1. About you

Today's Date:_____

Name: _____

I prefer to be called:_____ ❑ Male ❑ Female

Birthdate: _____

SS# _____

Home Address_____

_____

Home #: _____ Cell # _____

Work #: _____

Email Address:_____

Employer: _____

Occupation: _____ _____

Where & when are the best times to reach you?_____

_____

How did you learn about our office? _____

_____

Previous/Present Dentist: _____

Last Visit Date: _____

2. Spouse Information

His/Her Name:_____

Employer: _____

Wk # _____ SS #: _____

Birthdate: _____

Person Responsible for Account_____

Wk # _____ SS #: _____

Billing Address: _____

Relationship:_____

Employer: _____

Dr's. McDonald and Gruchalla, DDS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____

SIGNATURE **DATE**

BROKEN APPOINTMENTS: If you must change your appointment we require at least 24 hours notice to avoid a cancellation fee.

3. Dental Insurance

Primary Insurance

Insurance Co. Name:_____

Insurance Co. Address: _____

_____

Insurance Co. Phone #:_____

Group, ID, Policy #'s _____

_____

Insured's Name: _____

Insured's Birthday:_____

Insured's SS # _____

Insured's Employer:_____

Secondary Insurance

Insurance Co. Name:_____

Insurance Co. Address: _____

_____

Insurance Co. Phone #:_____

Group, ID, Policy #'s _____

_____

Insured's Name: _____

Insured's Birthday:_____

Insured's SS # _____

Insured's Employer:_____

Financial Policy

Payment is due at time of service unless prior arrangements have been approved.

- 5% discount on services paid by cash or check at time of service.
- 3% discount on services paid by Visa, MasterCard or Discover at time of service.
- Care Credit Card – Interest free payment option.

I assign directly to Dr's. McDonald and Gruchalla all insurance benefits, otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. **I am responsible for knowing my insurance benefits and yearly maximum amounts as stated in my insurance contract.** I hereby authorize Dr's. McDonald and Gruchalla to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

I have read the above Financial Policy and agree to adhere to it regarding my financial obligation for services rendered.

_____

Signature Date

Dental History

Why have you come to the dentist today?

_____

_____

_____

Are you currently in pain?

_____

_____

_____

Have you ever had a serious/difficult problem associated with dental work?

_____

_____

_____

Do you feel your current dental health is: ❑ Good ❑ Fair ❑ Poor

Do your gums ever bleed? ❑ Yes ❑ No

Have you ever been told you have periodontal disease? ❑ Yes ❑ No

Have you had your wisdom teeth removed? ❑ Yes ❑ No

Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? ❑ Yes ❑ No

Is there anything you would like to improve about your smile?

_____

_____

_____

Medical History

Do you have a personal physician? ❑ Yes ❑ No

Physician's name: _____

Date of last visit: _____

Are you currently under the care of a physician?

❑ Yes ❑ No

Please explain: _____

_____

Do you require antibiotics before dental work?

❑ Yes ❑ No _____

Have you ever been treated for osteoporosis or bone cancer? ❑ Yes ❑ No

Are you taking any prescription or over the counter drugs? ❑ Yes ❑ No

Please list each one: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Please list any allergies:

_____

_____

_____

_____

_____

I understand that the health information that I have given is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status. I also authorize the dental staff to perform any necessary dental services that I may need with my informed consent during diagnosis and treatment.

_____

Signature Date

Update:

Intitial: _____Date: _____

Intitial: _____Date: _____

Intitial: _____Date: _____

Intitial: _____Date: _____

Intitial: _____Date: _____

In the event of an emergency is there someone who lives near you we should contact?

Their Name: _____

Relationship: _____

Wk#: _____ HM/Cell#: _____

Please circle if you have or have had the following:

Y N Abnormal Bleeding
Y N Alcohol Abuse
Y N Anemia
Y N Arthritis
Y N Artificial Joints- when placed? _____
Y N Artificial Heart Valves
Y N Asthma
Y N Cancer/Chemotherapy/Radiation
Y N Colitis
Y N Congenital Heart Defect- corrected? _____
Y N Diabetes
Y N Difficulty breathing
Y N Drug Abuse
Y N Eating Disorder
Y N Emphysema
Y N Epilepsy/Seizures
Y N Fainting Spells
Y N Frequent Headaches
Y N Glaucoma
Y N Heart Attack- when? _____
Y N Heart Murmur (Rheumatic Fever/Scarlet Fever)
Y N Heart Surgery- when? _____
Y N Hemophilia
Y N Hepatitis Type? _____
Y N High Blood Pressure
Y N High Cholesterol
Y N HIV / AIDS
Y N Kidney Problems
Y N Liver Disease
Y N Low Blood Pressure
Y N Autoimmune Disease (MS, Lupus, Rheumatoid Arthritis, Sjogrens, etc)
Y N Pacemaker- when? _____
Y N Persistent Cough
Y N Pregnant/Nursing
Y N Psychiatric Problems
Y N Sickle Cell Disease/Traits
Y N Sinus Problems
Y N Steroid Therapy
Y N Stroke- when? _____
Y N Thyroid Problems
Y N Tobacco use - interested in quitting? ❑ Yes ❑ No
Y N Tuberculosis (TB) - when? _____
Y N Ulcers

Please list any serious medical condition(s) that you have experienced: _____

_____

_____

_____