders, notifications)

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Relationship to patient: \_\_\_\_\_

# MEDICAL HISTORY

Patient Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

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 medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

If you answer yes to the following questions, please explain on the blank provided.

	YES	NO
Are you under a physician's care now? _____	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been hospitalized or had a major operation? _____	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a serious head or neck injury? _____	<input type="checkbox"/>	<input type="checkbox"/>
Are you taking any medications, pills, or drugs? _____	<input type="checkbox"/>	<input type="checkbox"/>
If yes, please provide a <b>MED LIST</b> : _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you take, or have you taken Phen-Fen or Redux? _____	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever taken Fosamax, Boniva, Actonel, or any other medication containing bisphosphonates? _____	<input type="checkbox"/>	<input type="checkbox"/>
Are you on a special diet? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you use tobacco? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you use controlled substances? _____	<input type="checkbox"/>	<input type="checkbox"/>

\* Women, are you: (circle all that apply)    Pregnant    Trying to get pregnant    Taking oral contraceptives    Nursing

Are you allergic to any of the following?

Aspirin     Penicillin     Codeine     Local Anesthetics     Acrylic     Metal  
 Latex     Sulfa Drugs     Other    If yes, please explain: \_\_\_\_\_

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

	YES	NO		YES	NO		YES	NO
AIDS/HIV Positive	<input type="checkbox"/>	<input type="checkbox"/>	Cortisone Medicine	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>
Alzheimer's Disease	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A	<input type="checkbox"/>	<input type="checkbox"/>
Anaphylaxis	<input type="checkbox"/>	<input type="checkbox"/>	Drug Addiction	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B or C	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Easily Winded	<input type="checkbox"/>	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	<input type="checkbox"/>
Angina	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis/Gout	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy or Seizures	<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Heart Valve	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Hives or Rash	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Joint	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Thirst	<input type="checkbox"/>	<input type="checkbox"/>	Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Fainting Spells/Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Irregular Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Cough	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>
Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Leukemia	<input type="checkbox"/>	<input type="checkbox"/>
Breathing Problem	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Bruise Easily	<input type="checkbox"/>	<input type="checkbox"/>	Genital Herpes	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>
Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack/Failure	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Cold Sores/Fever Blisters	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Pain in Jaw Joints	<input type="checkbox"/>	<input type="checkbox"/>
Congenital Heart Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Heart Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Parathyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	Heart Trouble/Disease	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Care	<input type="checkbox"/>	<input type="checkbox"/>
						Radiation Treatments	<input type="checkbox"/>	<input type="checkbox"/>
						Recent Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>
						Renal Dialysis	<input type="checkbox"/>	<input type="checkbox"/>
						Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
						Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>
						Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>
						Shingles	<input type="checkbox"/>	<input type="checkbox"/>
						Sickle Cell Disease	<input type="checkbox"/>	<input type="checkbox"/>
						Sinus Trouble	<input type="checkbox"/>	<input type="checkbox"/>
						Spina Bifida	<input type="checkbox"/>	<input type="checkbox"/>
						Stomach/Intestinal Disease	<input type="checkbox"/>	<input type="checkbox"/>
						Stroke	<input type="checkbox"/>	<input type="checkbox"/>
						Swelling of Limbs	<input type="checkbox"/>	<input type="checkbox"/>
						Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
						Tonsillitis	<input type="checkbox"/>	<input type="checkbox"/>
						Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
						Tumors or Growths	<input type="checkbox"/>	<input type="checkbox"/>
						Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
						Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/>
						Yellow Jaundice	<input type="checkbox"/>	<input type="checkbox"/>

Have you every had any serious illness not listed above? \_\_\_\_\_

Comments: \_\_\_\_\_

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or the patient's) health. It is my responsibility to inform the dental office of any changes in my medical status.

Signature of Patient, Parent, or Guardian \_\_\_\_\_ Date: \_\_\_\_\_

# DENTAL HISTORY

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

How would you rate the condition of your mouth?    Excellent                      Good                                      Fair                                      Poor

Previous Dentist: \_\_\_\_\_ How long have you been a patient? \_\_\_\_\_

Date of most recent dental exam: \_\_\_\_\_ Date of most recent x-rays: \_\_\_\_\_

Date of most recent treatment (other than cleaning): \_\_\_\_\_

I routinely see the dentist every:    3 months                      4 months                      6 months                      12 months                      Not routinely

What is your immediate concern? \_\_\_\_\_

Please answer yes or no to the following:

YES NO

## Personal History

1. Are you fearful of dental treatment? How fearful on a scale of 1 (least) to 10 (most)? \_\_\_\_\_
2. Have you had an unfavorable dental experience? \_\_\_\_\_
3. Have you had complications from past dental treatment? \_\_\_\_\_
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? \_\_\_\_\_
5. Did you ever have braces, orthodontic treatment or have your bite adjusted? \_\_\_\_\_
6. Have you had any teeth removed? \_\_\_\_\_

