Patient Information

Patient Name: _____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other_____

Social Security #: _____ Birth Date:_____

Phone (Home): _____ (Work): _____ Ext: _____ (Cell):_____

E-Mail Address:_____

Address: _____
Street Apartment #

_____
City State Zip Code

Health Information

Have you ever had any of the following? Please check those that apply:

☐ AIDS
☐ Allergies_____
_____
☐ Anemia
☐ Arthritis
☐ Artificial Joints/Premed
☐ Asthma
☐ Blood Disease
☐ Cancer Type_____
☐ Codeine Allergy
☐ Diabetes Type_____
☐ Dizziness
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur/Premed
☐ Hepatitis Type_____
☐ High Blood Pressure
☐ Jaundice
☐ Joint Replacement/Premed
☐ Kidney Disease
☐ Latex Allergy
☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Nickel Allergy
☐ NSAID Allergy
☐ Pacemaker
☐ Penicillin Allergy
☐ Pregnant ☐ Yes ☐ No
Due date:_____
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever/Premed
☐ Rheumatism
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke (Year_____)
☐ Thyroid ☐ Hyper ☐ Hypo
☐ Tuberculosis Type_____
☐ Ulcers
☐ Venereal Disease
☐ Other_____
_____
_____
_____
_____
_____

Please list all prescription medications, over-the-counter medications, or herbal supplements that you are currently taking.

_____
_____

• Name of Physician: _____ Phone: _____ Fax: _____

Referral Information

Whom may we thank for referring you to our practice?

☐ Another Patient
☐ Another Doctor
☐ Insurance
☐ Newspaper
☐ Radio
☐ Website/Internet

Name of source referring you to our practice: _____

HIPAA

Effective April 14, 2003 the new federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that this office comply with certain rules regarding the maintenance of the privacy of your information that we have collected and will collect in the future.

To comply with one of HIPAA's requirements, we are giving you a copy of our Notice of Privacy practices, which contains information that HIPAA requires us to disclose regarding our privacy practices.

Existing Michigan law requires (in addition to our attempt to obtain your written acknowledgement, discussed above) us to first obtain your written consent prior to disclosing any of your information except for our disclosures in connection with: a defense to a claim challenging our professional competence; a review of entity's functions; a claim for payment of fees; a third party payer's examination of our records; a court order as part of a criminal investigation; an identification of a dead body; a licensure investigation; or a child abuse/neglect investigation.

Occasionally it may be necessary for us to make disclosures of your information in connection with your treatment. For example, we may make a referral to or consult with another dentist or other health care professional, provide a specimen to a laboratory testing or otherwise make disclosures of your information in connection with providing or coordinating your treatment.

Assignment of Insurance Benefits, Payment Policy, and Payment Options

The policy of MCDental Care, PLLC is to be paid directly by your insurance company. By signing the Consent for Services, you authorize direct payment to MCDental Care, PLLC and assume responsibility of all non-covered services or provider charges that may exceed insurance payment.

_____Our payment policy is as follows:
Initial

- **Payment is required the day services are rendered.**
- **Returned checks are subject to a $30 NSF fee and may be subject to an additional collection fee.**
- **Balances over 30 days may be subject to additional collection action.**
- **All accounts not paid within 90 days will be sent to a collection agency.**

For your convenience, we offer several payment options. Please read the following information:

- **Cash or Check.**
- **Visa, MasterCard, or American Express.**
- **Interest-free or extended financing through CareCredit or CapitalOne Healthcare Finance.**

Credit balances on your MCDental Care, PLLC account are subject to reimbursement. A check will be issued by MCDental Care, PLLC within thirty days of your request for a refund. However, processing/transaction fees will be deducted from any refund in which credit balances occur due to a personal overpayment by credit card, CareCredit, or CapitalOne Healthcare Finance.

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. This dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1 ½% per month (18% annum) on any unpaid balance will be charged to the patient on all accounts exceeding 30 days past due, unless written financial arrangements are satisfied.

_____MCDental Care, PLLC can only estimate insurance payments and laboratory costs. All dental services not paid by
Initial insurance are charged directly to the patient. Any unpaid balance, as well as attorney fees, court costs, and collection costs incurred by collection and enforcement of a debt are the responsibility of the patient.

Cancellation Policy

_____MCDental Care, PLLC requests 48 hours notice to reschedule an appointment. If two appointments are cancelled or no
Initial showed without 48 hours notice within a 12 month period, MCDental Care, PLLC will place you on a call list in which you will be contacted when an opening occurs. Three appointments without 48 hours notice within a 12 month period will result in permanent dismissal from the practice.

Patient Acknowledgement and Consent for Services

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

I have had full opportunity to read and consider the contents of this form and your Notice of Privacy practices. I understand that by signing below, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

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 have read the above conditions of treatment and payment and agree to their content.

_____ Date:_____
Signature of patient, parent or guardian

_____ Date:_____
Signature of dentist/hygienist