## Smile Characteristics

1. Is there anything about the appearance of your teeth you would like to change? \_\_\_\_\_
2. Have you ever whitened (bleached) your teeth? \_\_\_\_\_
3. Have you felt uncomfortable or self-conscious about the appearance of your teeth? \_\_\_\_\_
4. Have you been disappointed with the appearance of previous dental work? \_\_\_\_\_

## Bite & Jaw Joint

1. Do you have problems with your jaw joint? (pain, sounds, limited opening, lock popping) \_\_\_\_\_
2. Do you/would you have any problems chewing gum? \_\_\_\_\_
3. Do you/would you have any problems chewing bagels, baguettes, protien bars, or, other hard foods? \_\_\_\_\_
4. Have your teeth changed in the last 5 years, become shorter, thinner or worn? \_\_\_\_\_
5. Are your teeth crowding or developing spaces? \_\_\_\_\_
6. Do you have more than one bite and squeeze to make your teeth fit together? \_\_\_\_\_
7. Do you chew ice, bite your nails, use your teeth to hold objects or have any other oral habits? \_\_\_\_\_
8. Do you clench your teeth in the daytime or do they become sore? \_\_\_\_\_
9. Do you have any problems with sleep or wake up with an awareness of your teeth? \_\_\_\_\_
10. Do you wear or have you ever worn a bite appliance? \_\_\_\_\_

## Tooth Structure

1. Have you had any cavities within the past 3 years? \_\_\_\_\_
2. Does the amount of saliva in your mouth seem too little or do you have any difficulty swallowing any food? \_\_\_\_\_
3. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? \_\_\_\_\_
4. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth? \_\_\_\_\_
5. Do you have any grooves or notches on your teeth near the gum line? \_\_\_\_\_
6. Have you ever had broken teeth, chipped teeth, or had a toothache, or cracked filling? \_\_\_\_\_
7. Do you frequently get food caught between any teeth? \_\_\_\_\_

## Biology

1. Do your gums bleed or are they painful when brushing or flossing? \_\_\_\_\_
2. Have you ever been treated for gum disease or been told you have lost bone around your teeth? \_\_\_\_\_
3. Have you ever noticed an unpleasant odor in your mouth? \_\_\_\_\_
4. Is there anyone with a history of periodontal disease in your family? \_\_\_\_\_
5. Have you ever noticed gum recession? \_\_\_\_\_
6. Have you ever had any teeth become loose on their own (no injury), or do you have difficulty eating an apple? \_\_\_\_\_
7. Have you experienced a burning sensation in your mouth? \_\_\_\_\_

# FINANCIAL POLICY

This agreement is to inform you of your financial obligation to our practice. This financial agreement is intended to facilitate our ability to provide excellent service to you while minimizing our administrative costs.

## Insurance

As a courtesy to you, we will help you process all your insurance claims. In order for our practice to file your insurance claim, you must provide proof of insurance either with a card or information provided to the office when setting up the appointment. **All charges you incur are your responsibility regardless of your insurance coverage.**

## Payment Due at Time of Service

Our policy is: **"Payment Due at Time of Service"**. Your **estimated** co-payment for treatment, which is the amount not covered by insurance, is due at the time treatment is provided. Your **estimated** co-payment may be adjusted after the time of treatment depending on the final reconciliation of insurance payments. If you do not have insurance, we expect **full payment** for service at each office visit.

We accept these forms of payment:

Cash - Check - Master Card - Visa - Discover - American Express - Care Credit

## Payment Plans

Our office is able to offer a three month payment plan option. You are eligible for a payment plan if you are a **patient on record**, have shown **good credit**, and if your total balance exceeds **\$500**. Our policy for a payment plan is to only accept **post-dated checks** or a **valid credit card number** to draw from on a specified day of each month. The checks or card information must be given at the time of service. If your treatment exceeds the cost of \$1000, fifty percent will be the expected payment at the time of service. The remaining balance can then be processed on a payment plan.

## Interest

Returned checks and balances older than 90 days will be subject to collection fees and charges at the rate of 1.5% per month (18% annually).

Please don't hesitate to ask if you have any questions regarding this financial agreement. We are committed to providing you with the ultimate experience in dental care, but need your financial commitment as well.

**Print name of patient or responsible party** \_\_\_\_\_ Date: \_\_\_\_\_

**Signature of patient or responsible party** \_\_\_\_\_ Date: \_\_\_\_\_

## Appointment Policy

I understand the cancellation policy which states "Reserved times cancelled within 48 hours are subject to a \$50.00 cancellation fee". An appointment cancelled within 48 hours limits our ability to fill the time with a patient in need. We appreciated your understanding and working with us to avoid this scenario.

**Signature of patient or responsible party** \_\_\_\_\_ Date: \_\_\_\_\_